Bath & North East Somerset Community Safety & Safeguarding Partnership

Annual Report

2023-2024

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1. Welcome from Fiona Field, the Independent Chair of the B&NES Community Safety & Safeguarding Partnership

Welcome to the integrated annual report for BCSSP. The report covers children, adults and community safety issues for 2023-2024. This has been a challenging year in different ways for all partners of the BCSSP, but everyone has continued their support to the work of the Board and sub groups as evidenced within this report.

I have now been the Independent Chair for a full 12 months in BCSSP. I have led the development of a different approach for the Board in order to streamline work and clarify what our priorities need to be for the next 3 years. This work has involved all partners in the development of a new strategy for 2024-2027 and I thank everyone for their enthusiasm and willingness during 2023 as we developed our new direction.

During 2023, the Government published new Working Together 2023 guidance for children's services, following consultation. In planning our new approach to safeguarding and community safety through our integrated Board, we needed to ensure we were compliant with the Working Together requirements. The new structure in place from April 2024 gives a sharper focus to children's safeguarding and local leadership across partners. The structures in place still support our integrated partnership approach at strategic level to all safeguarding and community safety priorities but also create specific sub groups to scrutinise and challenge the delivery of local children and young peoples' services.

This report describes some of the learning that has taken place following a review of a child or vulnerable adult when potential harm may have been caused. It is a statutory part of our work to hold a review, but most importantly, it gives all partners opportunity to challenge each other in order to improve local services and avoid a similar situation happening again. Often, when family members have been involved in the review, the thing they tell us they most want to happen is that the same situation does not recur for another family. I would like to thank all the family members who have helped in the reviews described in this report, their experiences are invaluable to our learning and our ability to change and improve services.

The statistical information in the report shows concerns and safeguarding referrals have continued to rise locally - this is in line with national trends.

We can see that in both children's and adults' data, neglect, psychological neglect and self-neglect were the highest reasons for concerns being raised. This is not a good news story, but a raised level of referrals does demonstrate that awareness of safeguarding and reporting concerns is happening at earlier stages. We know that early interventions can make more of a positive difference to outcomes for families and individuals.

Unfortunately, we can also see that concerns about safeguarding are happening for adults in the residential and nursing home sector.

However, it is positive to see the fall in the number of child sexual exploitation figures in 2023-24 that can be partially explained by greater awareness of the issues in the community and amongst staff working with children.

The BCSSP will continue to carry out the statutory duties across 3 areas of work – children, adults and community safety. We recognise that we want to continue to have an integrated approach as much as possible but also be able to focus on specific pieces of work as identified in the new strategy.

I commend this report to you and hope you find it informative and engaging.

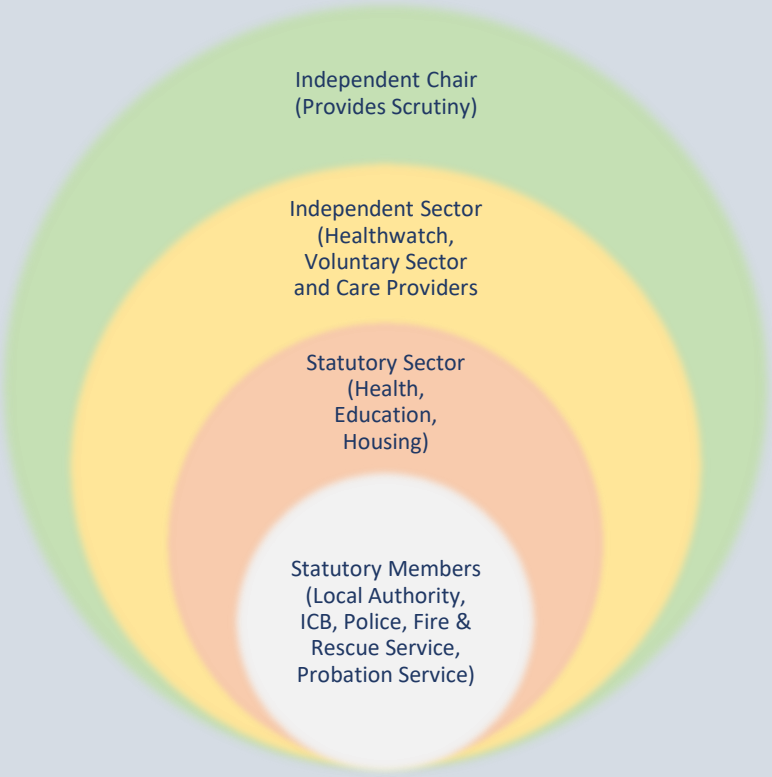
Fiona Field.

Independent Chair of BCSSP.

2. About the B&NES Community Safety & Safeguarding Partnership

Safeguarding is everyone's business.

The BCSSP is made up of the five statutory agencies with responsibility for safeguarding and community safety; B&NES Council, Avon and Somerset Constabulary, the B&NES Swindon and Wiltshire Integrated Care Board, Avon Fire & Rescue Service, the Probation Service and other statutory organisations (e.g. Health and Care providers) as well as independent sector organisations (e.g. Voluntary groups) to enable us to work effectively and with joint purpose to protect children, adults, families and communities who most need our help.



Partners in B&NES continue to work together to identify and respond to the needs of children, adults at risk and communities, with the core purpose of:

Safeguarding and promoting the welfare of children
Safeguarding adults with care and support needs
Protecting local communities from crime and helping people feel safer
Ensuring the effectiveness of what partners do both individually and together.

How we work

We work in **partnership** to safeguard children, young people and adults at risk; ensuring that effective systems are in place to promote their wellbeing.

We **support communities** to live free from the fear of crime and anti-social behaviour, enhancing the overall safety of communities.

We **listen** to people who use our services, professionals and our communities to keep learning.

We **learn** from case reviews to improve services.

What we do

Through our collective arrangements, we:

- Seek to ensure that the partnership delivers enhanced safeguarding arrangements across B&NES
- Strengthen the voice of children, families, adults at risk and communities
- 'Think Family, Think Community'
- Improve strategic decision making and leadership by having one cohesive conversation
- Focus on shared strategic objectives to achieve the greatest impact and improve outcomes for children, adults, families and the community
- Reduce duplication, therefore enabling us to use resources more effectively.

Our Statutory Duties

As the BCSSP was formed from merging three different statutory areas of work, we must ensure that our practice is compliant with the responsibilities set out in the legal frameworks for each of these areas.

Community Safety:

Community Safety Partnerships (CSPs) aim to reduce crime and the fear of crime, address risk, threat and harm to victims and local communities and facilitate the empowerment and strengthening of communities through the delivery of local initiatives. CSPs are a statutory body required under the Crime and Disorder Act 1998 (and subsequent amendments). The 'relevant authorities' that form the CSPs are the Local Authority, Police, Health, Probation and the Fire and Rescue Service.

Their function is to:

- Act as a legal body for CSP work, ensuring compliance with statutory duties and addressing community safety issues
- Ensure systems and processes are in place amongst partners to deliver their duties and address arising issues
- Set priorities, determine policy and strategic direction.

Safeguarding Children:

Working Together to Safeguard Children 2023 sets out that the three safeguarding partners should agree on how to co-ordinate their safeguarding services, act as a strategic leadership group in supporting and engaging others and implement local and national learning, including from serious child safeguarding incidents.

Safeguarding arrangements must include:

- Arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area
- Arrangements for commissioning and publishing local child safeguarding practice reviews
- Arrangements for independent scrutiny of the effectiveness of the arrangement.

Safeguarding Adults:

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

The overarching purpose of is to help and safeguard adults with care and support needs. The BCSSP should:

- Assure itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- Assure itself that safeguarding practice is person-centred and outcome-focused, working collaboratively to prevent abuse and neglect where possible
- Ensure agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- Assure itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

3. Partnership Structure

In 2022, the BCSSP commissioned the LGA to undertake an independent review of our partnership arrangements, which highlighted many strengths and some recommendations for change. In response to the recommendations, we reviewed the composition of the partnership to ensure effective involvement at an appropriate level. It was also noted that the structure (Fig.1 current structure) of the partnership was creating some challenges regarding clarity for accountability and focus, and in consultation with our partners we have developed a new structure, as set out below in Fig.2, which will be implemented on 1st April 2024. We know that to continue to improve we need committed, consistent senior leadership; the right level of engagement and resources from partner organisations; and the right governance structure and arrangements. This includes a precise approach to the sharing of relevant qualitative and quantitative information, enabling us to improve our proactive approach to holding agencies to account. We also need to be cited on related risks agencies are responding to that may impact upon community safety and safeguarding.

Fig. 1 Current Structure

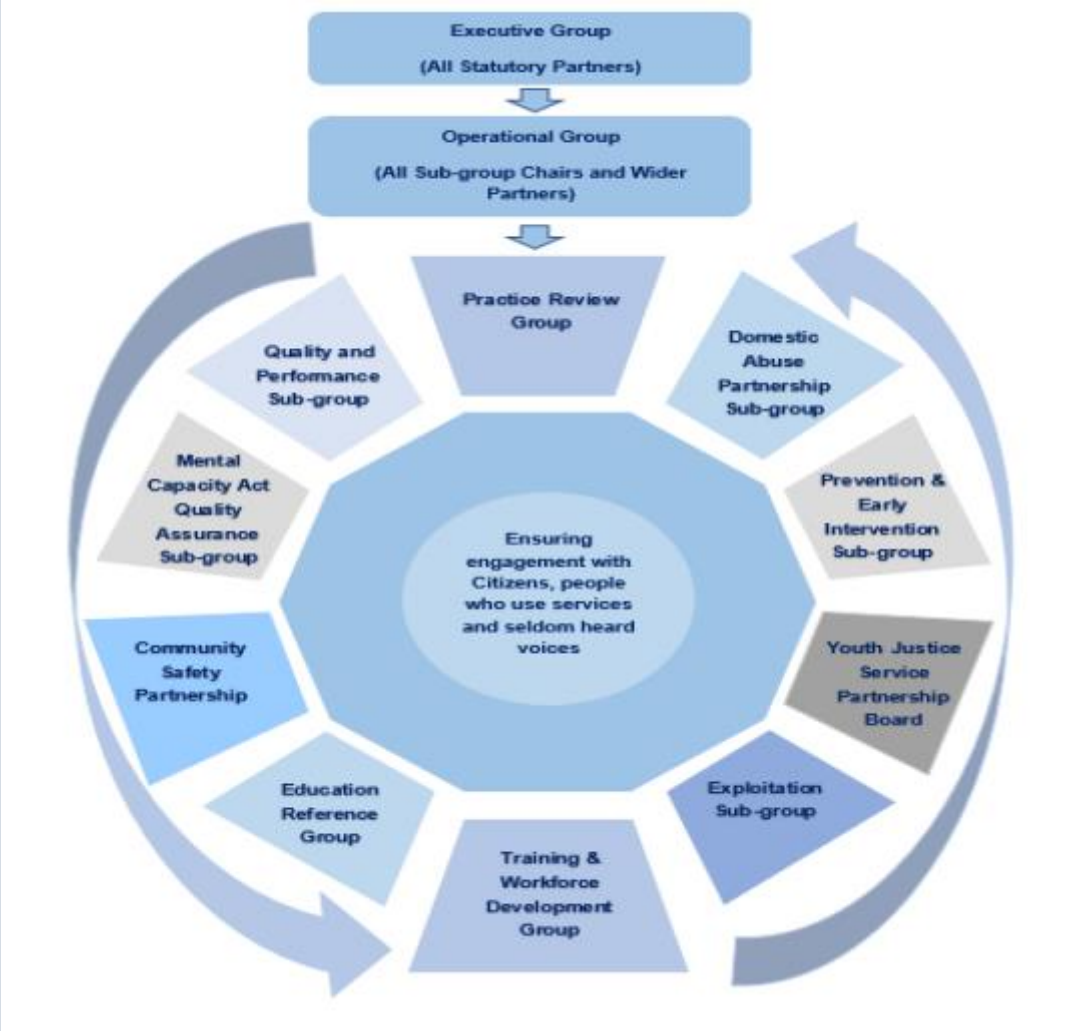
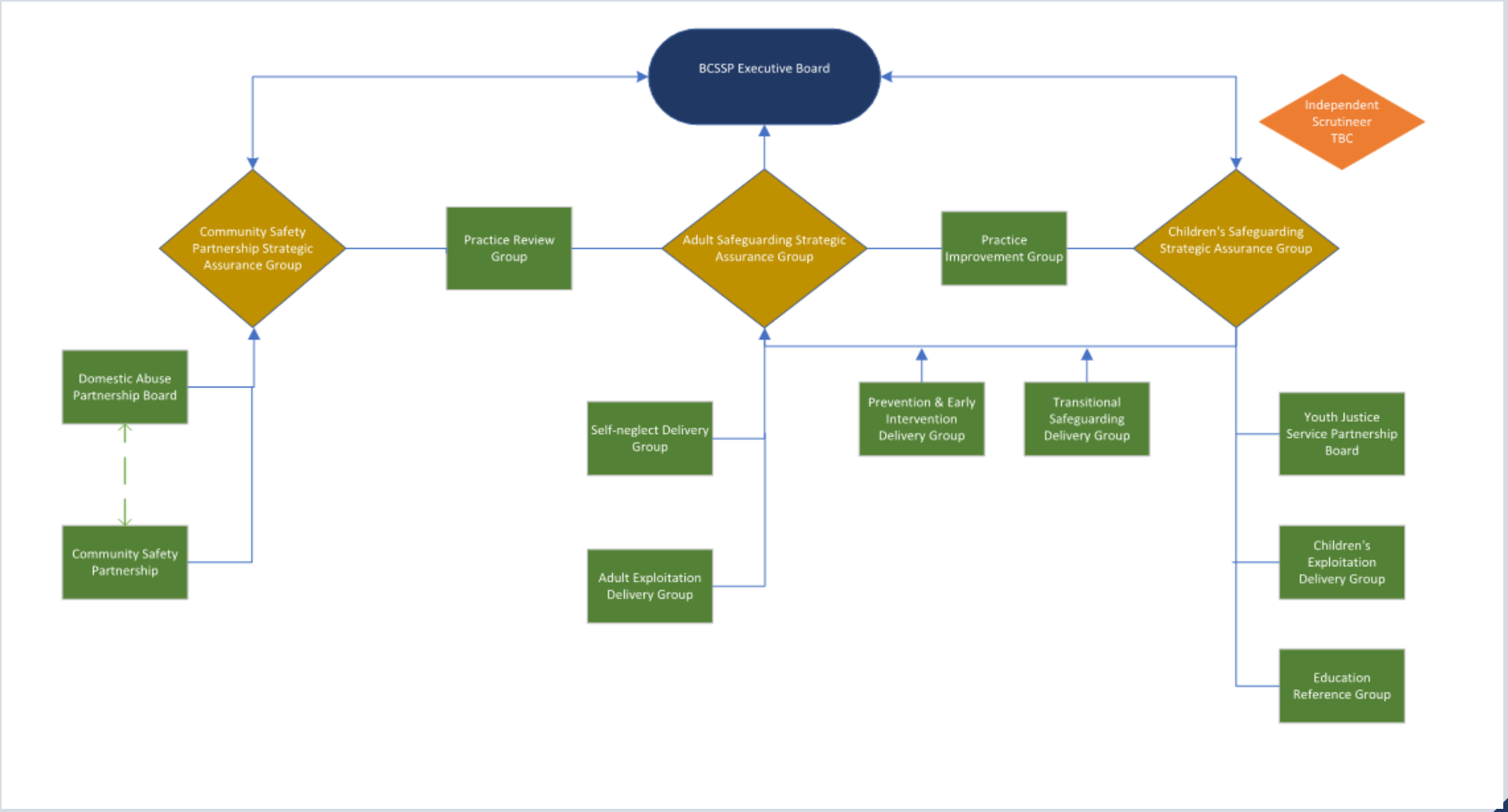


Fig 2. New Partnership Structure (from April 2024)



4. Multi-agency Learning and Practice Development

In this reporting period, the BCSSP has not undertaken any Domestic Homicide Reviews. It has undertaken 3 Child Safeguarding Practice Reviews, of which 2 have been published and 4 Safeguarding Adult Reviews.

Child Safeguarding Practice Reviews and Rapid Reviews

The purpose of reviewing serious child safeguarding cases is to identify improvements that can be made to safeguard and promote the welfare of children. Serious incidents are those in which abuse, or neglect of a child is known or suspected, and the child has died or been seriously harmed. Once the B&NES Community Safety & Safeguarding Partnership (BCSSP) receives a serious incident notification, it has fifteen days to complete a Rapid Review and submit it to the National Child Safeguarding Practice Review Panel.

This process is managed through the Practice Review Group. 2 serious incident notifications have been received for consideration by the BCSSP between 1st April 2023 and 31st March 2024. A Rapid Review was deemed appropriate for each notification, and it was agreed that local learning had been identified through this process. A CSPR conducted jointly with South Gloucestershire was completed and published in this period.

All 3 reviews involved babies under 1 year of age with suspected non-accidental injuries.

In response to the increased risk to under 1's from abuse and neglect and the National CSPR Panel publications 'Out of Routine' and 'The Myth of Invisible Men', B&NES have been working with Swindon and Wiltshire (BSW) to coordinate activity and system improvements in safeguarding unborn babies and under 1's. The aim is to improve awareness of the vulnerability of this group across all agencies through training and practice development opportunities; evidence response to local and national learning and case reviews and its impact; develop shared policies; and seek assurance of application of practice.

A BSW wide learning event was held on 4th March 24 covering key aspects of under 1s work. To date the bruising in under 1s policy has been developed and the unborn baby protocol. An under 1s audit has been completed and actions shared with the relevant agencies who are providing evidence against progress.

During this reporting period, 2 Child Safeguarding Practice Reviews have been completed.

Review 1 was in relation to a young person who was in care and review 2, a young person who lost their life through knife crime.

Key learning identified from review 1 included:

- A national shortage of suitable homes for children who are in care – this created a geographical barrier.
- The importance of specialist risk assessments in relation to past trauma and present challenges being fully understood by professionals involved in the care of the young person.
- Having robust transitional arrangements and strong links between children's social care and adult social care to ensure compliance with procedures is essential.

Key learning identified from review 2 included:

- Multi-agency threshold guidance should include the needs of children who are vulnerable to significant harm through peer-on-peer violence.
- Violence Reduction Partnership protocols should be developed for seeking and sharing information about individual children with other agencies and with parents to reduce the risk on inconsistency.
- Consider how best to stimulate the market and resource alternative provision for children less suited to/interested in academic study and identify children at risk of permanent exclusion from school who may not exhibit the standard risk factors or meet the usual criteria for alternative provision.

All learning and recommendations are developed into an action plan which is monitored through the Practice Review Group.

Partners have shown significant commitment to ensure the notifications were reviewed and required report completed to a high standard. There have been delays in submitting final reports to the national panel, this was to ensure that families had the opportunity to add their voice to the reviews.

Safeguarding Adult Reviews (SARs)

The BCSSP must arrange for a SAR to review a case involving an adult in its area (with needs for care and support). It can do this if there is reasonable cause for concern about how agencies or other persons with relevant functions worked together to safeguard the adult and either the adult has died and the BCSSP knows, or suspects the death resulted from abuse or neglect, or the adult is alive and the BCSSP knows or suspects that the adult has experienced serious abuse or neglect.

The BCSSP can arrange for there to be a discretionary review of any other matter involving an adult in its area with needs for care and support.

The purpose of a review is to identify the lessons to be learned from the case and apply those lessons to future cases.

The BCSSP Safeguarding Adult Reviews are managed through the Practice Review Group. During the period covered by this report, 1 case for consideration has been received, which did not meet the SAR criteria and 4 SAR reports have been ratified (Colleen, David, Andrew and Adult 'C').

Adult 'Colleen'

The case involved a serious incident which occurred in 2021 in relation to a 97-year-old woman, 'Colleen'. Colleen had care and support needs, she had been diagnosed with Alzheimer' in 2020, was reported to lack mental capacity, was refusing assistance at home, suffering from malnutrition, pressure sores and falls, despite a package of care being in place. Colleen died in January 2022.

Learning from this review included:

- Making Safeguarding Personal – the review found that the family were fully involved in Colleen's care, but they were left to do much of the coordination of care themselves. Despite expressing their frustrations and challenges, limited action was taken by professionals in response.
- Self-neglect featured in this case. All professionals should have an understanding of the self-neglect policy and feel confident in applying it.
- Professionals need to ensure that the Mental Capacity Act is fully understood and put into practice in the context of self-neglect, ensuring that the presence of mental capacity is not used as a validation for not acting.

Adult 'David'

David had a history of homelessness, rough sleeping and alcohol abuse. He was known to several agencies and was being supported to find appropriate housing but was ineligible for housing benefit due to the amount he had in savings. Whilst David had agreed to move into supported accommodation, he would only move to specific areas and was reluctant to explore other options. David did spend some time in a hostel, where concerns about his alcohol use and his physical and emotional wellbeing were raised, there were also concerns that he was vulnerable to financial abuse.

In November 2022, following a brief period in a hostel, David was asked to leave and began sleeping rough in a park. During this time, professionals were supporting David to access short-term housing and became increasingly concerned during a period of severe cold weather as he continued to decline temporary accommodation despite the potential risk to life. In December 2022, David was admitted to hospital. On admission, he was soaking wet and freezing cold with sores on his legs and back. Sadly, David died in hospital in January 2023, aged 68 years.

Key learning from this review included:

- Mental capacity assessments must be decision-specific and time-specific, and assessments should not be of the ability to make decisions generally.
- Care Act assessments should be conducted in a timely manner with particular focus on referrals for those with no permanent address.

- Consider how effective practice can be promoted and supported for adults experiencing homelessness

Adult 'Andrew'

Andrew had previously been living in Taiwan for 20 years where he worked as a teacher, before returning to the UK following the breakdown of his marriage and loss of his job

Following his return to the UK, Andrew had a period of time where he was homeless and living on the streets. He accessed temporary accommodation at Julian House homeless shelter, which he found this very stressful.

Andrew had a history of Hepatitis C, Chronic Fatigue Syndrome, and depression. He had a very long history of drug and alcohol addiction and was an ex IV-drug user. He had been on long-term benzodiazepines and anti-depressants which were prescribed by a Psychiatrist in Taiwan in addition to Tramadol which had also been prescribed.

Andrew has been under the care of B&NES Drug & Alcohol Service who reduced his Tramadol and Clonazepam and commenced him on Buprenorphine which he continued to be prescribed until January 2023, when he was found deceased in his home.

Learning from this review included:

- Effective communication between agencies is essential to enable appropriate information sharing. Clear records should be kept and shared where necessary.
- Professionals should give grater consideration to concerns of exploitation.
- Whilst there was no explicit evidence of this, given the events in other recent SAR's, consideration should be given as to whether organisations discharged their safeguarding duties due to unconscious bias around substance misuse and the complexities of self-neglect.

Adult 'C'

Adult C had a history of mental ill health going back to 2013 and from 2017 had become bedbound and was displaying significant self-neglect behaviour. Concerns were raised about the potential failure of a number of organisations in their duty to prevent ongoing harm to her, resulting in long-lasting physical and mental health impairment for her. Although the mental health and wellbeing of Adult C has improved since rehabilitation, she is left with significant physical disability.

Adult C describes herself as 'happy' and having a 'normal family life' and a 'successful' career prior to becoming unwell. She is educated to degree level and was employed until 2014, when she left her position due to mental ill health and a decline in her physical health. Practitioners described her as an intelligent and articulate woman who knows and speaks her mind.
Adult C is married, and both she and her husband participated in this review, along with her mother and sister-in-law.

Learning from this review included:

- Ensuring the voice of the person is central throughout single and multi-agency involvement and intervention
- Parity of esteem should be given to mental and physical health needs
- Understanding legal options and knowing when and how to access legal advice
- Understanding the impact on the carer and ensuring careful assessments for both the carer and person they are caring for

Domestic Homicide Reviews

A Domestic Homicide Review (DHR) means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they had been in an intimate relationship, or a member of the same household as themselves, held with a view to identifying the lessons learned from the death.

Domestic violence and abuse are defined as: *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.*

The BCSSP has had no DHR referrals in this reporting period.

Family Involvement

Hearing the families voice is exceptionally important within these reviews and we endeavour to engage the families with the process as much as we can. We are grateful to all those who support the reviews and assist in identifying learning.

The families of the young persons for whom CSPRs were conducted have contributed greatly and provided valuable feedback not just around how partner agencies worked with them, but also in relation to the CSPR process itself.

The families of the adults subject to SARs have also been keen to be involved, providing valuable insights into the lives of the individuals, and in one case, a family member joined the BCSSP self-neglect learning event to share their experience, which was an exceptionally powerful message.

The BCSSP extend their gratitude for this input, which assist us in developing increasingly effective systems, albeit through tragic circumstance.

What has happened as a result of these three review arrangements?

- BSW wide under 1's work and the development of new multi-agency policy and procedure.
- An under 1's audit.
- Implementation of the ICON (responding to infant crying) programme across BSW.
- A self-neglect and mental capacity learning event
- Introduction of a self-neglect delivery group
- Introduction of a transitional safeguarding delivery group
- Improving how we capture and reflect the voice of the child/adult/parent/carer
- A review of the self-neglect policy
- A business case submitted to the executive board to implement change in how we manage self-neglect cases
- Learning briefings have been produced and published.
- Exploration as to why we have not received any DHR referrals for consideration. Police colleagues confirmed there were no cases to refer.
- Commissioned an external training provider in relation to legal literacy (adults)

5. Multi-agency Quality Assurance

Section 11 Audit

Section 11 of the Children Act 2004 places duties on a range or organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

For 2023-2024, the five children's Partnerships across the Avon and Somerset region worked together to audit organisations working with children and families. The self-audit form was circulated to all partners across the 5 local authority area in August 2023 to assess monitor and evidence progress and achievements in relation to meeting safeguarding requirements. Some organisations work across more than one local authority and completed the audit once to cover all relevant areas. 17 audits were completed in total for B&NES, which is an increase on last year.

The specific areas the audit focussed on were:

- Safeguarding Structure
- Learning and Development
- Listening to Children
- Information Sharing
- Regional Themes
- Children's Partnerships

Overall, organisations participated well and reflected on practice to provide considered responses. Some organisations detailed a process and provided evidence of application and impact whilst others just said they had a process, with limited or no evidence against this which makes it challenging to gain assurance. This was particularly apparent in the question: How do you know that learning from local Child Safeguarding Practice

Reviews is impacting practice? when a third of respondents acknowledged that this is an area that requires improvement. This also reflects what the Partnership are seeing in practice.

A full report has been produced and shared with the partnership.

Section 175 Education Audit

All educational establishments have a legal responsibility to safeguard and promote the welfare of children and young people.

Keeping Children Safe in Education is the statutory guidance from the Department for Education issued under Section 175/Section 157 of the Education Act 2002, the Education (Independent School Standards) Regulations 2014, the Non-Maintained Special Schools (England) Regulations 2015, and the Education and Training (Welfare of Children) Act 2021.

Schools and colleges in England must have regard to it when carrying out their duties to safeguard and promote the welfare of children.

Regular monitoring is essential to ensure that the educational establishment has strong policies, procedures and mechanisms in place to safeguard children and young people; it also helps establishments to prepare for safeguarding aspects of inspections by Ofsted or other relevant inspectorates.

When the Education Reference Group was established, they agreed to take on the responsibility of the S175 audit. They made the decision to change the timeframe for conducting the audit, to align with the academic year. The audit was circulated in September 2023 and the deadline for responses was January 2024.

The mechanism by which the BCSSP established assurance was through individual schools self-evaluating their performance under an agreed framework. An audit tool was circulated to 84 education establishments and considered responses were received from 83 of them.

The majority of ratings were green, but where any ‘amber’ ratings were given, for example, where a policy is written and in the process of going to parents for consultation, schools establish and implement individual action plans to address these areas for development.

The action plans will be monitored against the following years returns.

Recommendations identified through the audit process are:

- Safeguarding Governors to be reminded that it is their duty to ensure that safeguarding and anti-bullying policies are updated. This needs to be included in their annual workflow.
- Promote the NSPCC training for Safeguarding Governors.
- Future audits should request that responses include details of when something will be achieved, e.g. All staff to complete Domestic Abuse training by June 2024.
- All DSLs to attend Managing Allegations training. Settings should encourage other staff to attend.

Safeguarding Adults Audit

The self-assessment audit tool was circulated to partnership members in October 2023 across the five partnership areas to assess, monitor and evidence progress and achievements in relation to meeting adult safeguarding requirements. The five partnerships worked together to ensure a consistent approach to the audit across the region and minimising the work required for those organisations who work across multiple local authority areas.

In B&NES, 18 completed audits were received. This is a 29% increase on the returns received last time the audit was conducted in 2021.

The specific areas the self-audit focussed on were:

- Leadership
- Evidence of Policy in Practice
- Safer Recruitment
- Learning from SARs
- Making Safeguarding Personal
- Exploitation
- Transition

Recommendations for the BCSSP from the audit included:

- seeking further assurance on organisational understanding of their responsibilities in relation to the Mental Capacity Act
- seeking further evidence of how learning from local SAR's and reviews has driven change and improved practice
- seek assurance that views of the individuals are gathered and accurately recorded in relation to safeguarding and informed consent
- evidencing systems and support are in place to enable professional curiosity to be demonstrated in practice.

There were a number of delays in submissions, which has caused a delay in a full report being produced.

6. Multi-agency Training and Workforce Development

The BCSSP training and development programme is designed to help ensure the continuing development of all staff in order to safeguard and promote the welfare of children and adults at risk and to keep our communities safe.

In April 2023, following an 18-month period of the BCSSP Inter-Agency Safeguarding & Community Safety Trainer post being vacant, it was extremely positive that a full-time trainer joined the team on a two year fixed term contract. The post holder is managed by B&NES Council Organisational Development Business Partner who specialises in Safeguarding and Multi-agency training.

The trainer is responsible for the development, and the delivery of the majority of BCSSP courses. Where there is a need for specialist input the BCSSP Trainer and the Business Partner will work with colleagues from partnership organisations or external independent trainers, to ensure the most appropriate knowledge and expertise is gained for course creation and delivery. The Business Partner also makes provision for the effective administration, evaluation, and quality assurance of all BCSSP learning opportunities.

The appointment of a BCSSP trainer has mitigated the need to use external trainers as frequently, which has enabled greater focus on local practice issues (previously external trainers tended to utilise national events in discussions rather than specific local incidents). This change has been reflected in course feedback whereby delegates have continually highlighted the successful use of local knowledge, with discussions and practice issues being based on local information.

The BCSSP trainer has also been able to re-establish links with partner agencies, arranging guest speakers from local organisations and the co- delivery of training with colleagues from across the workforce. This involvement fully embraces the multi-agency model of training and utilises specialist knowledge available across the authority.

The collaborative model of working with partners supports additional quality assurance to take place, with a shared approach to the development of course content and materials. Additionally, this year further peer reviews of courses have taken place with surrounding authorities to benchmark course complexity and learning outcomes.

Research into the effectiveness of inter-agency training suggests that for participants to gain the most from training they need to be able to make direct links to their own practice and consider how the knowledge gained in training can improve their practice. All delegates are therefore invited at the end of training to consider an action plan for changing their behaviour in the workplace and thinking through the impact that this change will have on those with whom they work.

The methods of evaluation used have evidenced:

- An increase in practitioner's confidence in applying knowledge and skills following training, and having further tools, strategies and techniques to use to gain better outcomes with families.
- An increased understanding of multi-agency roles and improved communication and information sharing between professionals, including the making of appropriate referrals.
- Practitioners hold a greater understanding of legislation, policy, procedure and guidance and how to apply this into practice.
- Practitioners found the training and trainer to be of high quality and beneficial in increasing their knowledge in the subject matter.

In line with last year, the requirement of independent study alongside some learning events has continued to receive a conflicting response. Some delegates have shared that they appreciate the opportunity to reflect on the information gained in the session before building on this knowledge with the activities set. Other delegates have advised that they

find it challenging to find time in their diary to undertake the necessary work and would find it easier for all learning to be trainer led; with the length of the session being extended.

The programme provided by the BCSSP resulted in the provision of 76 training sessions taking place which compromised of 27 different training topics. A further 13 courses were cancelled, 9 due to low numbers booked and 4 due to sickness / personal circumstances of different trainers.

Similarly to last year, liaison with surrounding local authorities highlighted that low attendance has been an issue with regards to either certain areas of the workforce attending multi-agency training or that particular themes appear to elicit limited interest.

Consideration has been given to the impact of ongoing challenges experienced across the children's and adults' workforce with relation to recruitment, retention and resources and the complexity for agencies of balancing the developmental needs of the workforce alongside other organisational necessities.

A multi-regional approach to exploring and responding to these issues is taking place whenever possible.

Examples of delegate feedback:

"I feel better informed to be able to make decisions and support s47 enquiries in future. As a future DDSL I may have to support ICPC and feel more informed about my role as part of this!"

(Teacher: Advanced Child Protection)

"This training has changed my understanding of the act significantly. Examples of practice have helped me understand how I can apply the act to my place of work."

(Anonymous: MCA)

"I am more confidant of being aware of safe guarding issues that may arise within my role"

(Home Care Assistant: Level 2 Adult Safeguarding)

"Great to discuss the topic with other practitioners . I feel confident in who to refer to and how this works."

(Student: Exploitation for Children's services)

"OMG: I learned so much…an understanding of the MCA, how and when to assess MC, the importance of record keeping, the importance of case law in making decisions, definition of Best Intentions and statutory assessment. I could go on!"

(Coach: MCA)

"[The trainer] got through what is necessarily a lot of information without feeling rushed, highlighting the main practical points in a way that was useful for my day to day work and brought a fresh focus to training I have now had several times working in this sector."

(Housing Co-Ordinator: Level 2 Adult Safeguarding)

7. Key Performance Indicators

The BCSSP agreed the following performance indicators for partners for 2023-2024. It was agreed that it is each agencies responsibility to determine which of their staff members fall into the category of 'relevant'. Relevant means to their role and responsibilities and awareness training can be face to face, e-learning or equivalent.

Indicator	Training	Target %
1.1	Relevant staff have undertaken Prevent training (WRAP or equivalent)	**85%**
1.2	Relevant staff have undertaken Prevent awareness training	**85%**
1.3	Relevant staff have undertaken FGM awareness training	**80%**
1.4	Relevant staff have undertaken Domestic Abuse awareness training	**80%**
1.5	Safeguarding leads have awareness of Modern Slavery/Human Trafficking	**100%**
1.6	Relevant staff have undertaken complex trio awareness training (also referred to as toxic trio, trilogy of risk or the trio of vulnerability.)	**80%**
1.7	Relevant staff have undertaken Exploitation awareness training	**80%**
1.8	(ADULT) Relevant staff have undertaken MCA/DOLS training within 6 months of taking up post	**90%**
1.9	(ADULT) New staff have undertaken safeguarding adult's awareness training within 3 months of starting in post	**90%**
1.10	(ADULT) Relevant staff have completed SA level 2 training within 6 months of taking up post	**90%**
1.11	(ADULT) Relevant staff have completed SA Level 3 training	**80%**
1.12	(ADULT) Relevant staff have undertaken self-neglect training	**80%**
1.13	(CHILDREN) New staff have undertaken Child Protection awareness training within 3 months of starting in post	**90%**
1.14	(CHILDREN) Relevant staff have undertaken Foundation child protection standard training	**90%**
1.15	(CHILDREN) Relevant staff have undertaken Introduction to child protection training	**90%**
1.16	(CHILDREN) Relevant staff have undertaken Advanced Child Protection Training	**90%**

Partner organisations who completed the annual report return submitted their training figures against the KPI's. The results are shown in the table below.

It is a complex representation as organisations decide which staff are considered 'relevant' and due to the varying numbers of staff in each organisation 100% could represent 1 staff member or 1000.

Both Adult and Children's Social Care have had issues accessing the training data and numbers may not be wholly accurate. This is being looked at. Adult social Care figures may also be impacted as a large number of social workers from HCRG Care Group have just been reintegrated into the Council and do not have training records.

Children's Social Care recognise the importance of accessing multi-agency training but given some of the workforce pressures and the demands currently placed upon the service they are trying to balance the workforce's learning needs alongside service provision. There is a plan in place to address their performance in this area and to ensure more staff are accessing the relevant training.

It is positive that the responses reflect an increase in the number of staff undertaking MCA training, given this has been identified as key learning from SAR's.

Agency ratings in % against the KPI's.

KPI	Target %	RUH	Midsomer Homecare	Project 28	Oxford Health	HCRG Care Group	Health watch	Avon Fire & Rescue	DHI*	Southside*	BSW ICB	Julian House	Children' s Social Care	Action for Children	POhWER	Police*	Adult Social Care	YCSW
1.1	85	90	100	100	90	98	N/A	N/A	/	100	100	N/A	33	100	100	100	/	88
1.2	85	94	100	100	100	92	N/A	TBC	/	100	94	N/A	74	100	100	/	14	88
1.3	80	88	100	100	88	96	N/A	0	/	100	94	N/A	73	100	100	/	5	81
1.4	80	88	100	100	88	96	N/A	0	/	80	94	100	68	100	100	100	0	80
1.5	100	100	100	100	100	96	N/A	100	100	100	100	100	54	100	100	100	4	100
1.6	80	89	100	100	88	96	N/A	100	/	100	80	N/A	67	100	N/A	100	0	93
1.7	80	88	0	100	88	96	N/A	100	N/A	100	95	N/A	72	100	100	/	25	93
1.8	90	91	100	100	76	98	N/A	0	/	100	95	N/A	100	100	100	/	27	N/A
1.9	90	92	100	100	93	95	100	97	100	100	95	100	N/A	100	100	100	N/A	100
1.10	90	91	100	100	93	92	100	92	90	100	95	N/A	N/A	100	100	/	39	100
1.11	90	93	100	100	86	85	N/A	100	/	/	95	100	N/A	100	N/A	/	18	100
1.12	80	91	100	100	86	N/A	N/A	97	/	100	/	N/A	N/A	100	N/A	100	7	/
1.13	90	88	N/A	100	97	98	100	97	/	/	95	100	93	100	100	100	N/A	100
1.14	90	88	N/A	0	97	84	N/A	N/A	/	/	95	N/A	100	100	100	/	N/A	97
1.15	90	89	N/A	100	88	91	N/A	N/A	/	100	95	100	87	100	N/A	/	N/A	93
1.16	90	89	N/A	100	100	100	N/A	N/A	/	100	100	N/A	55	100	N/A	100	N/A	90

Key:

Red = More than 15% below the KPI
Amber = Less than 15% below the KPI
Green = met or exceeded the KPI
Blue = N/A
/ = nil or narrative response given
* Where DHI show a number of / responses, the majority of these KPI's have a figure against the number of staff trained, but this hasn't been represented as a %, and therefore is not comparable within this table. Where Southside and Police KPI's show / , it is because there was nil response provided.

8. The Work of the Partnership Subgroups

The BCSSP Executive Group and Operational Group are chaired independently by Fiona Field. The Executive leads the production of the strategic plan, supported by the Operational Group and the subgroups. The Operational Group provides support and challenge to the subgroups to improve performance outcomes and gain assurance of good community safety and safeguarding practices.

The subgroups have each developed a delivery plan to assist in delivering against the BCSSP strategic plan. The groups provide reports to the Executive which will consider whether guidance, and assistance or direct action is needed to remove barriers to achieving outcomes.

Practice Review Group

The purpose of the Practice Review subgroup is to enable the Partnership to carry out reviews of cases that meet statutory and non-statutory requirements. This enables lessons to be learned and practice improvements to be made, to ensure better outcomes for children, adults and families.

This is an 'all-age' subgroup which focusses on the following key areas:

- Child Safeguarding Practice Reviews (CSPRs), including Rapid Review reports to the National Panel
- Safeguarding Adult Reviews (SARs)
- Domestic Homicide Reviews (DHRs)
- Learning/Discretionary Reviews

This subgroup has had strong commitment from all statutory partners and in 2023-2024 has:

- Ensured statutory compliance
- Identified key themes to review and explored preventative training options
- Reviewed the new Working Together 2023 statutory guidance
- Produced learning briefings in response to SAR's and CSPR's

Domestic Abuse Partnership

The purpose of the Domestic Abuse Partnership (DAP) is to promote partnership coordination of universal and targeted education about healthy relationships, protection of victims, provision for survivors and disruption of perpetrators related to adult and children.

In 2023-2024 it has:

- Continued the work against the DA Act action plan and developed a DA Act assurance plan
- Supported the completion of the B&NES DA Needs Assessment
- Continued to explore perpetrator programmes
- Provided a multi-agency response to the DHR Legislation consultation
- Reviewed the MARAC process and proposed a new way of working which will be progressed in 2024-2025

Prevention & Early Intervention

The purpose of the Prevention & Early Intervention subgroup is to ensure the provision of a holistic approach across the whole life course to ensure the quality and effectiveness of prevention and early intervention services for children and adults across the B&NES Service area. The subgroup aims to reduce the demands and needs for social care and specialist services, and it does this by understanding what services are available and raising awareness of them.

In 2023-2024, the subgroup has:

- Received the SUDI audit report
- Discussed the redesign of early help services
- Contributed to the Under 1's work, with a focus on the importance of working with fathers

Under the new structure discussions, this group was originally going to be disbanded, so did not have hold as many meetings in the year. However, it has now been agreed the

group will continue with a greater focus on the requirements of the Care Review.

Youth Justice Service Partnership Board

The Youth Justice Service Partnership Board is formally constituted and accountable to the BCSSP and the Health & Wellbeing Board. Its purpose is to manage the performance of the prevention and youth crimes agenda and ensure the delivery of the statutory principal aim of preventing youth offending at a local level. It provides governance for the Youth Justice Service (YJS) and ensures it can fully contribute to achieving positive outcomes for young people.

The Partnership Board have transformed the way they work to hear voices of the child and hold each other to account to ensure their agencies are taking a child first approach.

Staff have remained committed and shown great perseverance and creativity in offering support to children and their families.

Achievements for 2023-2024 include:

- An agreed vision statement between the YJS Team and the YJS Partnership Board
- Regular activity and outcome reports on key areas of service delivery including Out of Court Resolutions, Policing, Speech and Language Therapy, Nursing, Education, the Compass prevention service, Harmful Sexual Behaviour and the Enhanced Case Management initiative.
- The Board maintains and reviews Challenge and Risk Registers.

Looking forward, the group will continue to monitor and enable the YJS Team in its priorities to reduce disproportionality, strengthen participation, embed child first principles and reduce serious violence.

Exploitation

The purpose of the Exploitation subgroup is to develop, monitor and evaluate the effectiveness of the strategic and operational multi-agency response to exploitation. Its focus is all age and on the key areas of Missing Children and Adults, County Lines, Modern Slavery/Trafficking, Forced Marriage, Female Genital Mutilation, Honour Based Violence, Mate and Hate Crime.

Key achievements for 2023-2024 include:

- Ratification of the Missing Protocol
- Knife Crime audit findings review and an action plan
- Ratification of the Harmful Sexual behaviour Protocol
- A review of knife crime incidents in B&NES
- Received an update on learning from CSPRs

Under the new structure this group will focus solely on children and young people.

Community Safety Partnership

The purpose of the Community Safety Partnership is to ensure the provision of a holistic approach to those communities identified as ‘vulnerable’ across the B&NES service area. Whilst Community Safety is embedded in all of the subgroups, this subgroup predominantly focusses on the areas that would have been covered by the previous ‘Responsible Authorities Group’, which was brought into the BCSSP.

The subgroup focusses on identifying trends, risk factors and mitigations for the following areas:

- Night-time Economy
- Drug and Alcohol Use
- Regulation (licensing, MAPPA, Trading Standards
- Community triggers
- ‘Prevent’* – Violent Extremism
- Serious and Organised Crime – ‘Disrupt’
- Serious Violent Crime
- Anti-Social Behaviour
- Violence Reduction

In 2023-2024, the subgroup has:

- Received information on the Youth Space, Safe Bus, Sudden Death report and the Cost-of-Living Impact from Trading Standards
- Developed a community safety work plan covering both local requirements and those of the Office of Police and Crime Commissioner
- Reviewed ASB data
- Worked across the Avon footprint to develop a data dashboard which is part of a 2-year project.

Following a review of statutory requirements, under the new structure the Community Safety Partnership will be accountable to the Strategic Community Safety Group.

Mental Capacity Act Quality Assurance

The Mental Capacity Act Quality Assurance subgroup was established as a subgroup in September 2020. Its purpose is to provide assurance to the BCSSP, that health and social care providers across B&NES apply the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards.

In 2023-2024, the subgroup has:

- Completed an organisational policies spot check
- Reviewed the relevant actions from SAR's against the groups objectives

Under the new structure, this group no longer sits with the BCSSP, although it does still provide updates when requested.

Quality & Performance

The purpose of this subgroup is to quality assure, on behalf of the BCSSP, aspects of safeguarding and community safety work that is delivered to the population of B&NES. This includes themed quality assurance of key issues which present a risk to children, adults, families, and communities.

The subgroup focusses on safeguarding standards for children and adults, audit reporting, single and multi-agency data and implementing the Scrutiny and Assurance Framework.

In 2023–2024 the subgroup has:

- Continued to seek greater clarity on quality and performance across B&NES and refined the data set – although the data scorecard is still in development
- Received the service user feedback report
- Reviewed the MARMM audit report

Going into 2024-2025, this group will be disbanded under the new structure. 3 focussed strategic assurance groups will oversee the work of community safety, safeguarding children and safeguarding adults.

Training & Workforce Development

The purpose of this subgroup is to deliver a programme which enables the Partnership to discharge its responsibility to either directly provide or commission training and development opportunities for the workforce in B&NES. The programme ensures local and national standards are delivered and that emerging needs are identified, and appropriate training provided to meet these.

In 2023-2024, this subgroup has:

- Supported the design and development of the Stop Adult Abuse Week campaign
- Reviewed and agreed the key performance indicators in relation to training and submitted a proposal to the Executive Group
- Reviewed outcomes from learning reviews to ensure areas for development are captured in future training
- Evaluated the BCSSP training provision and the learning and development framework

Within the new structure, this group has been renamed the Practice Improvement Group to reflect its work more accurately and how it needs to integrate learning into practice.

Education Reference Group

The Education Reference Group (ERG) was established in January 2023 as a multi-agency subgroup of the Partnership. It constitutes a broad range of representatives who can ensure that appropriate practices and procedures are in place, regarding safeguarding and child protection within educational settings.

It robustly ensures that the education sector is embedded within the partnership and recognises the crucial role that education plays in safeguarding and promoting the wellbeing of children and young people.

In 2023-2024, the subgroup has:

- Discussed the prevalence of harmful sexual behaviour in schools
- Completed a S175 Audit
- Planned the CP Forum agendas
- Reviewed the child-on-child abuse survey report.

9. Reflecting on Partnership Achievements

2023-2024 has been a period of change for the BCSSP. In person development days were held in April and December of 2023, which brought together partner organisations to review the LGA Peer Review findings and the effectiveness of the current multi-agency arrangements. The engagement of partners over these 2 days was admirable, and demonstrated the level of commitment in leading the partnership to be the best it can be. This has been positive in that a structure has been agreed and chairs appointed for the new groups, but it has also meant that some groups will no longer continue and the BCSSP is cognisant that the work of those groups still needs to be reflected within the partnership. It must be noted that with impending changes, the partnership subgroups did lose some focus and attendance at meetings fluctuated with the uncertainty of change, and this has impacted on the output of the subgroups to varying degrees. It is the aim that the new structure will improve focus on each strand of work and that once membership of each group is agreed, there will be greater clarity for partners about their role and the expectations of each group

Our safeguarding partners were also asked to reflect on their achievements in relation to the following key requirements:

Requirement	Sample of Responses
How has your organisation contributed to the functioning and structure of the multi-agency arrangements?	• The safeguarding team have supported the work around restructuring the BCSSP and took part in the BCSSP development day in 2023-2024. (RUH) • Attending appointed subgroups, involvement in adult safeguarding portal work, attend SAR learning (Midsomer Homecare) • Specialist Safeguarding Nurses attend MARAC meetings and share information and contribute to safety planning for victims and children. (HCRG Care Group) • All members of the safeguarding team have a role in attending one or more of the BCSSP groups. Their role within the organisation is also to share key updates and learning back into our organisation (HCRG Care Group) • AFRS has contributed to the work of partnership agreements, supporting other agencies and working collaboratively with agencies. This included actively participating in a wide range of partnership meetings and consultation documents • Contributed to statutory reviews and seek assurance that learning is both identified, implemented and changed practice (BSW ICB) • Senior managers across Children's Services chair a number of sub-groups and are represented on ALL sub-groups so that we ensure the Children's Services effectively contributes to our multi-agency delivery of the partnership's safeguarding priorities.(Children's Social Care) • ASP have contributed to the functioning and structure of the multi-agency arrangements through active participation in the development phases of the restructure following review. (Police) • Adult social care support in discharging a number of assurance actions and chair a number of meetings, including the PRG and the MCA working group, and have agreed to chair a number of meetings within the new structure. • Representatives from the organisation contribute to multi-agency working to reduce serious crime and exploitation; we are represented on the Serious Youth Violence Steering and Operational Groups;

	Partnership Working to Reduce Exploitation and Violence Meeting; and the Serious Youth Violence Group. (Youth Connect South West)
How has your organisation contributed to the strategic priorities of the BCSSP? • Develop a 'Think Family, Think Community' approach. • Learning from experience to improve how we work • Recognising the importance of prevention & early intervention. • Providing executive leadership for an effective partnership.	• The training at level 3 Safeguarding Face-to-Face in both adults and children has strengthened the domestic violence narrative with a significant section related to this and the think family philosophy. (RUH) • There are robust Governance processes in place for discussions of safeguarding issues, including the highlight reports to the ICB, in order to meet safeguarding contract standard requirements. (RUH) • We use "lessons learned" from complaints and safeguarding to inform future care. (Midsomer Homecare) • Delivering outreach, we can get messages to the public and working with the Violence Reduction Partnership delivering and taking part in Knife Crime events and annual conferences. (Project 28) • Training opportunities relating to serious youth violence promoted and staff supported to attend. (Oxford Health) • Changes in policy and procedures developed by the partnership shared with clinical staff and CAMHS management. Application of the changes reviewed as part of safeguarding supervision sessions. (Oxford health) • A number of key colleagues, seventeen in total, attended a Learning event for a Safeguarding Adult Review in January 2024. The learning from this case has been shared locally in teams and continues to be referred to in SG champions meetings, Safeguarding supervision sessions, and closing the loop meetings. (HCRG Care Group) • AFRS support the prevention and early intervention throughout their day-to-day activities, information on how to spot indicators of concern is shown on the intranet, and we have recently employed an Onward Referral Advisor to ensure early intervention referrals can be made to relevant agencies. • We recognise that proactive measures aimed at preventing abuse and intervening early can significantly mitigate harm and disrupt unhelpful ways of managing the impact of trauma. (Southside) • Our outreach team engage with clients that are rough sleeping in the area and engage them with services to support their health and wellbeing and work to identify the most appropriate housing pathway. Working with our hostel and supported housing teams as well as other agency staff like DHI/HITT clients are given the opportunity to access the most relevant support services at point of contact. We work closely with colleagues in health services to ensure our clients are able to access primary healthcare including dentistry and vaccinations (Julian House) • Our Practice Framework, rooted in a strength-based approach, which focusses on identifying and building upon the inherent strengths and capabilities within families rather than solely addressing deficits or challenges. This approach not only empowers families but also fosters a more positive and supportive relationship between practitioners and the families they serve. (Children's Social care) • Produced a video in the last year promoting fact Bath West Children's Centre Services is part of the community and embedded within the Think Family model. Work with the whole family – for example opening Forest Families during school holidays to enable older siblings to join in activities as well as the under 5's. (Action for Children) • ASP have shaped an effective partnership approach in the aftermath of a number of serious violence incidents within BANES to provide community reassurance (Police) • The 'Think Family, Think Community' approach is informing the work we continue to do with our children's colleagues and wider partners on the Preparing For Adulthood pathway development (Adult Social Care)

	• One of the main changes following from serious incident, has been the introduction of the Concerns Log which helps to monitor those young people for whom there are escalating or changes in levels of concern. This data helps to ensure the young people are highlighted regularly to senior managers and safeguarding staff and each case is regularly reviewed (Youth Connect South West)

How has your organisation used data to encourage learning?	• Data is collected and analysed around the numbers of young people presenting to the trust with emotional dysregulation, social care involvement and length of stay. This shared with the Safeguarding Team in the ICB and through our safeguarding highlight reports. (RUH)
	• Number of referrals to children social care reviewed by the safeguarding service. Quality of the referrals made reviewed by the safeguarding service. Analysis used to discuss with clinical CAMHS staff in supervision sessions improvements in quality of referrals (Oxford health)
	• We currently collate quarterly data on safeguarding training compliance which is used to identify any areas of concern and which areas are doing well with training. (HCRG Care Group)
	• The data team monitor safeguarding registers. We have completed some analysis of self-neglect for example and are developing work streams around staffs understanding of Mental Capacity and impact of Executive functioning when considering self-neglect.(DHI)
	• Quarterly core data analysis has revealed patterns in service usage and underrepresented groups accessing Southside services. It also highlights gaps in support, prompting the development of targeted initiatives (Southside)
	• Data underpins commissioning and safeguarding practice. The NHS has invested considerably in digitalisation and is working across the Partnership to share data to identify trends, practices and locations in which to focus safeguarding practice. Work has been undertaken with BCSSP in developing a data dashboard to support learning (BSW ICB)
	• Regional Managers complete internal monthly compliance reports, and these are used to identify gaps and any training needs. We look at trends across services and look at how best we can respond to increasing need/demand for services (Julian House)
	• Regional scrutiny adds another layer of evaluation, providing a broader perspective on performance and highlighting areas for development. This external oversight helps to ensure accountability and transparency of our service delivery. (Children's Social Care)
	• there are two fundamental activities that adult social utilise data to support learning and understanding of needs. These being:
	  • Access to operational data to inform targeted support and analysis of needs – examples of this is the Client Level Data set and improved Safeguarding Dashboards, to better provide operational and strategic.
	  • Engagement with and findings from local research - Adult Social Care in Bath and North East Somerset Council are pleased to be part of a number of key research initiatives with Bath University (Adult Social Care)
	• The data collected from the concerns log helps provide an opportunity to collate themes of concerns within different teams in the organisation. This can be used to help target learning and training, making the use of resources (Youth Connect South West)

How has information sharing improved practice and outcomes?	• Sharing information with other professionals involved in the care of a client helps to make sure that the right people are supporting clients in the right way (Midsomer Homecare)

	• Joint working and information between the children's workforce have ensured that Young People are safer within the community and that their exploitation risk is managed with sharing information within multi agency meetings (Project 28) • Work with RUH regarding self-harming presentations has supported more effective working between CAMHS and RUH clinical staff to ensure outcomes for children are improved. (Oxford Health) • Disseminated information and findings from strategic meetings into operational team meetings and again further into 1-1 supervision. (Action for Children) • Improved access to advocacy services via professional referrals and drop ins e.g. care act advocacy (POhWER) • ASP have improved information sharing with partners to respond to incidents effectively as a partnership. Effective information sharing has ensured a rapid and efficient response to incidences of serious violence within BANES. This improvement has better safeguarded members of our communities (Police) • We continue to share and receive information that improves practice and outcomes for adults in various forums, such as; PREV, disrupt, ASB Case Conferences, MARAC and channel. We are reviewing how adult social care is represented in MARAC now adult social care staff have transferred to the council and we are seeking to strengthen our presence and relationship within MAPPA (Adult Social Care)

How has your organisation sought and utilised feedback from 'service users' to inform work and influence service provision?	• Using the Making Safeguarding Personal approach, patients and family are invited to participate in any safeguarding adult review meetings to ensure their views are captured and represented. (RUH)
	• When we receive feedback or send questionnaires, we use that information to change the way we work if this is possible. We always try to work with clients in a way that is suitable to them, as long as it is safe and effective. (Midsomer Homecare)
	• Service user forums and feedback is an integral part of the development of Project 28 with exit surveys and an opportunity to carry out a survey on the Wrap. All feedback is collated and delivered back to service users by 'you said ' ' we did ' posters.
	• participation group in BSW is very strong:
	  • Contributing to the development of the 16-25 pathway: Being part of the transition project group and supporting the team in designing information and a film about transition
	  • Helping create a questionnaire to gain feedback from young people using the Single Point of Access
	  • Working with BaNES youth groups to plan and run a mental health event
	  • Training session with CAMHS staff around supporting neuro divergent young people. (Oxford health)
	• Hearing from service users is core to Healthwatch – these views relate to health or social care service providers, rather than our own 'service users'. We primarily act as a conduit for sharing views and feedback back to local decision makers and service providers in the public but also private and voluntary sector.
	• Regular feedback and making safeguarding personal means that lived expertise and voice is sought from individuals and stakeholders, through survey and exit questionnaires. This then forms learning and development to make changes to improve system wide issues (DHI)
	• ICB seek information from Service Users through co-ordinated engagement consultations when reviewing services, however through contract monitoring we also seek users views through Friends and Family questionnaires (BSW ICB)

	• We have a range of 'Participation' work, which includes working alongside our commissioned services to gather the voices of young people, such as our in-care councils and care experienced council. We are committed to working collaboratively with our Young Ambassadors. We have a proactive team of Care Experienced Young people, who are helping us to shape our service (Children's Social Care)
	• examples of changes we have made are:
	  • amendments to the Disability Related Expenditure [DRE] policy because of a complaint, which also lead to changes in process; ensuring the correct people are involved in decision making when the safeguarding issues are present.
	  • We have introduced trauma informed learning and are continuing to explore how to provide learning opportunities around affiliating trauma informed approaches within adult social care, because of a complaint (Adult Social Care)
	• There is also representation for young people at trustee level- the board has a specific post for a young person trustee- this must be someone who has accessed services provided by YCSW over the past three years (Youth Connect South West)

10. Our Commitments for 2024-2025

The BCSSP reviewed its performance for 2023-2024 and is firmly committed to working in partnership to achieve the objectives as set out in the 2024-2027 strategic plan. Our priorities have been identified through a range of evidence. This includes learning from Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews, bringing executive partners together for two development days and consulting with wider partners. We have also considered current legislation, national, regional and local plans, local strategic needs assessment, including crime and disorder, public health and housing.

Much work has taken place to restructure the partnership and ensure our partners were involved and in agreement with the changes. The new structure has been positively received and the following commitments were agreed at a multi-agency level.

Community Safety Priorities

The Avon & Somerset Office of the Police and Crime Commissioner (OPCC) produces a Police and Crime Plan for Avon & Somerset. The B&NES joint community safety plan, in line with statutory requirements, identifies evidence driven priorities for B&NES whilst being mindful of supporting the OPCC priorities. B&NES joint community safety plan is produced with the Avon & Somerset Office of the Police and Crime Commissioner and our local priorities are:

- Protecting the most vulnerable from harm
- Strengthen and improve local communities to improve outcomes for local people

The overarching community safety priorities of the BCSSP are:

Priority 1: To develop the strategic oversight and scrutiny of the CSP arrangements

Priority 2: We will further develop our work with partners to prevent people from becoming involved in and reduce instances of serious violence.

Priority 3: Continue to identify opportunities for longer term funding to reduce domestic abuse incidents and improve outcomes for survivors.

Safeguarding Children Priorities

Priority 1: We will strengthen the role of education in the partnership.

Priority 2: Ensure a child-centred approach with a whole family focus.

Priority 3: Keeping children and young people safe from harm from exploitation.

Safeguarding Adults Priorities

Priority 1: Improve understanding of and support professionals to work with those individuals who self-neglect.

Priority 2: We will create confidence in practitioners in the application of the Mental Capacity Act and understanding of the interplay with the Mental health Act.

Priority 3: We will connect with our communities and hear their voice within the partnership.

Overarching Priorities

Priority 1: Have policies and procedures that are current and in line with best practice.

Priority 2: We will create confidence in practitioners to be professionally curious and improve this practice.

Priority 3: We will ensure effective collection, sharing and analysis of data, enabling early identification of community safety and safeguarding risks, issues, emerging threats, and joined-up responses across relevant agencies.

Priority 4: Ensure clear transitional arrangements are in place between children's and young adults services

How we will achieve this

Each of the delivery groups has developed an action plan to support the BCSSP Strategic Plan 2024-2027.

The action plans have been developed for a 12 month period and progress is monitored quarterly. The work of the delivery and of individual organisations contributes to the plans and evidence of outcomes is sought to provide assurance to the Strategic Assurance Groups.

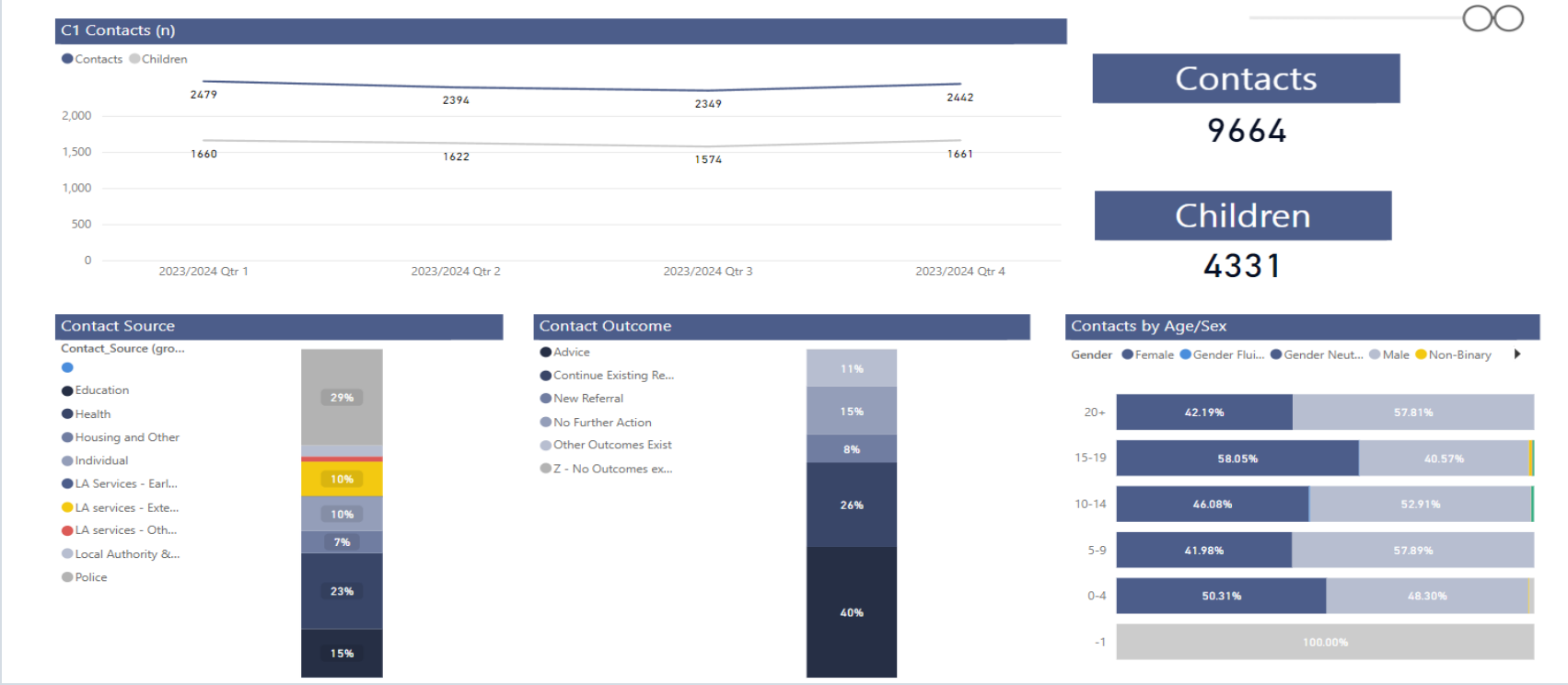
Alongside this, data submitted by our partners is monitored and analysed, allowing the BCSSP to remain agile to the community safety and safeguarding needs of B&NES.

11. Appendices

11.1 Children's Social Care

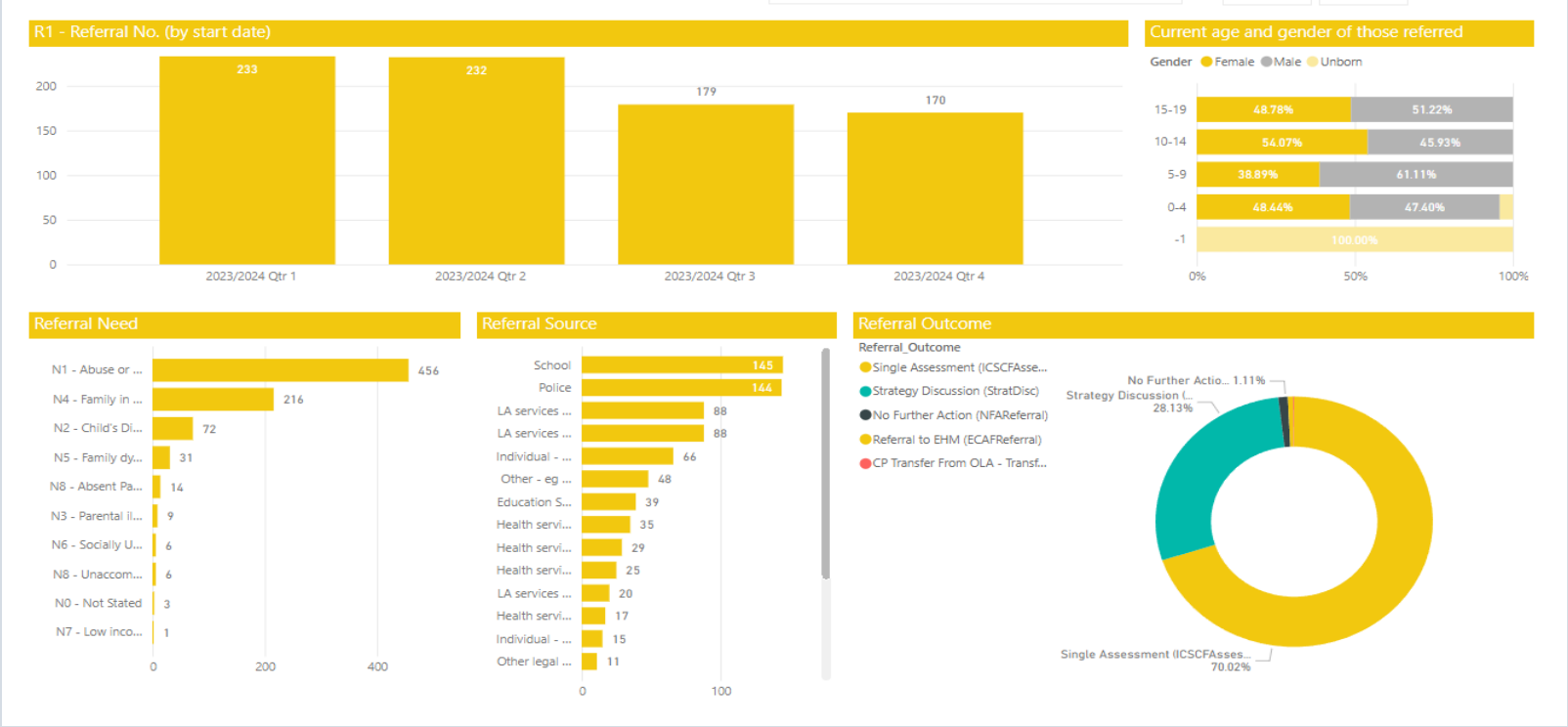
Contacts for the period 01.04.2023 – 31.03.2024

There has been a small increase in number of contacts and number of children in comparison to last year. Police remain the highest contact source. There has been an 11% increase in the contact outcome being advice and this is the main outcome of contacts coming in to Triage. Only 15% of new contacts go on to be assessed by Children's Social Care.



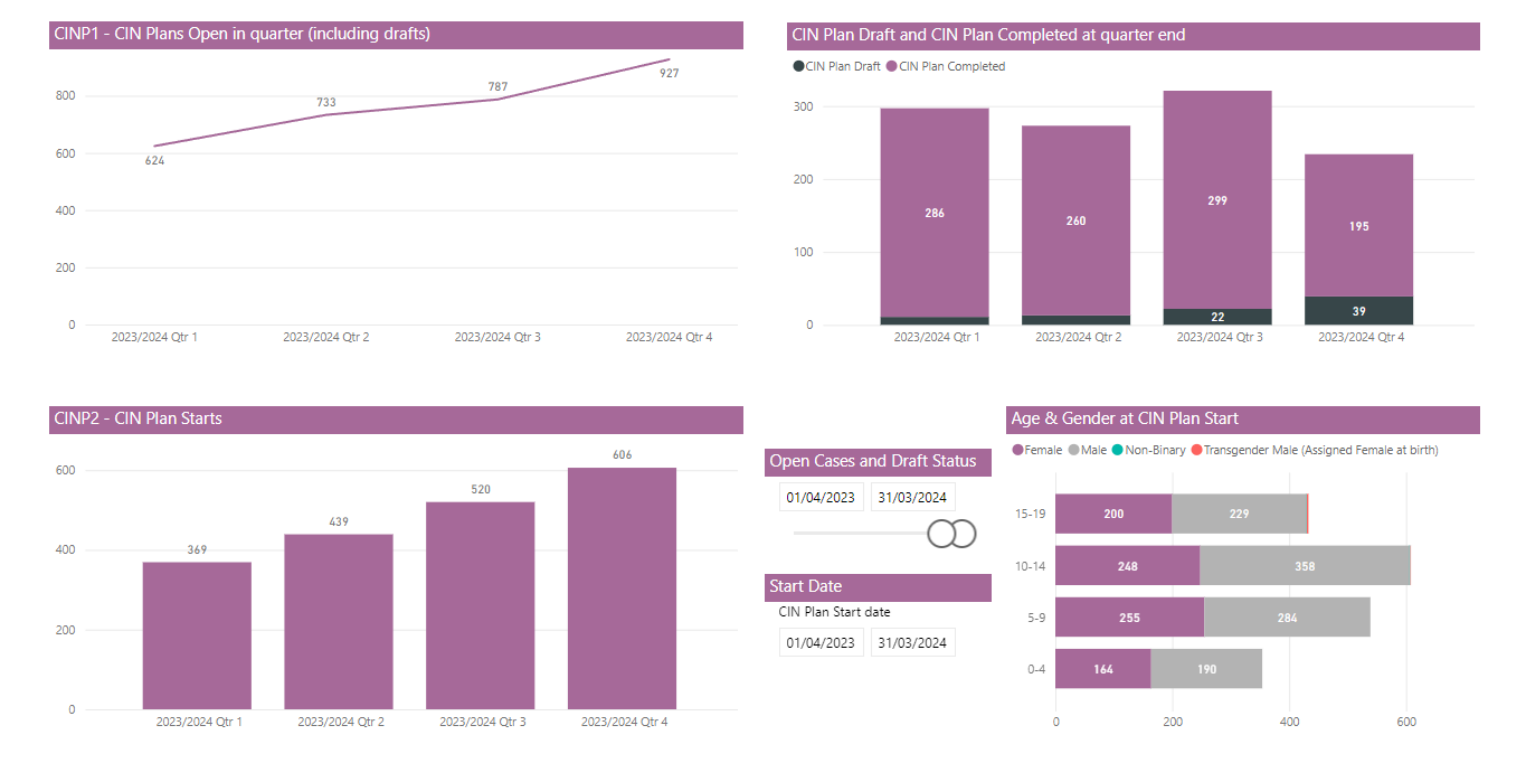
Referral Trends 01.04.2023 – 31.03.2024

There is a decrease in referral conversion over the last two quarters in 23/24, despite contact numbers remaining similar, although these have risen again in Quarter 1 24/25. The greatest conversion from contact to referral remain School and Police.



Child in Need Plans

Child in Need numbers have increased within the safeguarding service and the Disabled Children's Team. This has continued to rise throughout the year. A small number of children that are supported through CIN processes escalate to CP & CLA. This demonstrates the effective relationship-based work within Children's Services whereby 82% of children and young people that receive a CIN service step down from Children's Social Care.



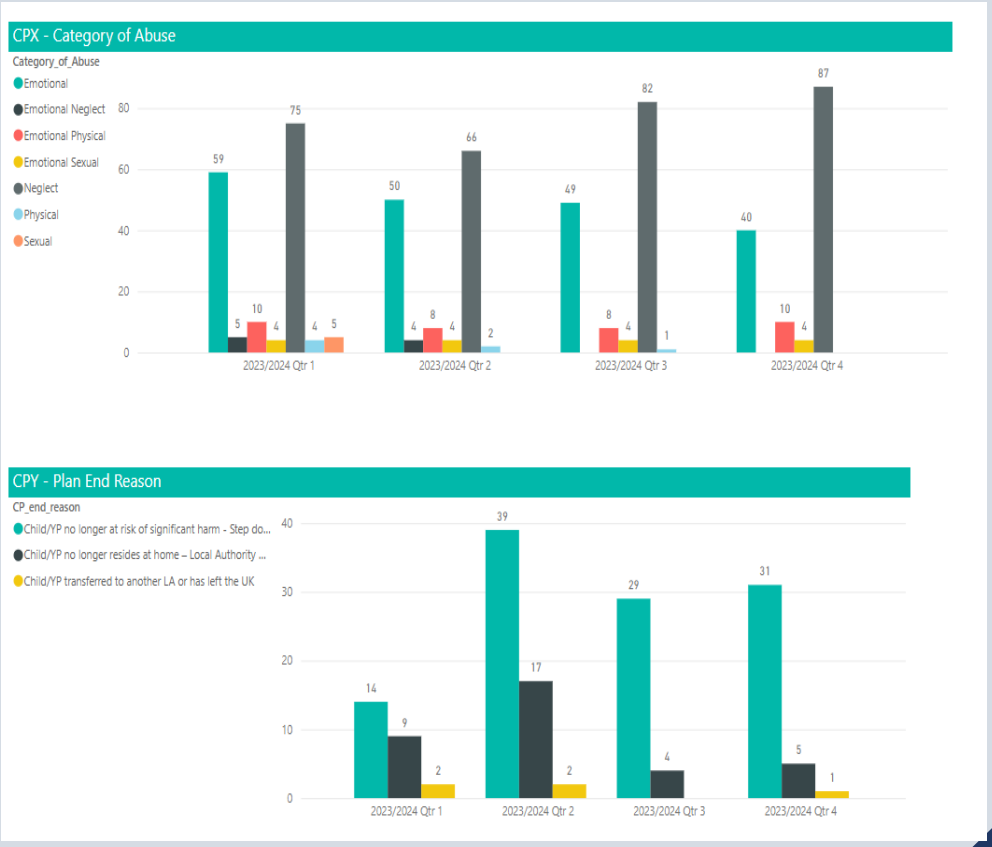

CIN Plans Ended and the Reason
CLA start
CPP start
Referral end
Number of Plans Ended
120
100
80
60
40
20
0
56
19
75
16
6
88
23
4
92
13
7
2023/2024 Qtr 1
2023/2024 Qtr 2
2023/2024 Qtr 3
2023/2024 Qtr 4
CIN Plans Ended and the Reason
CLA start
CPP start
Referral end
Number of Plans Ended
100%
80%
60%
40%
20%
0%
73%
25%
3%
77%
16%
6%
77%
20%
3%
82%
12%
6%
2023/2024 Qtr 1
2023/2024 Qtr 2
2023/2024 Qtr 3
2023/2024 Qtr 4

Children Looked After

Children Looked After numbers have come down again slightly with children leaving care due to their age and care proceedings concluding with family arrangements or children remaining with their parents. Numbers remain slightly higher than previous years due to increased complexities within families.

Child Protection

Only between 34% and 45% of Child Protection Enquiries result in threshold being met for an Initial Child Protection Conference. The rise in the child protection numbers in 2023 reflects the increased complexity that families are presenting to Children's Social Care, this has come down slightly, however remain high. In Banes as of 31.03.24 there were 141 children and young people subject of a CP Plan, only 9 of those young people have been subject to a CP Plan for more than 18 months. Emotional abuse and neglect have remained consistently the most notable category of need for children on child protection plans. Effective support is provided enabling the majority of families to step down to CIN with only a small amount becoming subject to legal proceedings.



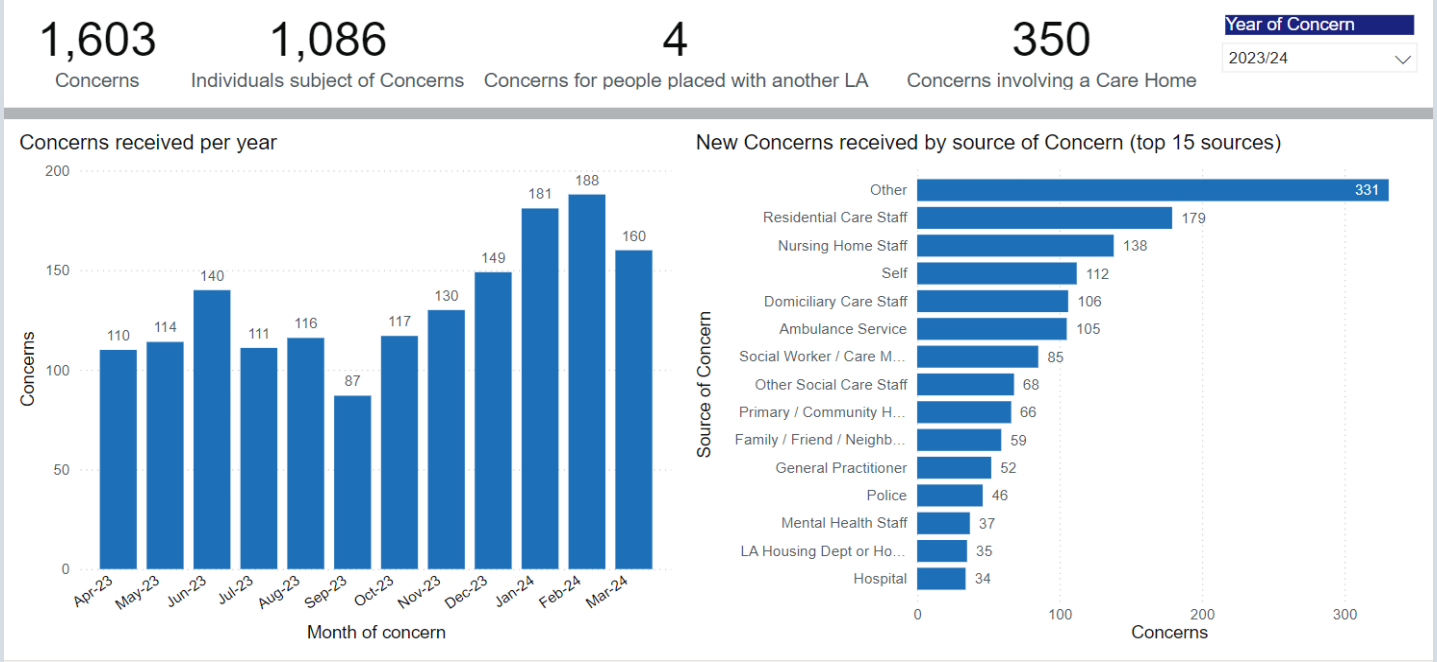
11.2 Adult Social Care Data

Concerns Received

The analysis undertaken in this section has been produced for the purposes of providing information for the Partnership Board, for the period of Q1-Q4 of 2023-2024.

For 2023/24 the reporting is based on the number of safeguarding concerns raised with B&NES Council that met the Care Act description of a safeguarding concern [Reasonable cause to suspect the risk of abuse or neglect].

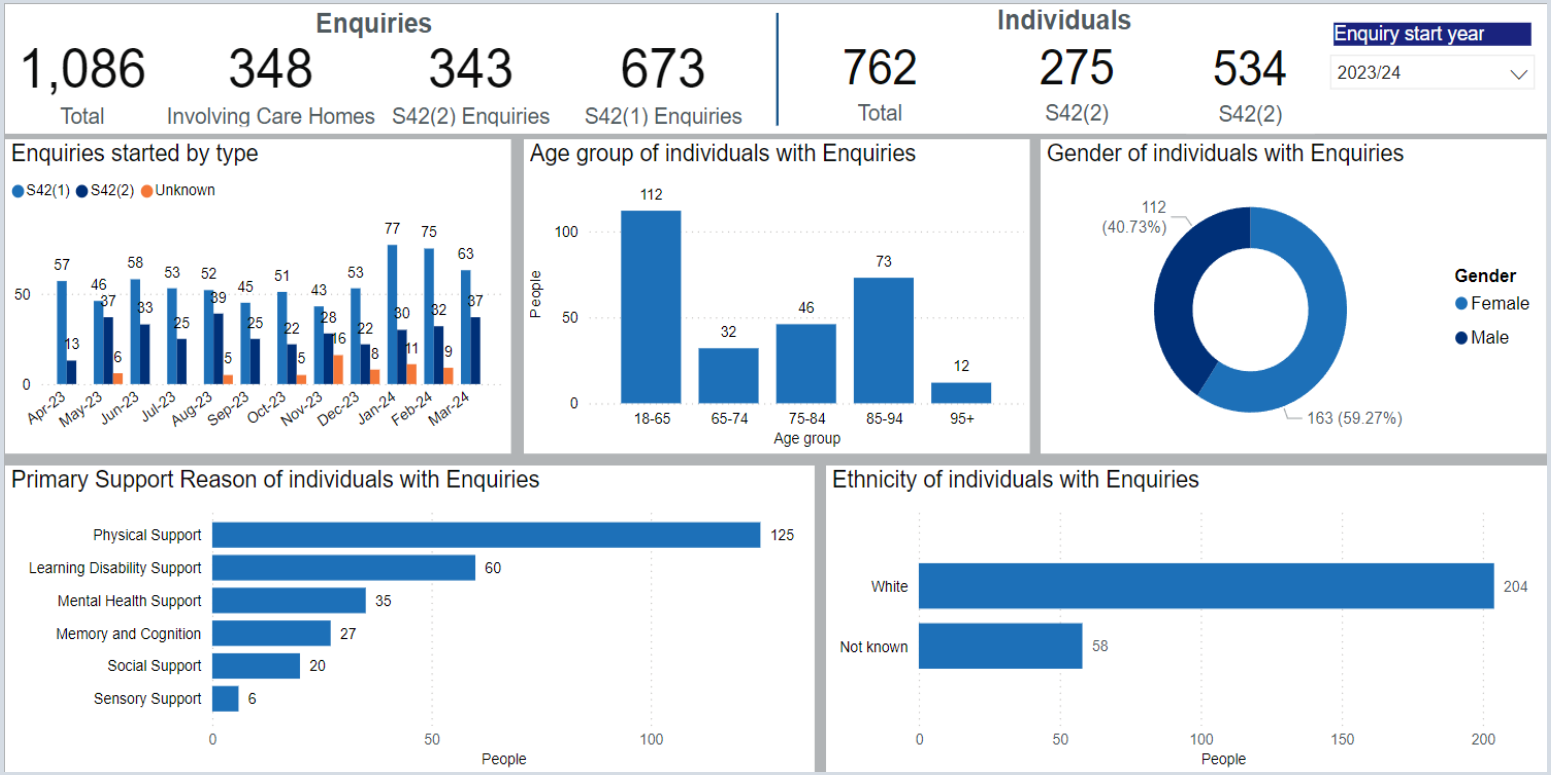
These are then described as s42(1) and s42(2) enquires. To note, when referenced both s42(1) and s42(2enquires are actually s42(2) enquires pursuant to the Care Act 2014. S42(1) enquiries are concerns that fit the s42(1) Care Act description, but alternative actions can be set, that will address the concern being raised, without a need for further enquiries. Actions are monitored by the Council Safeguarding and Quality Team and are not closed until assurance is received that all actions have been completed. A S42(2) enquiry is an enquiry where; further enquires and actions are required. These enquiries ordinarily lead to a Safeguarding Planning Meeting, an enquiry report being recorded and an action plan to reduce the risk to the person, developed.



Enquiries Starting

During the reporting period April 2023 – March 2024, 1603 concerns were raised relating to 1086 people. Previously we would report in addition to this, cases that were “screened out” before a threshold decision, as the concern did not relate to a safeguarding issue [Reasonable cause to suspect the risk of abuse or neglect]. We ceased to continue to capture these referrals on the introduction of the Safeguarding Portal in November 2023, whereby we had recorded 260 referrals were treated in this way.

Although we received 51 less concerns than in 2022-23 period, there is still a 57% increase in safeguarding alerts (from 1021 in 2021-22 to 1603 in 2023-24). The organisations that are reporting the most are residential homes, which were the highest reporting organisation type in the 2021-22 reporting year, compared to the highest number of concerns being reported last reporting year were by nursing homes. This is in comparison to last year being residential care settings. Reporting under ‘other’ continues to be high.

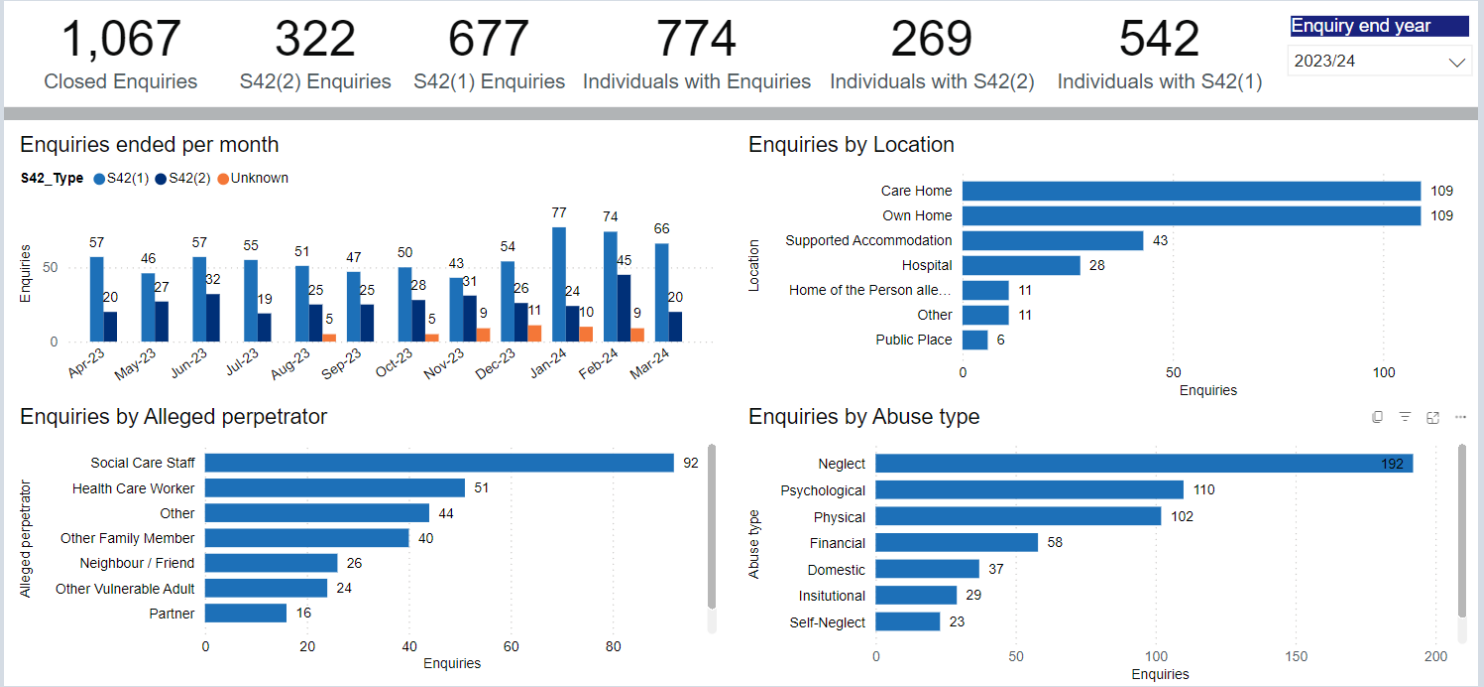


Enquiries Ended

Of the 1603 concerns, 343 progressed to S42(2) enquiries, with a conversion rate remaining at 21%, as reported last year. The report this year also shows that concerns which progressed to S42(1) have dropped from 809 last year to 673 this reporting year. The remaining concerns received did not met the Care Act s42(1) criteria and therefore did not required safeguarding actions. There have been 517 of these contacts received. The Safeguarding Team continue to monitor these referrals to see if there are organisations or types of issues that are reported that do not meet the Care Act criteria.

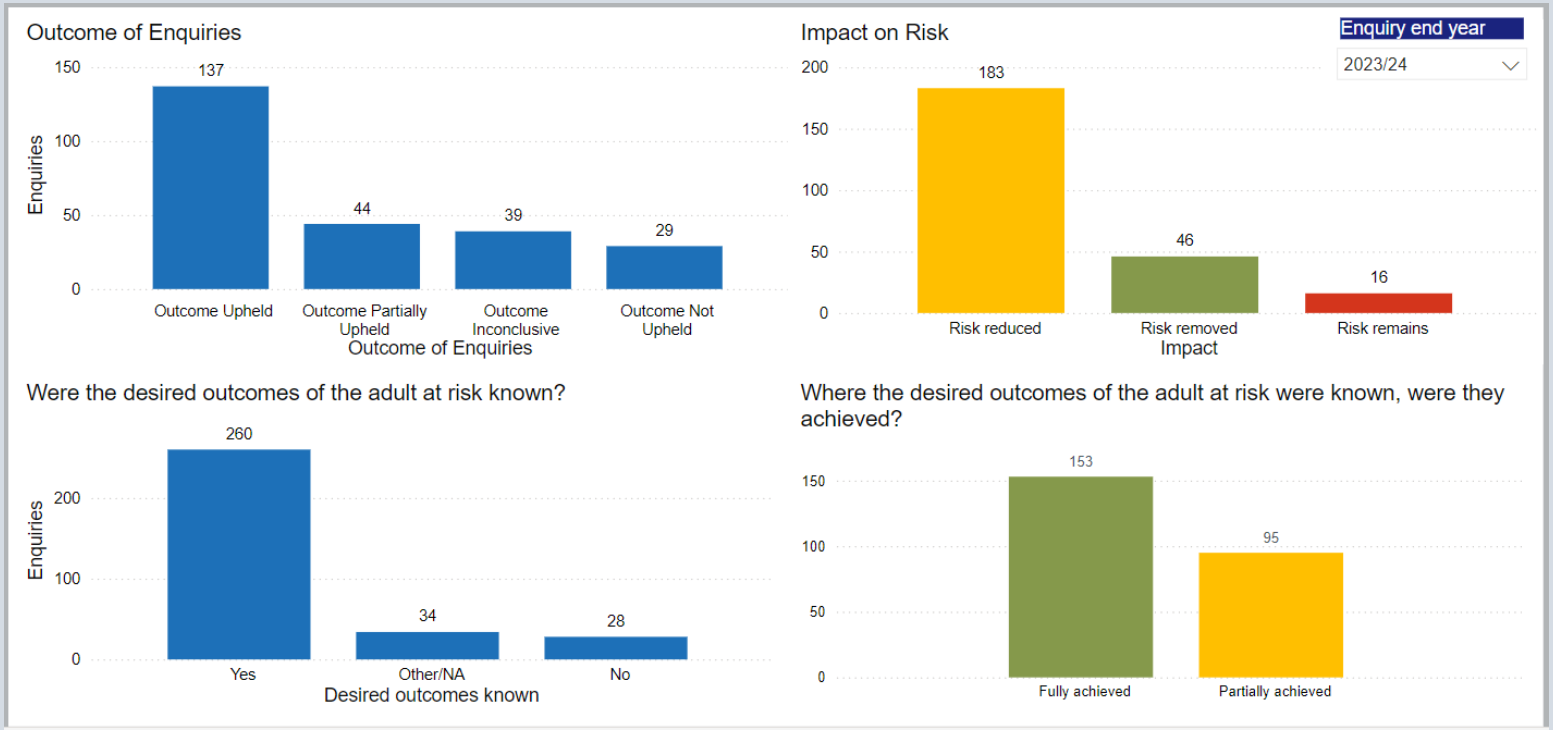
Primary Support Reason. There continues been an increase in the reported number of people with a physical disability, mirroring what was reported in last two annual reports. As part of the review of the data set and Liquid Logic changes, we have changed this to include “not divulge”, as well as “not known”. We will be able to report on this in the next annual submission.

Adults aged 18-65 continue to be the prevalent group, where enquires are being made, with enquires where the adult has been recorded as female, continue to be higher. As part of the review of the data set and Liquid Logic changes, although we report on biological assigned gender, we are now also capture self-identified gender identity.



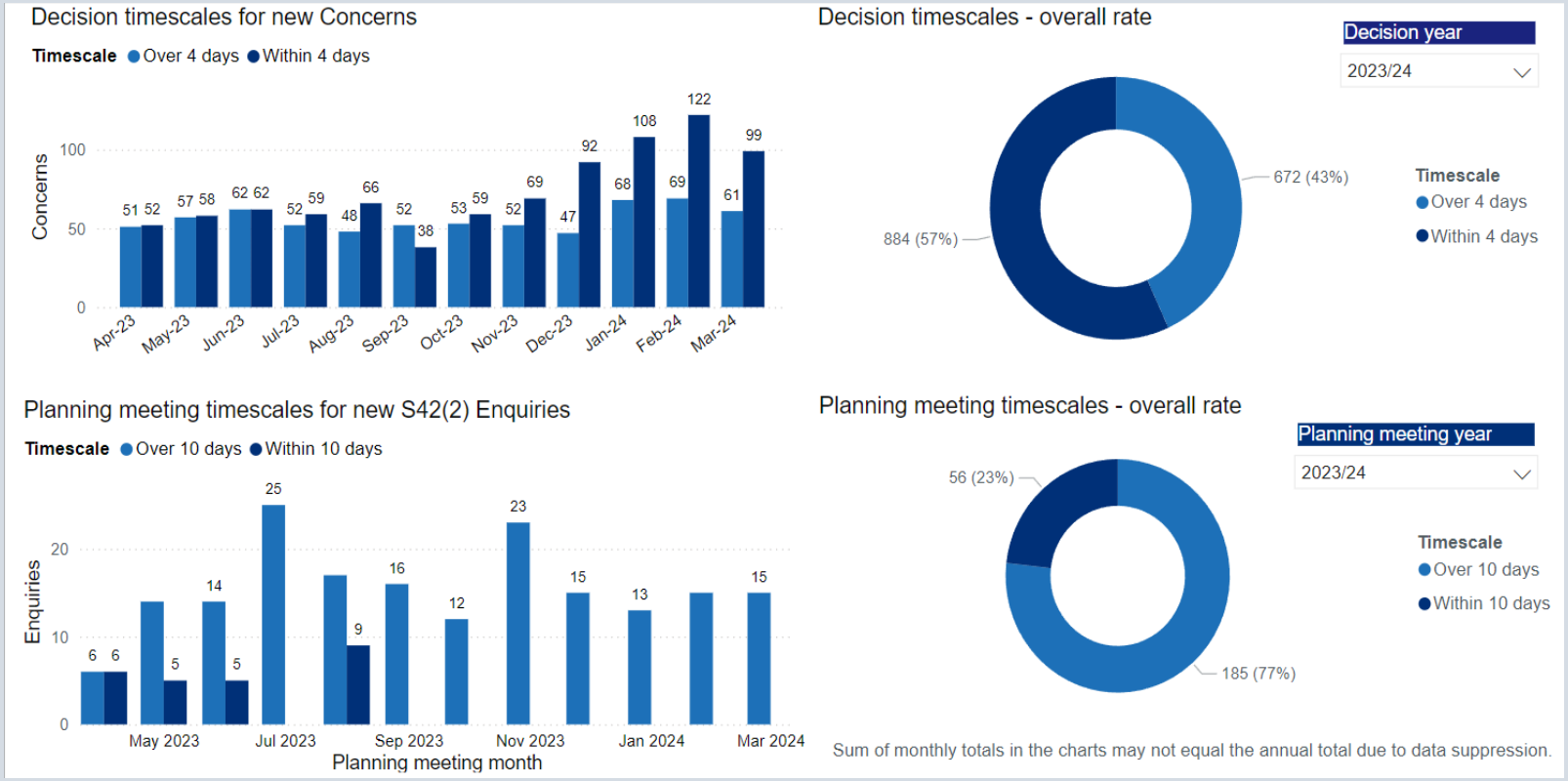
Outcomes of Closed Section 42(2) Enquiries

We previously reported that we had seen a decrease in adults being asked, and outcomes being expressed [from 70% in 2021-22 to 57% in 2022-23]. We are pleased to advice that we have seen this increase again. Out of the 322 s42(2) enquiries, nearly 81% of adults were asked and their outcome was known. Although we have seen a decrease in adults' outcomes being fully achieved, from 77% in 2022-23 to almost 59% this year. We attribute this change to more adults providing their desired outcomes and fewer, in fact no situations, where adults outcomes were not achieved [contract to last year where there were 9]. We have seen that the percentage in risk being reported to have been removed remains at 17% and in 70% of enquiries the level of risk experienced by the person is reduced during the safeguarding process, as reported in 2022-23.



Processing Performance

Although we do not have 100% of decisions being made within 4 days of the concern being raised, we are pleased to report that this has increased to 57%, from 42% reported last year. The performance for planning meetings currently sits at 23% being completed within 10 day. We continue to work towards these performance measures and continue to strive for 100% but attribute this to several factors. The increase in referrals, with no comparable increase in resources to manage this demand and the fact that “enquires” are being made earlier in the process, at the contact stage of receiving the referral.



11.3 Avon & Somerset Constabulary Data

Missing Children	12 Month Rolling			
	Current	Previous	Chg	% Chg
Number of Missing Children	105	98	+7	+7.1%
Number of Missing Children Reports	282	178	104	58.4%
Number of Repeat Missing Children	54	57	-3	-5.3%
Number of Children Missing from Care	8	6	+2	+33.3%
Number of Repeat Children Missing from Care	2	3	-1	-33.3%

The number of children reported missing, and the number of missing children reports, in Bath and North East Somerset continue to rise. 105 children were reported missing in the last 12 months, rising by 7 children or by 7.1% compared with the previous 12 months. 54 of these children were reported missing repeatedly, 3 fewer children than were reported missing repeatedly in the previous 12 months. The number of missing children reports rose to 283 in the last 12 months compared with 178 in the previous 12 months, an increase of 58.4%, significantly above the 5.6% rise recorded across the force area as a whole.

The number of children reported missing from care in Bath and North East Somerset remains low at 8 children in the last 12 months, rising from 6 children in the previous 12 months. The number of children going missing from care repeatedly fell to 2 children in the last 12 months compared with 3 children in the previous 12 months.

Safety and Anti-Bullying	12 Month Rolling			
	Current	Previous	Chg	% Chg
Number of Child Suspects of Crimes	590	560	+30	+5.4%
Number of Domestic Abuse Incidents (Excluding Crimes)	944	1,043	-99	-9.5%
Number of Domestic Abuse Crimes	1,926	1,696	+230	+13.6%
Number of Domestic Abuse Crimes - Victim Age 16 - 17	46	37	+9	+24.3%
Number of Child Victims of Crimes	908	719	+189	+26.3%
Number of Child Victims of Race Hate Crimes	26	28	-2	-7.1%

The overall number of child victims of all crime types in Bath and North East Somerset rose by 189 victims to 908 victims in the last 12 months, or by 26.3%, compared with the previous 12 months. This rate of increase is above the 17.7% increase recorded across the force area as a whole.

The number of Domestic Abuse Crimes with a victim aged 16 or 17 recorded in Bath and North East Somerset rose by 9 crimes in the last 12 months compared with the previous 12 months. The numbers recorded in Bath and North East Somerset are relatively small. However, the 24.3% increase does contrast with the position across the force area as whole where the number of Domestic Abuse Crimes with a victim aged 16 or 17 remained almost unchanged.

The number of child victims of recorded Race Hate Crimes in Bath and North East Somerset fell by 2 victims to 26 victims in the last 12 months from 28 victims in the previous 12 months. Given the relatively small numbers involved, care should be taken when comparing the percentage change in Bath and North East Somerset with the percentage change recorded force-wide. All forms of Hate Crime are subject to a high degree of under-reporting and it can reasonably be concluded that the actual levels are greater than the levels reported.

Child Sexual Exploitation	12 Month Rolling			
	Current	Previous	Chg	% Chg
Number of Child Sexual Exploitation Crimes	72	129	-57	-44.2%

Child Sexual Exploitation (CSE) is not a Home Office “offence type” and CSE offending is made up of a wide range of offences. A CSE flag is therefore attached to qualifying offences on police systems. The number of Child Sexual Exploitation tagged offences in Bath and North East Somerset fell in the last 12 months, compared with the previous 12 months, by 44.2% or by 57 crimes to 72 crimes in total. This fall is greater than the 37.9% fall recorded across the force area as a whole. As highlighted in past commentaries, changes in this measure can be difficult to interpret, given that it measures both the effectiveness of activity to reveal this often “hidden” form of abuse and increase recognition and reporting, and the effectiveness of activity to prevent sexual exploitation, including repeat victimisation. This measure shows wide fluctuations in identified offences and the reductions reported here should not be interpreted as indicating a decline in the prevalence of CSE.

Child Protection	12 Month Rolling			
	Current	Previous	Chg	% Chg
Number of Child Protection Crime (excluding Domestic Abuse Crimes)	339	303	+36	+11.9%
Number of Child Protection Serious Sexual Offences	94	67	+27	+40.3%
Number of Non-Familial Sexual Crimes - Child Victim	145	107	+38	+35.5%
Number of Child Protection Crimes for Cruelty and Neglect of Children	172	64	+108	+168.8%

The “Child Protection Crimes (excluding Domestic Abuse Crimes)” are recorded crimes where there are child protection concerns (Child Abuse, Child Sexual Exploitation, Child Safeguarding), with this particular measure excluding Domestic Abuse Crimes where there are child protection concerns. The measure also includes peer-on-peer crimes where both the victim and suspect are children. The measure includes non-recent child abuse allegations, regardless of whether the victim was a child or adult at the time of reporting.

The data shows that the volume of recorded “Child Protection” crimes in Bath and North East Somerset rose by 11.9%, or by 36 crimes, in the last 12 months compared with the previous 12 months, rising to 339 crimes. This increase is in line with the 12.3% increase recorded across the force area as a whole. This should be viewed in the context of sustained increases in the volume of these offences across the last decade.

Demand on the system from Child Abuse offences remains high across the force area as a whole and the long-term trend remains one of significant growth. Force forecasting indicates that overall demand from Child Abuse offending (excluding Indecent Images of Children (IIOC) offences) is likely to increase by about 13.2% over the next 4 years to about 8,760 offences by 2027/28. The sustained increases in the numbers of suspects downloading and sharing IIOC and engaging with children online are expected to continue. A simple projection of demand dealt with by the Internet Child Abuse Team (ICAT), based on previous referral increases, indicates a 46% - 65% increase on current volumes of referrals by 2026. Recent legislative provisions are expected to increase industry detection which will contribute to increased IIOC referrals to the Constabulary.

Within the partnerships’ agreed broad measure of “Child Protection” crimes, there were increases in recorded offences in Bath and North East Somerset in all 3 offence groups. Recorded child neglect offences in Bath and North East Somerset rose by 108 crimes in the last 12 months compared with the previous 12 months to 172 crimes. This 168.8% increase is above the 148.6% increase recorded across the force area as a whole. The increases might be attributable, in part at least, to the work of the child safeguarding partnerships to increase professionals’ awareness and understanding of child neglect and the action to take. Non-familial sexual offences against children in Bath and North East Somerset rose by 38 crimes to 145 crimes; this 35.5% increase is more marked than the 11.5% increase recorded across the force area as a whole. Recorded Child Protection Serious Sexual Offences rose by 27 crimes to 94 crimes in the last 12 months in Bath and North East Somerset, a 40.3% increase which is well above the 10.7% increase recorded across the force area as a whole.

Initial Child Protection Conferences

The Police were invited to 17 Initial Child Protection Conferences (ICPCs) in Bath and North East Somerset in the fourth quarter of 2023/24 and attended all 17. The police attended all 78 ICPCs held in Bath and North East Somerset in 2023/24.

Use of Police Protection Powers

Across the force area as a whole, the Constabulary used police protection powers under Section 46 of the Children Act 1989 on 384 occasions in 2023/24, compared with 317 occasions in 2022/23, a 21.1% increase. The volume remains high compared with historical levels.

The reporting of the use of police protection powers at local authority area level is subject to data quality issues whereby 27 records in the last 12 months, and 15 records in the previous 12 months, were not linked to a beat code. The Constabulary used police protection powers linked to beat codes in Bath and North East Somerset on 41 occasions in the last 12 months, compared with 45 occasions in the previous 12 months, and 8.9% fall.

Children in Custody

In the last 12 months, 70 children and young people aged under 18, whose latest recorded address was in Bath and North East Somerset, were arrested and brought into custody, 8 of whom were charged and detained. Of these 74 children and young people, one of whom was arrested and brought into custody in the fourth quarter of 2023/24, none of whom were charged and detained.

12. Glossary

Term	Meaning
ACEs	Adverse Childhood Experiences – traumatic events occurring before age 18. Includes all type of abuse and neglect, as well as parental mental illness, substance misuse, domestic violence.
ADASS	Association of Directors and Adult Social Services – a charity representing Directors and a leading body on social care issues.
AMHP	Approved Mental Health Professional – approved to carry out certain duties under the Mental Health Act
ASSSP	Avon and Somerset Strategic Safeguarding Partnership – Avon area multi-agency group focussed on children's safeguarding
AWP	Avon & Wiltshire Mental Health Partnership NHS Trust
B&NES	Bath & North East Somerset
BCSSP	B&NES Community Safety & Safeguarding Partnership
BIA	Best Interest Assessor – ensure that decisions about patients/service users which affect their liberty are taken with reference to their human rights
BSW	B&NES, Swindon Wiltshire area
CAMHS	Child and Adolescent Mental Health Services
Care Act 2014	Sets out the duties of the local authority in relation to services that prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.
Community Triggers	This is related to anti-social behaviour. Where anti-social behaviour has been reported and it is felt not enough action has been taken, a community trigger can be used, which means the case will be reviewed by those agencies involved.
Contextualised Safeguarding	An approach to understanding and responding to, young peoples experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse.
CP	Child Protection
CSE	Child Sexual Exploitation – a type of sexual abuse. When a child is exploited, they are given things like gifts, money, drugs, status in exchange for performing sexual activities

Term	Meaning
CSPR	Child Safeguarding Practice Review – should be considered for serious child safeguarding cases where abuse or neglect is known or suspects and the child has died or been seriously injured.
CQC	Care Quality Commission – regulates all health and social care services in England
Cuckooing	The practice of taking over the home of a vulnerable person in order to establish a base for illegal drug dealing, typically as part of a County Lines operation.
Dark Web	Is part of the Internet that isn't visible to search engines. It is used for keeping internet activity anonymous
DHR	Domestic Homicide Review – is conducted when someone aged 16 or over dies as a result of violence, abuse or neglect by a relative, household member or someone they have been in an intimate relationship with.
DHI	Developing Health & Independence
Discharge to Assess (D2A)	Where people do not require an acute hospital bed but may still require care services are provided with short term, funded support to be discharged to their own home or another community setting. Assessment for longer term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
Disrupt	Work to disrupt serious organised crime
DoLS	Deprivation of Liberty Safeguards – ensures people who cannot consent to their care arrangements in a care home or a hospital are protected if those arrangements deprive them of their liberty
ICB	Integrated Care Board

IDVA	Independent Domestic Violence Advocate – specialist professional who works with victims of domestic abuse

Term	Meaning
JTAI	Joint Targeted Area Inspection – of services for vulnerable children and young people
LADO	Local Authority Designated Officer – responsible for managing child protection allegations made against staff and volunteers who work with children and young people
LPS	Liberty Protection Safeguards – set to replace Deprivation of Liberty Safeguards
Local Safeguarding Adult Board	Assures itself that safeguarding practice is person centred and outcome focussed, working collaboratively to prevent abuse and neglect. Now part of the BCSSP
Local Safeguarding Children's Board	Assure itself that local work to safeguard and promote the welfare of children is effective and ensures the effectiveness of what member organisations do individually and together. Now part of the BCSSP
MARMM	Multi-agency Risk Management Meeting – convened regarding self-neglect and hoarding concerns
MARAC	Multi Agency Risk Assessment Conference – a victim focussed information sharing and risk management meeting attended by all key agencies
MASH	Multi Agency Safeguarding Hub – Information sharing where decision can be made more rapidly about whether a safeguarding intervention is required
MCA	Mental Capacity Act – designed to protect and empower people who may lack the mental capacity to make their own decisions about their care
Ofsted	Office for Standards in Education, Children's Services and Skills.
Prevent	Prevent is about safeguarding and supporting those vulnerable to radicalisation. It aims to stop people becoming terrorists or supporting terrorism
RAG	Responsible Authorities Group – the local strategic partnership delivery arm for community safety in B&NES, now part of the BCSSP
SAC Data	Safeguarding Adults Collection Data – NHS digital collate data nationally
SAR	Safeguarding Adult Review – may be carried out when an adult' dies or is seriously harmed as a result of abuse and/or neglect and there is concern that agencies could have worked together more effectively to protect the adult

SARI	Charitable organisation – Stand Against Racial Inequality – which provides training and advocacy services
SCR	Serious Case Review now replaced by Child Safeguarding Practice Review
Term	**Meaning**
SHEU	School Health Education Unit
SICC	Senior In Care Council – empowered to undertake projects to make the changes they want to see to improve the experiences of young people in care
Section 11 Audit (statutory)	A self-assessment audit designed to seek assurance that key people and agencies make arrangements to ensure their functions to safeguard and promote the welfare of children
Section 175 Audit (statutory)	A self-assessment audit that seeks assurance that education establishments make arrangements to ensure their functions are carried out with a view to safeguarding and promoting the welfare of children
VAWG	Violence Against Women and Children (funded) project
VRU	Violence Reduction Unit – provides a local response to serious violence
WRAP	Workshop to Raise Awareness of Prevent