Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Bristol Safeguarding Children Board Annual Report	
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Report for Information/Discussion/ Decision [delete as appropriate]	

1. Purpose of this Paper

Fulfil the statutory requirement for the Health and Wellbeing Board to receive a copy of the Bristol Safeguarding Children Boards Annual Report.

2. Executive Summary

The full Annual Report is provided with this paper as required under legislation.

Key areas for discussion are:

- National changes to Local Safeguarding Children Board arrangements
- Learning from recent Serious Case Reviews
- Mental Health provision for children in Bristol
- Commissioning of school nursing
- Commissioning of services which are accessible for fathers
- Responding to violence in families
- Safeguarding Disabled Children
- Neglect strategy

3. Context

Local Safeguarding Children Boards (LSCBs) are required in every Local Authority are under the Children Act 2004. The LSCB is independent and is not subordinate to, nor subsumed within, other local structures. One function of the LSCB is the production of an Annual Report which sets out transparently the performance and effectiveness of local services in safeguarding children. This must be submitted to the Health and Wellbeing Board Chair and other key decision makers as set out in “Working Together to Safeguard Children” HM Gov 2015. “Working Together” also sets out the expectation that the Health and Wellbeing Board provides the Joint Strategic

Needs Assessment to the LSCB to inform their response and oversight of services for vulnerable children. This paper is being submitted along with the 2016-2017 Bristol Safeguarding Children Board (BSCB) Annual Report. This report was sent to the Chairs of the Health and Wellbeing Board when it was completed last summer however due to the changes to the Health and Wellbeing Board it has only now been possible to bring it to the Board.

The legislation that underpins Safeguarding Children is currently changing. The Children and Social Work Act 2017 received Royal Assent April 2017, abolishes the requirement for Local Safeguarding Children Boards (LSCBs) and provides permissive legislation to allow the partnership to develop arrangements that best suit the area. Responsibility for LSCBs currently rests with the local authority working with partners. New arrangements will be a shared responsibility between Local Authorities, Police Constabulary and Clinical Commissioning Groups. Models are currently being considered including opportunities for closer working across the region and better working between the existing strategic partnerships in the city. This is an opportunity for the HWB and BSCB partners to consider what safeguarding arrangements best suit Bristol in improving outcomes for children and families. The new legislation is currently expected to require arrangements to be independently audited and fully implemented in localities by July 2019.

4. Main body of the report

Safeguarding Arrangements in Bristol:

The Annual Report highlighted concerns about the safeguarding of disabled children in the city. The numbers of disabled children on child protection plans is disproportionately low for the number and vulnerability of this group. We are concerned that these areas of practice need greater focus to identify the abuse and neglect of disabled children.

The report also highlights that there is a significant number of repeat Child Protection Plans and Child Protection Plans which are open for excessively long times. This raises concerns that there are children exposed to abuse and neglect in the city for too long and that interventions have not been effective at reducing risk. The BSCB is monitoring the impact of the Transformation programme in the Local Authority to seek assurance on this issue.

Furthermore we are concerned that the number of referrals to the Local Authority Designated Officer in recent years has been very low for health staff. Organisations and commissioners need to ensure there are robust procedures in place to enable concerns about health professionals to be identified and responded to.

Recent information brought to the BSCB in 2017-18 has escalated our concerns about the provision of mental health services for adolescents in Bristol. We understand there are not sufficient places of safety and that children are inappropriately being taken to emergency departments when in mental health crisis. We are also deeply concerned about the findings of the

inquest into Rebecca Romero's death which found organisation neglect due to lack of resourcing of mental health services contributory to her death. We would request that child mental health services and resolving these resourcing concerns is an urgent priority of the HWB.

Performance data provided to the BSCB has also indicated that the safeguarding and provision of services for boys and young men is not as effective as that provided to girls and young women. The identification of males as vulnerable is an area of concern, with a low proportion of males being identified as victims of sexual exploitation or sexual abuse, and high numbers of young adolescent males entering the care system in middle adolescence suggesting that early intervention and family support strategies are not as effective in safeguarding them. There is also evidence of an attainment gap within education settings for boys and young men. The BSCB will be taking a strategic lead on this area in 2018-19 however we request the support of all agencies and partnerships to consider the outcomes of boys and young men, and how we can ensure equality of access.

Serious Case Reviews:

Our 2016-2017 Annual Report highlights progress made in increasing scrutiny of the safeguarding system in Bristol. We published one Serious Case Review in this period in response to Operation Brooke, a high profile criminal investigation which resulted in the prosecution of 18 men for sexual exploitation offences against children in the city. The findings of this review highlighted the importance of commissioning integrated health and social care services to respond to complex adolescent risk and need, and the necessity for responsive policing that does not rely on victim disclosure. There has been significant progress made in these areas as outlined fully in the report.

Since the Annual report we have published three further Serious Case Reviews [ZBM, Baby L and Aya]. Two of these reviews concerned the death of children as a result of maternal mental ill health in the perinatal period. The commissioning of a specialist perinatal service in Bristol has improved access to specialist support for some of these mothers. However the Board remains concerned about the coordination of care between adult and children services. The Aya Serious Case Review identified concerns that the commissioned universal midwifery and health visiting services are not sufficiently resourced or structured to support the engagement of fathers as required through the Healthy Child Programme. This issue has yet to be resolved and we would ask that the HWB consider the accessibility of services for fathers and working parents within all commissioned services for children and families as this is repeat finding in the city.

Joint Targeted Area Inspection:

Bristol organisations were subject to a Joint Targeted Area Inspection (JTAI) into abuse and neglect in October 2017. The Inspection team is made up of CQC, HMI Constabulary, Ofsted and HMI Probation. This inspection praised

the work of the BSCB in identifying issues and facilitating a robust partnership approach, particularly with the effectiveness of young people being central to this model. The JTAI raised issues that are relevant to the HWB. These are particularly due to concerns that the school nursing and health visiting services were not sufficiently resourced or able to meet their statutory health checks. This is an ongoing issue for the safeguarding of children in the city.

In response to the JTAI the BSCB has produced a Neglect Strategy for Bristol. Key health and wellbeing areas identified as requiring improvement are a reduction in the number of obese children and a reduction in the number of children with dental caries. We would ask that progress in these areas overseen by the HWB is reported to the BSCB. Furthermore we identify that wellbeing services for adults, particularly adult mental health services, need to be commissioned and designed to facilitate closer working with children's services and would ask that this is considered in commissioned discussions and approaches.

5. Key risks and Opportunities

The development of new safeguarding arrangements is both a risk and an opportunity in the city. We need to ensure that cross-cutting issues such as domestic abuse, exploitation, mental health and adverse childhood experiences, have clear strategic governance across the services.

To build the two partnership's scrutiny roles we would welcome the development of some key measure or indicators, and the development of a shared mental health dashboard that minimises duplication but supports the functions of the BSCB, Bristol Safeguarding Adults Board and HWB.

6. Implications (Financial and Legal if appropriate)

The Children and Social Work Act 2017 also has implications for the Child Death Overview Panel. This is a national requirement and Bristol is a member of the West of England CDOP. Responsibility for CDOP will transfer from the local authority to health and current funding and other arrangements will need to be reviewed as the role for LSCBs in connection with CDOP is removed.

7. Evidence informing this report.

What evidence have you used to inform:

- Evidence of need and the case for change (eg. **JSNA,** activity data, patient feedback, national directive etc)

- Evidence of effectiveness of proposed solution/initiative/new service

The BSCB Annual Report includes evidence from multi agency data sets, audits, serious case reviews, practitioner events, national research and consultation with children.

8. Conclusions

Many of the City Partnerships are undergoing a time of change. The potential and required changes to the BSCB, as an independent Board, are significant and the HWB needs to be sighted on and assured that any new arrangements have a positive impact upon the important working relationships between these strategic arrangements and the shared responsibilities with the HWB.

There are key areas relevant to the commissioning and delivery of health and wellbeing services that are impacting the effectiveness of safeguarding of the children in Bristol. I am respectfully requesting the HWB take particular focus of these areas in their strategic plan.

9. Recommendations

1. The HWB reviews the place of safety arrangements for under 18s in mental health crisis
2. The HWB reviews the commissioning of mental health provision for children to ensure that acute and early intervention services are sufficient resourced
3. The HWB develops a shared partnership dataset with the BSCB and BSAB in respect of mental health services
4. HWB focus on child obesity and health inequalities is understood in the context of neglect and responded to in line and as part of the BSCB Bristol Neglect Strategy
5. HWB maintains oversight as to the effectiveness of services to meet the needs of disabled children and identification of abuse and neglect in this group

10. Appendices

Bristol Safeguarding Children Board Annual Report 2016-2017