GLOUCESTERSHIRE SAFEGUARDING CHILDREN PARTNERSHIP SECTION 11 AUDIT.

2020

Section 11 of the Children Act 2004 Places duties on a range of 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. (WT2018 p.g.58)

Gloucestershire Safeguarding Children Partnership

NHS
Gloucestershire
Clinical Commissioning Group

Gloucestershire
COUNTY COUNCIL

Report of the Gloucestershire Section 11 Audit 2020.

Kevin Crompton Independent Scrutineer March 19th 2021

1. Introduction.

In December 2019 the Gloucestershire Safeguarding Children Executive (GSCE) agreed a themed S11 audit as recommended by the Gloucestershire Safeguarding Children Delivery Board. This process was agreed by the key agencies linked into the Gloucestershire Safeguarding Partnership with the exception of schools whose compliance with safeguarding is monitored through the S175 audit process.

The themed audit was designed to check compliance with 4 of the S11 standards previously agreed by the partnership chosen due to the overlap with key recommendations arising from Serious Case Reviews (SCR). The four standards chosen were:

1. Leadership and accountability
2. Staff safe recruitment, induction, training and development
3. Safeguarding policies and procedures
4. Listening to children and young people

Agencies were also provided with 12 SCR recommendations against these standards and were invited to prepare a submission outlining how their agency was performing in these areas with evidence of how the recommendations had been met. A panel was established consisting of:

Kevin Crompton	Independent Scrutineer and Chair of the Panel
Andy Dempsey	Director of Partnerships & Strategy, GCC and Chair of the GSCE Delivery Board
Caroline Eardley	GSCE Delivery Board Lay Member
Joanna Nicolas	Independent Safeguarding Specialist

And supported by :

Dave Jones	GSCP Business Manager
Jackie Barnes	GSCP Senior Administrator

Due to Covid 19 restrictions the panel met 'virtually' which in itself presented some difficulty as the chosen platform did not perform well meaning one member of the panel could not engage in dialogue easily and another, Andy Dempsey, had to leave the panel due to technical issues. Nevertheless, a meeting was conducted with the following agencies all of whom provided a written submission:

- Gloucestershire Clinical Commissioning Group (GCCG)
- Gloucestershire Health and Care NHS Foundation Trust (GHC)
- Gloucestershire Hospitals NHS Foundation Trust (GHT)
- Gloucestershire County Children's Social Care (GCSC)
- Gloucestershire County Children's Commissioning (GCC)
- Gloucestershire Youth Offending Service (YOS)
- Gloucestershire Probation Service (PS)
- Gloucestershire Constabulary (GC)
- District Councils Sub Group (formerly the Gloucestershire District Safeguarding Network) (DSG)

Gloucestershire Safeguarding Adults Board (GSAB) submitted a report giving general reassurance that there are good links with children's safeguarding and GCSC but they did not attend the panel. Attendance at the panel was not mandatory under this process. During the panel sessions there were a number of discussions on the interface between children's and adults' services which were generally reassuring however this may be an area for GSCP to consider in the future given the correlation between children at risk and adults with challenging behaviour / vulnerabilities.

Written submissions were also received from British Transport Police (BTP) and the National Probation Service (NPS). These submissions were national responses to S11 compliance and as such were not specific to the Gloucestershire Partnership but gave general assurance that both were compliant with their section 11 responsibilities.

The submissions varied in style and some were accompanied by other documents often inserted as hyperlinks some of which worked better than others. These submissions were received by the panel members 5 working days before the panel was due to be held. This was less than the 15 working days lead in time envisaged in the original timescale for the panel. The main consequence of this truncated timescale, and the volume of paperwork submitted, was that the panel had a number of questions on the day. The panel agrees with the view of some of the participants that it would have been better if some of the questions had been provided to agencies in advance of the meeting but there was insufficient time for the panel to read all the reports and distribute their questions to agencies in advance.

The response to questions also varied in respect of the seniority of the representative as some could not be expected to hold the full picture. Nevertheless, all agencies engaged well with the process and the dialogue was positive. Appendix 1 aims to capture the dialogue and the views of the panel based on our discussions, the documentation received and other conversations with the IS outside of the panel.

If this process is to be used in future some of the issues raised above need to be considered and a more refined process agreed which would include strict adherence to timescales; agreement on the level of seniority of those attending; more guidance on the required submission; and, ensuring time for any panel questions to be circulated beforehand.

The panel also agreed to explore two questions of all agencies attending.

Firstly, a question was asked around the agencies view of the impact of the implementation of the Working Together 2018 arrangements on partnership working.

Secondly, given the themed approach included the implementation of SCR recommendations the panel asked agencies about the impact of the recommendation from the James SCR (July 2019) authored by Joanna Nicolas. The recommendation was:

'The Safeguarding Partnership to review and amend the Levels of Intervention (LOI) threshold document to reflect the additional risk if the mother is pregnant, or there is a child under one, and there is domestic abuse. Once this is done the amendment and the reasoning for it must

be widely disseminated through the Safeguarding Partnership with particular emphasis on CSC, as the lead agency in child protection, and the Multi Agency Safeguarding Hub (MASH).'

The LOI was amended in January 2020 but the panel was interested in how this change was impacting on practice. The panel also explored specific actions from James for individual agencies e.g. changes to GC's "how to" guide on domestic abuse.

Whilst this specific recommendation was not within the scope of this S11 process the panel wanted to explore the overall understanding within agencies of SCR recommendations in general and the impact within their agency.

The panel wish to acknowledge the challenges faced by all agencies this year. It was clear that the response to Covid 19 had impacted on them. Whilst a variety of evidence, for example the recent Ofsted letter, confirms that Gloucestershire agencies have responded well to the challenge of the pandemic, finding ways to continue service provision and keep children and young people safe, it was clear that some plans and 'business as usual' activities had either been postponed or happened at a slower rate due to the need to prioritise the response to Covid-19. This audit process had; for example, been postponed as some agencies had struggled to prioritise the writing of their submission. The Panel acknowledges this and has tried to take it into account when considering the evidence and the recommendations made within this report

The findings are based mainly on the written submissions and evidence from the discussion at the meetings. The IS has however supplemented the evidence through other reading and conversations with key partners.

The panel wishes to thank all those participating in this review for the openness of the dialogue and particularly for allocating time to the exercise given the pressures on all agencies at this time.

Kevin Crompton
Independent Scrutineer and Chair of the Review Panel

2. The findings.

Leadership and accountability: **Green**

- There is a good level of compliance with S11 duties within partner agencies.
- Senior leaders are appropriately qualified experienced and committed.
- Professional accountability structures are clear in all partner agencies including in respect of commissioning and commissioned services.
- All required designated and named posts are filled within the NHS sector. Capacity has also recently been increased to ensure the posts have a single focus. Prior to this some post holders held more than one role.
- Capacity may still be an issue within the partnership especially time for partnership working but this is an area where Covid -19 has had an impact and therefore will need further review in the post pandemic era.
- The professional support for designated and named professionals is in place.
- Governance of the GSCP has been revised and is 'fit for purpose'.
- Individual agencies appeared to be aware of their strengths, weakness and areas for improvement.
- Agencies all have internal systems for monitoring and quality assuring safeguarding.
- There is strong vertical compliance within the partnership in respect of safeguarding within single agencies.
- It was less easy to discern horizontal alignment between single agency improvement work/plans/QA systems and GSCP priorities.
- The CSC Accelerated Improvement Plan is the most visible of the single agency plans yet most agencies have a safeguarding plan in place.
- The GCSC Improvement Board provides visibility to partner agencies of the AIP; the performance of GCSC and progress with the improvement journey. Recent attention to partnership issues such as strategy discussions; threshold and children of concern initiated through this route has provided the basis for improved working between partners particularly the three safeguarding partners.
- The MASH continues to provide a basis for positive partnership working and performance review.
- The GSCP annual report sets out the priorities for the partnership but there is currently no overall partnership plan; this might well emerge through the work of the new management group and sub-groups.
- The knowledge of agencies of each other could be improved through the routine sharing of key documents such as annual reports; internal performance reports, single agency case file audits and external audits.
- Child Friendly Gloucestershire has now gained greater momentum and provides a context for wider partnership ambition for children and young people. This also evidences good links between the Health and Well Being Board and the GSCP. However, this link could be more visible e.g. there is no obvious link between the GSCP website and CFG.

Staff safe recruitment, induction, training and development - **Amber**

- Safe recruitment practice was in place in all agencies
- Most agencies have an induction process which includes a safeguarding element.
- There are some excellent examples of single agency training in respect of safeguarding, however, GSCP training and development would appear to need a review which the panel understands is underway.
- The language of 'levels 1 to 3' was most current in discussions as opposed to a broader concept of a 'curriculum for safeguarding' which the panel understands is the proposal for the future.
- NHS training could be more coordinated as each agency appears to be doing their own version of L1 through to L3. There is further divergence depending on whether agencies use the GSCP training or not.
- The level of commitment and attendance on multi agency training needs to be reviewed. Level 1 and 2 training is largely single agency. Some level 3 is single agency aligned to the GSCE level 3 training.
- Given the possible benefits of multi-agency training, as opposed to single agency training that is aligned to a multi-agency approach, GSCP should review it's training and development policy.
- The GSCE training 'offer' is not yet widely known (see above)
- C-19 has seen an increase in the development and use of on-line training some of which it is claimed is of good quality.
- Most agencies have supervision policies and procedures in place but a number are still in development.
- The effectiveness of supervision is an area for review/monitoring in some key agencies.
- There are some good examples of practices aimed to encourage staff to feel comfortable in raising concerns and if required escalating them through the appropriate single agency or GSCP Escalation Policy and Procedure.
- Regular reflective review of safeguarding practice is in place in most agencies.

Safeguarding Policies and procedures - **Amber**

- There are a range of single agency strategic and operational documents which set out clear priorities for safeguarding and promoting the welfare of children and young people.
- The challenge is that it is not clear how GSCP priorities are consistently reflected in the single agency documents.
- There is a need to ensure that all versions of policies and procedures available online are the most up to date versions.

- There has been a lot of updating of policies/procedures in single agencies and it is not always clear how such policies relate to partnership wide policies and procedures.
- The GSCP Escalation Process is used more by some agencies than others. The evidence suggests that agencies are taking steps to ensure staff are aware of the process.
- Whilst the process for dealing with allegations of abuse made against staff members was not explicitly addressed other evidence would suggest that the work of the LADO in Gloucestershire is widely understood as is the associated process.
- The MASH and other work has enabled greater understanding of information sharing. Given though it still features as an issue in some Rapid Reviews and SCRs it remains a priority for the partnership.

Listening to children and young people - **Green**

- There is a strong commitment across agencies to engaging with children and young people and trying to ensure their voice is heard and makes a difference.
- The GCC Ambassadors are engaged by several partners and their feedback to the GCC Improvement Board is welcomed by all partners.
- Individual agencies have a range of 'tools' and practices to capture the voice of the child or young person. There was less evidence of how effective those processes are or how they are viewed by children and young people. The partnership should consider further audit of the effectiveness of each major partner in engaging and responding to children and young people.
- There was some good practice within some Districts which could be replicated by others.

The impact of WT18 - **Green**

- Agencies differed in their view of the impact of the changes varying from ''yes there is real change" through to the "jury is still out"
- The audit work and plans for a cases of concern group (CSC, GC, GCCG and GCSC) were cited as an example of positive change.
- The neglect audit and the work of the task and finish group on the pre-birth protocol were also mentioned as marking a real change in the work of the partnership.
- There were positive comments on the way individuals now talk to and with each other.
- The new governance is seen as being on a journey with the recent establishment of the management group as a break with the past.
- The Children First Scheme run by the YOS was cited as an example of excellent partnership working.
- There was a positive view of the potential for the partnership to improve further in the future.

- It was recognised that the key challenge is to evidence that the partnership is having a strong impact on the quality of safeguarding practice in all agencies and improving the lives of children at risk.

The implementation of the SCR recommendation from James - **Red**

- There were delays in implementing the recommendations from the James SCR
- Opportunities had been missed by some agencies to emphasise the significance of the recommendation regarding domestic abuse; pregnant mothers; and children under 1.
- Because of the delays in implementation it was not possible for the panel to identify real change as intended by the recommendation.
- The action taken within the MASH and through the GCSC essentials programme though should now ensure a better impact from the change in the LOI in respect of the James recommendation but this will need to be evaluated in due course.

3. Summary.

Overall the S11 audit provided evidence of strong compliance and therefore provides good assurance that the GSCP agencies are fulfilling their duties but this includes a good awareness of the areas in which performance can and needs to be improved. The real challenge is that the partnership has historically failed to deliver too many SCR recommendations in a timely and effective manner and some key responses (neglect strategy/tool kit, pre-natal protocol etc) have not had the intended impact on practice. In respect of the 12 SCR recommendations most agencies can show what they did as a response but few could point to evidence that it was having a positive impact on front line practice where this was the intention. Better evidence was available around changes to staff supervision; use and awareness of the GSCP Escalation Process; or, the training to improve safeguarding practice. There was less evidence to be confident that levels of 'professional curiosity' had increased or that there was a better understanding of what 'professional curiosity' means within GSCP. The panel felt that the GSCP should review the SCR/RR/LCSPR 'tracker' as it was clear that the existence of over 200 recommendations was in danger of overwhelming the partnership. The panel concluded that the GSCP RRs and LCSPR had superseded the SCR era and that implementing those more contemporary recommendations should be a priority given that they capture much of previous SCR learning. It was also the case that the single agency plans discussed all appeared to have incorporated actions required as a result of SCR recommendations. Some agencies had their own 'tracker' sometimes using a RAG rated system and these still had a number of amber ratings.

1. Recommendations

- The GSCP should consider giving greater visibility to their overarching strategy including the commitment to Child Friendly Gloucestershire.
- The GSCP should consider developing a more visible plan that captures the improvement work being done between agencies.
- The GSCP should consider the overall training being utilised across the partnership and consider whether alignment is sufficient to underpin multi agency working.
- The GSCP should review its commitment to all agencies attending relevant multi agency training
- The safeguarding partners should share more of the information they use themselves to quality assure their safeguarding activity.
- This S11 process could be improved by a greater lead in time, a standard template and a consistency in terms of seniority of attending representative.
- Include an ambassador on any future S11 panels
- The partnership needs to continue to monitor the speed and effectiveness of partners response to recommendations from SCRs, RRs and LCSPR'

Appendix 1. Key issues from discussion.

1. Health Sector:

Gloucestershire Clinical Commissioning Group

a. Leadership and accountability

The GCCG provided extensive documentation and an overview report setting out how the organisation is complying with the NHSE Safeguarding Assurance and Accountability Framework (SAAF) and WT 18 S11 responsibilities.

There had been two external audits of safeguarding – Adults (2018) and Children (2019) which were reported to the GCCG audit governance group which in turn reports to the GCCG Governing Body on progress in implementing actions arising from these audits.

Safeguarding Governance appears to be strong and this is reflected in a clear professional line of accountability encompassing all safeguarding roles and reporting to the accountable officer through the GCCG Executive Nurse who leads on safeguarding. This has also been supported by additional investment in the designated Dr and Nurse for children in care roles. The Dr is a salaried GP in a Gloucestershire GP practice and the Nurse is employed by the CCG. The GCCG also convenes and leads the Gloucestershire Safeguarding Children's Strategic Health Group which has been put in place to coordinate children's safeguarding across the Gloucestershire health economy. It meets regularly and is evolving as an effective forum to discuss safeguarding policy, practice and performance across all NHS agencies. It is chaired by the Executive Nurse.

There is a separate group for adult safeguarding.

The CCG participates fully in the regional and national arrangements for safeguarding which includes regular reports feeding into local, regional and national reports on safeguarding on a bi-monthly and annual basis. These reports are not currently shared with the GSCP.

The Safeguarding Annual report (2020) is a good summary and gives an overall view. It would be helpful if this was formally shared with the GSCE to allow the safeguarding partners to understand the work of each other.

The GCCG has a safeguarding strategy but the panel had difficulty locating this on the GCCG website.

The external audit (2019) identified that processes for monitoring safeguarding practice in primary care were ineffective. As a result, the GCCG has introduced a primary care annual audit effective from April 2020.

The GCCG takes steps through its commissioning process to ensure that commissioned services are compliant with safeguarding responsibilities.

b. Staff safe recruitment, induction, training and development

All GCCG contracts include a safeguarding section which sets out expectations to ensure compliance with safe recruitment. The GCCG employment process follows safer recruitment practice. An introduction to safeguarding is included in the GCCG induction programme.

Designated, named, and specialist staff are all receiving appropriate professional development and training supported by a regular appraisal process. There are meetings with similar staff in provider services on a regular basis.

A new GCCG safeguarding supervision policy has been implemented initially focussed on continuing healthcare nurses.

Progress is being made with primary care. All Primary care practices are required to have a designated safeguarding lead (DSL). From around 2013 the designated Dr has organised safeguarding forums for the DSLs. The GCCG promotes Level 3 multi agency training to ensure practices develop their safeguarding competencies. GP practice safeguarding leads are asked to attend 2 of 3 forums per year. One has an annual update of 1 hour formatted so they can take back learning and deliver in their practices. Though it is not mandatory to attend 60/65 out of the 74 practices attend. Whether they attend the forums or not, all 74 practices get learning updates. The lead GP, a practicing locum GP, has good connections across the county. The new primary care audit will assist the GCCG to monitor safeguarding practice in primary care and to continue to promote good practice through the GP forums.

GCCG directly employs 360 staff, most of those employees don't hit the need for Level 3 multi-agency training. Training is done through e-learning and inhouse learning processes. Level 1 is done once a year. Level 3 training is done by GCCG employees who have other responsibilities, e.g. PS or nurses with direct contact with children in other roles. The GCCG also has to maintain a focus on adult safeguarding. CHC nurses in the GCCG cohort have, in the last 2 years, focused on their adult safeguarding training.

If staff do need Level 3 training it is provided through the GSCP pathway. It is less certain that NHS providers use the GSCE offer and the GCCG safeguarding team are currently reviewing safeguarding training across all health providers.

GCCG thinks there is duplication across providers and wants to increase training provision in primary care. They are looking at how to integrate the safeguarding service across health providers, this has already been raised with directors of nursing who support this. It is early days but the sense of direction is to develop more of a whole health system approach to delivering and supporting children's safeguarding in the NHS system as part of the wider multi agency partnership.

The GCCG chairs the partnership Quality and Improvement in Practice sub group and is committed to working with other partners to ensure the learning from SCRs, RRs and LCSPRs are implemented and have an impact on practice. Discussion focused not only on specific GCCG actions arising from reviews but on the challenge of a partnership which currently has over 200 recommendations from all reviews. The recent review work on 'children of concern', pre-birth protocol and neglect were noted as good examples of how the partnership might evolve a more focussed learning and development approach in the future.

The panel thought that there were areas for improvement as described by the GCCG representative.

c. Safeguarding policies and procedures

The GCCG has re written it's safeguarding policy however the panel thought there were areas which needed slight revision. There is an opportunity within section 9.1 to have emphasised the importance of the James SCR recommendation mentioned above. The section 8.4 on CSPR's whilst giving a link to the GSCE process does not mention Rapid Reviews.

A policy to support and advise staff on issues related to domestic abuse has been introduced this year but it was not clear whether this reflected the James SCR.

d. Listening to children and young people

The GCCG has a positive culture of working in co-production when designing services. This is also expected of commissioned services providers. All providers have a children and young people forum. GCCG has recently worked with the County Council in developing a joint engagement strategy. GCCG works with the GCC Ambassadors. The mental health 'trailblazer' has undertaken surveys of the views of children and young people. The evidence suggests that the GCCG and its commissioned services are taking steps to engage with children and young people. The impact of this engagement could not be evaluated by the panel and with hindsight the panel should have included one of the Ambassadors.

e. Working Together 2018

GCCG thought the new arrangements had massively improved partnership working. Discussions between individuals in key roles across the safeguarding partners are now working together better. A monthly forum involving key staff from GCSC, GCCG, GC and GCC has been established to work as a multi-agency problem solving group. Conversations are now characterised by high challenge and support. Collectively NHS agencies feel they are on an improvement journey, but we have not got it quite right yet as a health partnership. The new arrangements feel better – and with the new subgroup chairs replacing the Delivery Board the scene is set for further improvements. QIIP has a big agenda and one of the challenges is managing the work given all the pressures on agencies.

The panel also discussed about the opportunity to further develop the 'think family' approach in relation to GCCG commissioned services for adults such as mental health/substance abuse etc. The GCCG was looking at this and has been and remains part of the Adverse Childhood Experiences (ACEs) programme led by the County Director of Public Health.

Gloucestershire Clinical Commissioning Group		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good	• Panel observed that some of these key documents should be shared with the GSCE so the other safeguarding partners were aware of them e.g. annual report and safeguarding strategy • The policy and strategy are not easily identified on the GCCG website
• Staff safe recruitment, induction, training and development	Good with areas for improvement	• Mandatory level 1 training for all new staff • Effectiveness of Primary Care audit • Work on consolidating the training offer across the NHS economy • Safeguarding supervision policy to be rolled out to other roles • Consistency of training across the NHS economy • Links with GSCP training
• Safeguarding policies and procedures	Good with Areas for improvement	• GCCG is already undertaking reviews of all policies • Opportunity to mention James SCR recommendation not taken in key documents
• Listening to children and young people	Good with areas for improvement	• The engagement activity looks good but there is a need to evidence impact

Gloucestershire Health & Care Trust

GHC was formed on 1/10/2019 from the merger of 2gether NHS Foundation Trust and Gloucestershire Care Services. A constant theme in panel discussion was about the work GHC had been doing to become 'one organisation' given the inheritance of two sets of policies, procedures and working practices. All policies were combined in time for the start of the new organisation. The two safeguarding teams have been merged and given they both worked slightly differently in the past the service is being developed in line with the new policies and procedures.

GHC provided a RAG rated proforma setting out how GHC was complying with the four S11 standards.

a. Leadership and accountability

There is a clear governance structure. Weekly safeguarding team meetings report into a Safeguarding Group (monthly) which reports to a quarterly Quality Assurance group which reports to the Trust Board. There is an Annual Safeguarding Report which is taken to the GHC Board.

There is a clear line of professional accountability for safeguarding within the organisation. There is a Head of Safeguarding; Named Doctor; Named Nurse for Safeguarding Children and Young People; and, a number of and Specialist Nurses for Safeguarding Children and Young People in post.

Safeguarding updates/information are disseminated to all staff via the monthly safeguarding group; on the staff intranet; comms alerts; and, within supervision and team meetings.

Supervision is rated amber due to the combination of two inherited systems and it is anticipated a single system will be introduced in the next few months.

Supervision policy includes multi professional supervision sessions which discuss children's cases.

A need to bring together ICT systems has been identified but this is work in progress.

There is a safeguarding telephone advice line for practitioners. If professionals phone in with a concern the advice line practitioners have access to all of the different systems in use in GHC, System One, Rio, so they can have oversight of a particular case or a particular family.

It the intention of GHC to conduct an annual audit of contacts to the advice line. This will help also to understand the balance between issues concerning adults and those concerning children and young people.

The Trust has identified a need to do further work to ensure staff understanding of safe, effective information sharing is effectively monitored. This was a GSCP objective for 2020/21 which The Trust has taken forward.

Management oversight is used to identify concerns. Issues are clearly documented and reported in a quarterly dashboard. This documents when there are child safeguarding issues and where from, e.g. inpatient mental health, part of that work looks at issues and identifies themes.

Escalation is used internally or to multi agency colleagues using the GSCP protocol.

It has been a difficult year due to Covid, and The Trust had to redeploy staff, although the safeguarding team were not and were maintained as an essential service.

MASH has worked really well once ICT issues had been resolved.

15-17 year old self-harm has been identified as an area of concern.

b. Staff safe recruitment, induction, training and development

There are job descriptions for all safeguarding staff and persons appointed are appropriately qualified and experienced. Staff have protected time to fulfil their training requirements. Training needs should be discussed regularly in supervision.

The panel asked 'How does GHC safeguarding training align with GSCE training?'

It depends on the role, there are approx. 5600 staff. Everyone does level 1, clinical staff do level 2, then Level 3 every 3 years. There is still an expectation during supervision that staff evidence refreshing learning.

Corporate induction includes L1 safeguarding. GHT L2 training has been on hold since Covid because it was Face 2 Face (F2F). A new L2 training course using Zoom has been launched.

The L2 training is also aligned to intercollegiate training requirements. There are two parts – e-learning NHS England L2 Safeguarding Children training (2.5 hrs) and the second is an interactive F2F webinar session, using scenarios, local pathways and local escalation policies.

GHT uses GSCP training at L3.

c. Safeguarding policies and procedures

Safeguarding policies were all combined when The Trust merged. There is a review underway to ensure learning from more recent reviews are included, and that any reference to Herefordshire is removed. Domestic Abuse is included in the review and will be amended to reflect the recommendations from the James SCR.

d. Listening to children and young people

GHC believes it has good networks within its service to enable the 'voice of the child' to be heard and GHC encourages professionals (through supervision etc.) to talk and plan together to ensure the lived experience of the child is key focus of their work. There is a section on the system called 'analysis' which encourages practitioners to ask "what does this mean for every young person".

e. Working Together 2018

The Trust has had a challenging year due to the merger and is now beginning to emerge as a new single organisation. On top of this The Trust has had to manage the impact of the pandemic. It is hard therefore to give a definitive answer regarding the impact of WT18 but the recent work aimed at moving away from escalation when things get difficult to a professional dialogue through a cases of concern group is definitely a step in the right direction as has been all the audit work and associated workshops.

Gloucestershire Health & Care Trust		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good	• Clear lines of professional accountability • Internal Governance is clear
• Staff safe recruitment, induction, training and development	Good areas to improve	• The challenge of continuing to develop the new Trust's culture
• Safeguarding policies and procedures	Good	• All safeguarding policies were reviewed in time for the merger on 1/10/2019
• Listening to children and young people	Good	• There is clear involvement from children and young people which is evidenced in the GHC annual report and the Service User Experience report

Gloucestershire Hospitals Trust

The panel found it difficult to read the submitted papers due to formatting errors. Nevertheless, there was good discussion with the GHT representative who was the Named Nurse and Named Midwife for GHT.

a. Leadership and accountability

There is a clear governance structure within GHT which includes clarity on professional responsibility for safeguarding. The Deputy Chief Nurse chairs the Safeguarding Strategic Group which reports to a sub committee of the Board - The Quality and Performance Committee.

GHT produces an Annual Safeguarding Child Report. This is not currently routinely shared with GSCP.

The GHT representative had been the Named Nurse and Named Midwife for some time and explained that there were plans now to appoint separately to the two roles. Her substantive role is Chief Midwife and Divisional Director of Quality and Nursing (Women and Children's Division). The separation of the two named roles is a clear move by GHT to address a lack of capacity within GHT to ensure safeguarding gets appropriate support. The new structure will enable the Chief Midwife to take a more strategic oversight and to ensure matters such as supervision are addressed (see below).

Once the two posts are filled GHT will have all designated and named posts filled by appropriately training individuals.

The panel picked up the phrase "impromptu supervision is more common than scheduled" and asked how it is recorded? In response the GHT representative stated that this was an area where GHT struggles. There is a GHT supervision policy which is due to be updated. Staff dealing with safeguarding issues on a regular basis have planned supervision every month; for example, midwifery staff. In other areas of The Trust some would not be dealing with safeguarding regularly so they receive 'unscheduled supervision' when they identify safeguarding concerns, escalate and get advice from safeguarding specialist staff e.g., the Associate Named Nurse and band 7s in departments. Such support and advice is available 24/7 and there is always a safeguarding person on call who would also offer debriefing.

The panel was informed that GHT had quite a bit to do to improve safeguarding but that there was clarity on what needed doing and a plan. In addition to the need to increase capacity and review supervision GHT also has ICT systems issues which prevent the clear recording of internal

escalation of safeguarding issues including a lack of clinical codes for safeguarding activity. These ICT issues also impact on information sharing. GHT is intending to review other Hospitals practice and then procure a new system particularly for midwives.

GHT is clear on priorities and action plans. There is an annual work plan which is monitored every 6 months by the chief nurse. This plan includes the quality improvement initiatives described below.

b. Staff safe recruitment, induction, training and development

GHT complies with safe recruitment policies including DBS checks and mandatory safeguarding training for new staff. 90 % of staff are compliant with statutory mandatory training.

GHT intends to use the GSCP level 3 training once the offer has been clarified. In the absence of GSCP L3 training GHT had developed their own L3 package which is about to be rolled out to relevant staff in GHT. It is based on some lectures which have already been recorded. GHT intends however to utilise the GSCP L3 offer when it is finalised as a general course whilst delivering 'in house' specialist modules for different disciplines within GHT. There is currently a training 'deficit' and this new programme is aimed at addressing this. It is envisaged that there will be a 'pick and mix' approach with the GSCP L3 being a common element.

c. Safeguarding policies and procedures

SCR recommendations are not yet fully reflected in GHT policies and procedures but they have been incorporated into the training described above. GHT maintains a tracker (the panel was subsequently sent the tracker) which has reduced the SCR recommendations to 13 key tasks and progress is measured against these tasks. The actions on the tracker are classified as 10 'amber' with 3 'reds' indicating a lot of work that is 'in progress' but not yet complete.

Whilst the specific recommendation from James SCR had not been specifically added GHT have a whole new policy on NAI and non-mobile infants that we didn't have before for doctors to follow. Midwifes identifying safeguarding concerns are required to complete a 'Concern' form that is referred to the Safeguarding Vulnerable Women's Team who consider what action should be taken then they feed-back to the midwife.

GHT has completed significant work highlighting non-mobile injuries and participated in an ACEs project including a pilot with maternity in Gloucester City working with GCCSC and Early Help. We followed up by obtaining feedback from the women and a National Paper accepted the findings for publication.

GHT also undertakes quality audits of safeguarding work

It should be noted that GHT follows the South West Child Protection Procedures in line with GSCP practice. It should be noted though that the GSCP is in the process of launching a new website and is in the process of reviewing all policies to ensure a consistent set of information on policies and procedures is available.

GHT staff intranet signposts staff to the GSCE Escalation of Professional Concerns process. Staff are encouraged to use 'healthy challenge' in their work and GHT has a Freedom to Speak Up Team who support staff.

A new self-harm policy and pathway is under development.

d. Listening to children and young people

GHT stated it is policy to routinely ask safeguarding questions of all children. An audit identified that paperwork that should prompt the questioning was not always completed consistently. The audit findings were concerning so GHT undertook a quality improvement initiative, audited again and found improved compliance (up to 95%). There is currently an audit looking at the 'voice of the child' as a key focus. Two matrons are looking at nursing documentation to see how their voice is captured for routine admissions for all children There is not yet a consistent way of recording so now a QI approach is one of our top priorities for the year ahead. A paediatrician is to lead a project on 'voice of the child' during 2021.

e. Working Together 2018

The evolution of the NHS Safeguarding Strategy group is beginning to show benefits in understanding and improving safeguarding practice across the sector. The group is chaired by the Executive Nurse at the CCG which gives the group an appropriate profile. It feels like there is greater ownership of the safeguarding agenda at senior level across NHS agencies.

Gloucestershire Hospitals Trust		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good with areas for improvement	• There is a plan in place • There is work to do on supervision • There are ICT issues impacting on safeguarding
• Staff safe recruitment, induction, training and development	Requires Improvement	• Note the plans to improve training
• Safeguarding policies and procedures	Requires Improvement	• Some SCR recommendations need to be reflected in policies and procedures
• Listening to children and young people	Requires Improvement	• Note the planned QI initiative of 'voice of the child/young person'

2. Police and Crime

Gloucestershire Constabulary

a. Leadership and accountability

Child Friendly Gloucestershire is a priority in the Police and Crime Plan

The current PEEL assessment (18/19) rates GC as 'Good' and includes the statement

'It protects vulnerable adults and children well. But there are some delays in referring vulnerable children to other agencies, such as social services. Delays in processing 'Clare's Law' applications are unacceptable.'

There is reference to the MASH as an 'area for improvement '.

'The force should ensure that the capability and capacity of the MASH enables it to process referrals promptly and effectively; it should ensure this approach is sustainable for the long-term'.

This has been addressed as can be evidenced by the increase in resources within the MASH and the increase in speed of processing contacts. Further work is still required however in terms of the recommendations of the recent LCSPR regarding quality of VIST forms and strengthening work across all categories of child exploitation and the disruption of perpetrators.

Gloucestershire Constabulary (GC) has a structured internal process for setting priorities including for the Public Protection Branch. Overall the Force prepares a Force Management statement in line with national requirements. GC has a control strategy which sets out operational priorities which currently include Child Criminal Exploitation; Child Abuse; Missing and Mental Health; Organised Crime; and Domestic Abuse.

There is a clear line of command within the force in respect of safeguarding/Public Protection (of which children's welfare is a part). Senior managerial responsibility sits with the Assistant Chief Constable (Operations) with all day-to-day management under the Head of Public Protection.

Safeguarding is included in vulnerability and these matters are considered by the operational policing Board and the Performance Improvement meeting. The Head of PP is held to account by both these governance fora.

Senior officers have successfully brought things together in a more coherent way. A Force vulnerability strategy has been produced, in consultation with partners and is aligned to policing's national vulnerability action plan. The strategy is force wide and not just related to the public protection branch. The panel asked about the multi-agency aspect of such a plan and the intention is to share the strategy once it has internal and strategic partner's approval. Subsequent to the panel the Vulnerability Strategy has been shared with the Gloucestershire Safeguarding Partnership.

GC has a Child Protection QA Framework which includes regular single agency audits. The panel thought this was good but raised the issue of visibility to other partners. The 'supervisory footprint' is included in the audit of investigations.

The representative informed the panel that in Public Protection, considerable time was being spent on generating performance information to measure safeguarding. The Safeguarding dashboard produced did not give information needed, and under the new Head of PP we want to re-frame that and build a better picture. The PP branch were doing own performance data (quite robustly), but this is now coming from the centre. There are other vulnerabilities PP want to include e.g. mental health. Our aim is to get a 'one stop shop picture' which we will share with partners.

There are several levels of supervision within safeguarding including checks on VISTs which are reviewed by a Police Sergeant and MASH decision makers.

The Chair of the panel commented that he hadn't seen any escalation originating from Police. Is this because escalation was being dealt with effectively earlier in the process?

The Escalation Policy is online through the constabulary staff intranet. All PPU staff have been briefed on escalation. The recording of escalation can be done on Unifi, but this is not 'searchable'. GC intends to improve the collection and analysis of data on escalation. Current escalations are often dealt with by e-mail or telephone call rather than the escalation template. That this was an area for development was confirmed by the representative.

The representative was less happy with escalation and how effective it is. It is something GC need to keep working on. The representative felt the Police know how to escalate. The key is to build relationships across partners to review where we don't agree. The Head of PP will be a part of the proposed 'cases of concern' group.

Subsequent to the panel further information was received illustrating how the Police are now using escalation to good effect.

b. Staff safe recruitment, induction, training and development

GC follows safe recruitment practice including where appropriate DBS and other checks

MASH decision makers attend SCAIDP training which is the same training undertaken by CP Detectives.

GC participated in the ACE's project and all staff have been trained to recognise ACE's and their impact on families and individuals.

The panel explored Police lack of attendance at multi agency training. The representative knew of no reason why this should be as the force have a strong CPD and skills development approach. It may be that the benefits of attending multi agency training do not get prioritised above other training. This could be an area for review.

There is a decision maker induction programme and training document for staff in the MASH.

c. Safeguarding policies and procedures

GC works to the GSCP procedures and WT18. In terms of 'compliance' with WT18 GC will always try to work within the letter of the guidance where it is specific but within the 'spirit' where guidance is not as clear. There is consultation with other forces on how best to comply with and implement WT18.

In response to the James SCR the DA VIST has been reviewed twice. The representative could not confirm that the 'how to' guide had been re-written. The standing operating procedure within MASH had been re-written to identify the greater risk when a child under 1 was in the household.

d. Listening to children and young people

Improvements have been made this year:

- VIST has been revised to improve recording and analysis of child's lived experience
- All officers trained on ACE's
- GC audits found 75% compliance with completion of the direct record of child's voice section

However, recognised as an area for improvement with plans as follows:

- Force wide 'team talk' campaign planned to spread messages about VOCYP.
- Child Safe County project (OPCC initiative) which will have children's panels giving direct feed back

e. Working Together 2018

Communication between partners has improved and the recent revision will strengthen this further. The RR and LCSPR system are effective.

The work within MASH and the recent analysis of the outcomes of Police contacts and the work of strategy discussions were acknowledged as evidence that the partners were working better together.

There is regular contact between the GC Head of PP and the GCSC Director of Safeguarding which is leading to joint review of front line practice e.g. Strategy Meetings/discussions and thresholds.

Gloucestershire Constabulary		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good	• Governance and accountability structures are in place • Appropriate professional structure including supervision • QA system in place • Improvement plans in place and delivery good
• Staff safe recruitment, induction, training and development	Good with areas for improvement	• Participation in multi-agency training needs review
• Safeguarding policies and procedures	Good with areas for improvement	• Working through MASH to review procedures • Joint work on quality of SDs • Joint work on thresholds
• Listening to children and young people	Good with areas for improvement	• Child Safe project • Team Talk campaign • Impact of revised VIST

Youth Offending Service

The YOS provided a template against the standards written by the new Head of Service who had been in the role for 6 months and had little preparation time to complete the report.

a. Leadership and accountability

There is a clear line of accountability through the 2 Heads of Service to the Operations Director and thereafter to the Shaw Trust Head of Safeguarding.

All staff receive routine monthly supervision with their line manager. All managers have been trained to supervise.

Staff can get additional support from safeguarding leads within the trust and there is 'out of hours' support from a Duty Manager.

b. Staff safe recruitment, induction, training and development

YST practises safe recruitment and all managers are trained to comply with the requirements.
All new employees undertake an induction programme which includes safeguarding training as part of the Shaw Trust mandatory training programme.
All staff can access GSCP training.
Shaw Trust has a trainer who delivers training to part time and volunteer staff.
All staff are subject to the Shaw Trust performance appraisal scheme
Shaw Trust regularly runs awareness events such as a recent 'safeguarding week' involving a variety of activities including courses/speakers/awareness raising.

The representative confirmed that the message has come out to all staff that everyone should be trained to a good standard. Performance appraisals state you have to go on safeguarding training, people now have an appetite for online training and there is a lot of good training out there. Shaw Trust had a safeguarding week, it feels like its finally aligned, there have been shared policies since the beginning of November, safeguarding week was interesting and lots of staff have gone in after to look at training they couldn't make at the time.

Who is responsible for escalation and deciding when something is escalated?
GCC escalation process is quite helpful e.g. in a meeting about a young person concerns were raised that the social care team weren't taking seriously enough the risk of significant harm to him and his younger siblings, he was nearly 18 and would not benefit from interventions, but the siblings were at risk as he had lost drugs and owed money. I escalated manager to manager and they went through Child Protection procedures which she deemed appropriate. When different organisations are working with the same child we probably see risk a bit sooner than CSC, if we don't agree my staff know to come through escalation. I had a conversation with the manager, sent minutes, I didn't need the form she took that. I spent years as a designated lead in schools, I am confident in risk and know when to keep pushing. I feel I can go to the next manager and feel it's a conversation appropriate for me to have.

c. Safeguarding policies and procedures

YOS have both Gloucestershire and Shaw policies and procedures. Regards safeguarding they are usually symmetrical and align. Shaw Trust has a comprehensive safeguarding approach. In Gloucestershire the trust follows the GSCP policies and procedures and aims to comply with WT18.

d. Listening to children and young people

YST regularly seeks feedback from C&YP through surveys; 1:1 sessions; group sessions and by speaking to children as part of case file audits. Practitioners are trained by Shaw Trust Speech and Language Therapists

e. Working Together 2018

The representative had not been in Gloucestershire prior to WT18 arrangements so couldn't compare. The representative was previously working in the SE (Feltham) where safeguarding felt more 'raw and alive' (very small boroughs) than in Gloucestershire as it is a large County. In London things would have been picked up much quicker. On a positive note though she has never seen such collaboration as Gloucestershire has, it's phenomenal. People know each other. Everyone has the same perception. Scheme joint decision panel any child any crime has the option to divert from the justice system. That is incredible work. In Gloucestershire there is no court backlog due to Covid. This is reflected in performance stats. The children first programme shows that with the right people round the table including police (who have shifted massively in their approach) you can achieve good things for children and young people. This programme is something Gloucestershire should be proud of. Gloucestershire has a lot to be proud of.

Youth Offending Service		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good	• Appropriate professional accountability in place • Regular supervision
• Staff safe recruitment, induction, training and development	Good	• Regular training and promotion of safeguarding
• Safeguarding policies and procedures	Good	•
• Listening to children and young people	Good	• Be useful to establish how children and young people feel about being listened to • The partnership should consider what could be learned from the work done by the Speech and Language Therapists

Probation Service/Community Rehabilitation Company

Point of clarity: The NPS report is a national response. Probation Community Rehabilitation Company (CRC) report response is localised. The two are unifying in June 2021. The panel discussion was with the CRC. The panel queried the date of the NPS national response as the footnotes dated it as September 2018.

a. Leadership and accountability

The CRC largely deals with adult offenders and has appropriate operational and leadership structures in place. The CRC is part of a regional agency (Bristol, Gloucestershire, Somerset and Wiltshire) and is part of Kent, Surry and Sussex CRC, who also run Dorset, Devon and Cornwall CRC. As noted above they will be going through another reform programme with CRCs being unified again with the NPS.

Within KSS there is an 'excellence team' whose job is to identify learning from serious offence reports. (SFO). The Excellence team who take the learning from the DHRs/SFOs and cascade. We have Quality Development Officers (QDO) who run training for Probation Officers based on best practice.

Supervision is regularly between staff and their line manager. It includes a regular review of safeguarding practice and is an opportunity for reflection on practice. There is also day to day communication/case discussion which gives further informal management oversight. Cases are RAG rated and supervision looks at the riskiest cases, we look at every red case. It's an ongoing process.

In term of Gloucestershire SCRs there have been no significant recommendations for Probation. Their role in Operation Acorne was commended. The representative thought that with hindsight that escalation could have been done more forcefully and earlier.

Operational Managers (OM) are aware there is an Escalation Policy if something is not satisfactorily addressed. They also know how to refer into MASH if we know of a child at risk. If an OM gets a case and a service user is in contact with children they will make a request for information and a referral if they felt necessary.

b. Staff safe recruitment, induction, training and development

PS, GCRC practices safe recruitment. All staff are required to undertake child safeguarding training relevant to their role.

PS has its own in-house training suite and program. They work with several Local Authorities who have different offers which allows PS to 'pick and mix'. PS prefer face to face training and get more out of it than online. The focus in 9m to 12m has been the remote offer. We were owned for 3-4 years by Working Link and there were resource issues. KSS took over in February 2019 and links into training have improved greatly.

c. Safeguarding policies and procedures

PS has a clear set of policies and procedures and has a group Child Safeguarding Policy. This links to an extensive range of CRC policies.

CRC Probation also has processes in place to ensure that Safeguarding checks are instigated at the start of a Community Order or Licence and are entered on to our Case Management system. We also complete Police checks regarding Domestic Abuse to inform our Risk of Harm Assessments. The Escalation Policy is in place locally and staff have regular Supervision Sessions with Line Manager's to discuss any potential escalation issues.

We have high risk planning meetings and they are held every month; we invite everyone to them. We have a shared understanding of language alongside CSC. I'm not sure we always do speak the same language. An Offender Manager will only get involved over age 18 but we'll try to get them more involved. Some children aged 17 are on a path, its important as when they hit 18 there is no support any more. (YST)

MAPPA would be cases serving 12 months or more for violence so go to the NPS side of business. Our caseload is safeguarding, poor mental health, substance misuse etc. We get MARAC request through and our OM will respond with their feedback. Is the pathway right for you? Val: Often cases we manage are already referred to MARAC before we get them post sentence. We have a referral process to follow as per our website. We often get email enquiries from MARAC and an individual OM will follow that through and liaise as necessary.

sounds like a similar relationship with MASH, do you get requests for information? The representative was not aware of any recent requests for information but thought they would go to individual OMs.

d. Listening to children and young people

PS have issued all staff with the HMPPS Risk of Serious Harm guidance which includes a section on safeguarding children and guidance for Offender Managers when they complete their risk assessments. This provides guidance in four domains - Neglect/Emotional abuse/Physical abuse/Sexual abuse. The guidance also emphasises the need for OM's to identify and listen to the voice of the child and to think about the impact on them. If relevant, OM's must refer concerns through local safeguarding procedures e.g. MASH referral.

CRC Probation work with adults who have been sentenced to Community Orders at Magistrates or Crown Court or those released post custody who are subject to Licence arrangements. However, our initial assessments and ongoing Risk Management will always involve considering the Risk of Serious Harm posed to Children and Young People.

If in direct contact with children where safeguarding issues are identified CRC staff have a duty to refer to Children's Services.

If applicable Pre –Sentence reports and risk assessment processes recognise and incorporate 'The Voice of the Child'.

MAPPA and MARAC meetings also incorporate victims and child safeguarding considerations and OM's are required to attend Child Protection and Core Group Meetings.

Cases where the service user has contact with a child subject to a current child protection plan and the service user is considered to contribute directly to the risk of serious harm to the child will be allocated more resource and will be held by a Probation Officer (PO). This will mean that our most experienced Offender Managers will hold the cases to ensure that the voice of the Child is heard.

When an Initial Child Protection Conference is called concerning a child whose parent or carer is current to Probation CRC it is the expectation that the Responsible Officer attends and also submits a written initial child protection conference report. If they are unable to attend, a written report must be submitted. There is an expectation that the Probation Officer will attend on-going child protection conference reviews whilst supervising the service user, or at least submit a written report.

There is close management oversight of all cases where children have child protection plans. Line Managers are responsible for ensuring that back-up arrangements are in place and that regular supervision takes place to ensure the Risk of Harm to Children is identified and managed appropriately.

e. Working Together 2018

Although PS felt Working Together needed a refresh PS didn't have major issues with the pre WT18 system, it was working. There were, however, some good points about the new structure - There are 3 clear lead agencies, alerts, training offers, escalation policy and there is a lot more tangible bite size information coming through.

Probation Service/Community Rehabilitation Company		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good	• Leadership and management structures in place • Supervision places emphasis on risk identification/management
• Staff safe recruitment, induction, training and development	Good	• Safe recruitment practice • Training in place • QA officers driving practice
• Safeguarding policies and procedures	Good. Query link to local policies and procedures	• Be worth confirming that PS policies sit alongside GSCP framework
• Listening to children and young people	Good, But need to evaluate from children/young person's point of view	• Intention of policy is good but would need to see evidence of what this meant in practice

3. Local Government

Gloucestershire Children's Social Care

a. Leadership and accountability

There are appropriate governance arrangements in place for Corporate Parenting, safeguarding/scrutiny

Professional leadership in place

Compliant with Lead member and DCS guidance

Strengthened leadership and management in the last 12-18 months

GCSC has a monthly Improvement Board, chaired independently by Andrew Ireland. Clear plans long term. Transition plan, Improvement Plan and AIP. QA and PI stuff excellent. Agenda clear and shared with partners. Work on S10 progressing via Health & Wellbeing Board.

The plan contains responses to all SCR recommendations and is aimed at improving practice within CSC. Includes a focus on the effectiveness of Early Help.

Staff supervision is an AIP priority.

Ofsted feedback increasingly positive on improvements made but GCSC acknowledge that there is still much to do to achieve the level of consistent good practice across the whole service.

The service has a number of improvement advisers. Through Domestic Homicide Reviews Kanchan Jadeja has picked up a number of issues including in domestic abuse, we have roadshows and workshops to pick up key learning. The DHR provides current learning to take back so all practitioners and managers are aware of the learning. Kanchan helps with the roll out of learning in the service.

b. Staff safe recruitment, induction, training and development

Safe recruitment practices are in place

There is a significant programme of training via the Social Work Academy Essentials programme and the Team Leader programme.

There have been a number of practice issues for a long time, Ofsted confirmed the service has moved at tempo. There is an energy in the service currently to push forward at pace and this is one of the issues the Interim Director has focused on as part of improvement work. She agrees there is no excuse for GCSC not to engage in training. Historically, in terms of distance travelled we are not where we were. Moving forward the message cannot be "attend if you fancy", the service can't maintain that going forward. It will now be a particular concern she will take interest in. Some of this is due to workforce instability and some pressure in the system. Management oversight has not been as tight as it needed to be but that has been tightened up.

c. Safeguarding policies and procedures

The HoS for MASH has a pivotal role to ensure roll out of change. Is clear the LOI document is used as a very practical arrangement within the front door and we evidence threshold using the document. It was shared in a MASH learning circle; every practitioner is aware of that risk and how we respond utilising the LOI document and also the Essentials Training framework and how that fits within the context of domestic abuse and other specific areas of concern for children. There has been a shift to responses to domestic abuse and how that is understood within MASH and threshold for tier 4. He is confident his staff would know that due to how learning is rolled out to the services.

When is the privacy notice approach going to launch and roll out - do you have a timetable?

An all staff communication announcement has gone out from the Director of Children's Services to alert people. There have already been various iterations of the privacy notice. It is not just about sending an email and expecting it to be fine, it represents a change of practice. In addition to preparation work done, an information leaflet and programme of work, to ensure the direction of travel and detail of difference a privacy notice makes, is due to roll out from the beginning of 2021 with CSC teams. There will be a period of implementation with opportunities to test out, ask questions and share experience. After a period of implementation this will be tested by a QA process to check impact once we've had an opportunity to see a difference in practice

d. Listening to children and young people

The ambassadors provide feedback to the Improvement Board. They are also promoting a 'language that cares' approach within social work. Essentials training promotes a child centred approach. All social work is expected to be child focussed. The service has made good use of social media platforms particularly during the pandemic which has been welcomed by many children and young people according to the feedback to/and from the Ambassadors.

e. Working together 2018

There is inevitable healthy tension within partnership working, it would be worrying if we all agree all the time. Looking at things from a different perspective helps keep children safe. The Interim Director doesn't have the historical experience of GSCB to be able to compare with GSCP. She felt that the work on children of concern was a good example of partnership working. She presented a paper to the Delivery Board and Executive Partnership of deep dive of 10 young people in care who were of concern. She wanted to test out with Strategic Safeguarding colleagues the buy in to equal statutory duty to Working Together. Although this was initially a single agency piece of work GSCS wanted to open it to all the partnership to review the 10 children of concern. Yesterday she met statutory partners in health, police and commissioning and agreed Terms of Reference for reviewing the responses so we can feedback to the Executive Partnership to ask what they want to do about those themes and concerns coming from the deep dive.

There have been further discussions on how, on an ongoing basis, can the statutory partners come together to troubleshoot? They have agreed to meet on a monthly basis to flag with each other any child of concern. Usually a child is known across the piece and all agencies are struggling. They will now come together to problem solve and find a solution.

We have reviewed the escalation protocol to include the group at Level 3 to ensure key partners are talking to one another. Recent experience is that does not happen and some cases end up as Level 4 escalations criticising GCSC about issues that have not been brought to her attention. She is challenging the partnership on how we can work together and communicate at a much earlier stage. GCSC have been proactive in relation to lack of judicial dates. We led the way in setting up 8 virtual courtrooms to deal with delays due to Covid. That would not have been possible without communication with partners.

One success is the change from SCRs to Rapid Reviews which is something we should be very proud of; across counties that is not a shared experience and we should promote this as an example of best practice. The thematic LCSPR (CSE) went to the heart of the MACE issue; GCSC is

working closely with GC and they have a joint Child Exploitation team. On the back of the LCSPR there is work to do differently together in the year to promote CE. There are things that need to change, e.g. whether going forward, MACE should be organised to reflect a hub and spoke approach (central oversight plus support) into localities. This is important when trying to promote disruption and a disruption plan is missing in our safeguarding practice.

The shift of the Delivery Board to a Management Group is a good indication of flexibility and an ability to review arrangements. It will bring connectivity to the Executive and amongst Subgroup chairs. Activity undertaken shows a clear partnership and information gathering. Where there is an allocated Social Worker there is a clear route into MAPPA, and in Level 3 intervention there is the opportunity to continue multi agency risk analysis. MARAC information sharing - MASH research takes place for MARAC enquiries, whether that provides L2, 3 or 4 there is a very clear route out of MARAC. There is a plan to reduce times, there is overlap with MASH and MARAC enquiries that needs to be ironed out.

GCSC have nominated individuals to be part of multi-agency audit activity to be fed into QIIP, e.g. the recent Neglect multi agency audit and buy in from GCSC. The old MAQUA has been replaced by QIIP who should be able to respond to any recommendations from reviews or audit.

You appear to have a good focus on Looked after Children – how is GCSC working with disabled children and their families?

GCSC have recently taken a decision to ensure the DCYPS is line managed via the Interim Director for Safeguarding and Care, not the Director for Education. Interim Director was happy to provide further information outside the meeting on the service improvement plan for DCYPS.

Gloucestershire County Council Children Social Care		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good	• Governance and accountability structures are in place • Appropriate professional structure including supervision • QA system in place • AIP and other Improvement plans in place and delivery good • Improvement Board monitors progress • Performance information - good
• Staff safe recruitment, induction, training and development	Good with areas for improvement	• Participation in multi-agency training needs review • The continued roll out of essentials/

		practice fundamentals/ leadership training is reaching more staff • Team Improvement Plan and QA work reducing inadequate work and increasing RI or better
• Safeguarding policies and procedures	Good	• Working positively with partners in MASH to review procedures
• Listening to children and young people	Good	• Engagement with and through Ambassadors is excellent • Feedback from Ambassadors to IB • Engagement of Ambassadors in QAF • Evidence from audits of IRO seeking Voice of C and YP

Gloucestershire County Council Commissioning

GCC provided a report which described the audit commissioning conducts on providers, this does not include internal providers (e.g. in house fostering) as they are subject to other QA processes.

a. Leadership and accountability

The section has recently developed a compliance and quality team but decided they would not cover internal services as there is quality and performance oversight within the fostering teams already. As a commissioning hub their view is to report on commissioned services only. As part of their work they have stumbled over things which have raised questions which have been raised with the appropriate manager.

Q: The first level of compliance is using a standard questionnaire which a provider completes and returns – they could just say they are brilliant.

They do an annual review using RAG ratings. Red receive a quick response, amber a slightly more measured one, but green they would not ignore. If there is sufficient concern they plan to visit the home, otherwise meetings are by phone. The team are behind the timetable due to changes of staff, but the intention is still to use the information. Some providers have been struck off, one lost a regional office due to an

OFSTED inspection; one failed on framework, one very dodgy, went in under one company which 2 weeks later ceased and its name was taken by someone else. Commissioning gain evidence from a variety of places including the children and young people.

Q: How do you link with CQC and Ofsted inspections when you look at the results from the questionnaires.

A: We use the Ofsted inspection reports, we don't have formal links with Ofsted at this time. We have no contact with CQC, adult colleagues do. Only a few services would be jointly Ofsted and CQC inspected, our remit is young people up to 18. We don't go into the SEND agenda.

Q: Commissioning is for all services in relation to children but the report is targeted on children in care, why is that?

A: This may be the way we viewed it. To report on all commissioning would have been a large piece of work; he was asked to do the children in care part. Checking safeguarding compliance is a regular part of contractual monitoring. We surveyed 80 providers, and they did not come back very quickly.

Question on James SCR and LOI updates. How widely understood are the services of GDASS, how frequently are they used and with which agencies. This was not raised with him as a question to look at. The representative thought that in the past actions would go through the SCR subgroup representatives to cascade across he would need to check on current practice.

Q: Where does Commissioning's responsibility lie that you learn lessons from reviews?

A: The QA process, if it comes up it is to be expected to ask the questions, check it out and work through what the issues were. If we are commissioning a service, if a finding from a SCR is relevant he would be going back and asking the question of that provider.

b. Staff safe recruitment, induction, training and development

The section follows safe recruitment practices

c. Safeguarding policies and procedures

GCC works within the GSCP policies and procedures and WT18.

d. Listening to children and young people

Q: Voice of the child - how do you pick up their views within those independent establishment?

We have our own form we share with young people to give their views; we have access to Liquid Logic, can go through case files, talk to SWs and IROs to see what young people are saying to them. For some unregulated provision we've spoken directly to young people and if they have brought us complaints we check the quality of what is provided.

Q: Could we do more?

A: We could always do more but it depends what we have time for. Non-verbal face to face communication tells you a lot rather than just words.

Q: Do Social Workers know they have route to you if their young person has a complaint about their provider?

A: Some do, but not all, we've had direct referrals about quality and videos from young people.

Q: Are you proactive about asking SWs?

A: We have been, it depends. With schools we were proactive asking SW what was being said. I don't know if we've been as pragmatic as we need to be. We are a reactive service; we get told about things and I am not sure it is our role to be proactive with SWs. If a provider is not meeting the standard, given there is a shortage of providers we do work with them to improve. The school in Tewkesbury was rated inadequate and we set up a working group with CSC and the head to focus on the education and social care side to help them improve. Ofsted had felt the school was less than straight with them. We were sufficiently interested in them due to their offer for children with autism which didn't exist in the county, then they closed. We've done similar work at times with an accommodation provider.

The panel suggested including young people in presentations; member of the panel had been involved in bidding on contracts where young people have been on the panel. The Ambassadors are a good resource.

e. Working together 2018

The representative was too new in post to have a view on WT18 impact

Gloucestershire County Council Commissioning		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Difficult to rate given scope of the audit submitted	
• Staff safe recruitment, induction, training and development	As above	
• Safeguarding policies and procedures	In respect of this audit Good	
• Listening to children and young people	Good	

District Councils

Cheltenham Borough Council (CBC)
Forest of Dean District Council (FOD)
Stroud District Council (SDC)
Cotswold District Council (CDC)
Gloucester City Council (GCC)
Tewksbury Borough Council (TBC)

a. Leadership and accountability

All the Districts have senior level leads and designated officers named. In some cases, districts also have a named Elected Member with safeguarding in their portfolio.

Districts have intranet pages that support staff to with safeguarding this includes information about the relevant responsible officers and their contact information. It is clear who is responsible/accountable for each part of the districts safeguarding response.

Cheltenham, Tewkesbury, Forest of Dean and Cotswold all have processes in place to ensure relevant commissioned services are fulfilling their safeguarding role. Dependant on the district this might include clauses included in the contract (TBC), annual assurance certificates (CBC) or requirement to see policies (CDC and FOD). Gloucester and Stroud do not commission relevant services.

b. Staff safe recruitment, induction, training and development

All districts have safer recruitment practises in place that include pre-employment checks, interviewer training, promoting safeguarding in job adverts and probationary periods. There is however some concern that several of the districts have gone back to the use of C.Vs within their recruitment procedures.

All new employees and elected members undergo induction which includes policies, procedures and responsibilities including safeguarding.

Through training districts try to inspire people to be curious and worried about things and seek help, whilst not always understanding the particular safeguarding issue, and be tenacious if they don't get that help. Safeguarding crosses over with emergency planning and Districts have been '…on the backfoot as we've been supporting staff to deal with Covid, we've been fire fighting'.

Q: Level 3 training, what is the relationship with Districts and GSCP training and do councils all have separate training.

The new Districts Subgroup under the GSCP is promoting more alignment between Districts so all get the same training. We are waiting for GSCP level 3 training to come live so we can roll that standard out across the county. We are planning to talk about joining the GSCP training. We talk at every Districts meeting but there is high staff turnover and diverse staff. Training is something we are constantly tackling.

Districts currently take advantage of the Level 3 GSCE training to support their designated officers.

c. Safeguarding policies and procedures

Districts must and do work within the GSCP framework.

Q: Why do all districts have to have different safeguarding policies & procedures; can you not have one?

A They tried one in the past but it goes through our different cabinet processes separately. It shows a different initiative focus in districts, e.g. Stroud is the only district with housing in house. They have tried but it's never happened. It shows we have a diverse county. Stroud has a community system it is very broad in decision making, we update, align and learn from each other

The report says "All the Districts have up to date safeguarding policies and procedures". Why do they all have separate safeguarding policies and can you be confident they have all been updated to reflect the learning from the James SCR on domestic abuse? Is it fair to say that there is a variance between the 6 districts in terms of safeguarding from those doing the basics to those doing more?

Yes, and they put a different emphasis but no district has fallen behind, they have good practice in the areas they focus on, community building, '

d. Listening to children and young people

There is some good practice in some Districts

Good practice noted in Stroud re voice of the child. It's been over 21 years in the making and there is a fairly well developed and award-winning youth voice vehicle facilitated by Stroud District Council (SDC) Youth Service. 60-70 young people are actively involved as youth voice representatives across the district. The vehicle includes 9 youth forum groups based in market towns and large villages. Representatives from these groups along with those from secondary schools make up Stroud District Youth Council. SDC do a lot of community development-based youth work, work with partners, parish and town councils, county wide services including health and well-being. There is regional and national involvement through membership of the British Youth Council. The authenticity of the voice of young people comes through from this diverse range of young people geographically and demographically. This which enables young people to have a say, on any issue, for their families, communities and peers. It takes time to build such a youth voice vehicle but it is supported by SDC's youth work strategy and dedicated budget.

Cheltenham – no child left behind (where plans changed due to Covid.) We have 51 organisations signed up to work in a more strength based and trauma informed way, including the private sector (10 businesses - some of which have come to training, in the past it's been sponsorship). The Queens have just had a competition for designing an advent calendar, they got £300 into schools and children who took part got personalised Christmas card.

e. Working together 2018

It's early doors yet, the pandemic has thrown a lot of ways of working up in the air. In terms of restructure and bringing Districts in as a subgroup this will help us become a bit more aligned with that. How it works for service delivery takes time to do. Tracey: it feels like the Board under a different name with no real change to the systems. It will be more positive if we move to a more action focused group to follow through the change, we send out documents but never see if they've landed properly. GSCP Districts Subgroup wants the new Management Group to drive change forward.

District Councils		
Standard	Panel Rating	Additional comment
• Leadership and accountability	Good – with areas for improvement	• There is variation between Districts
• Staff safe recruitment, induction, training and development	Good	•
• Safeguarding policies and procedures	Good -with areas for improvement	•
• Listening to children and young people	Good in some Districts. area to improve in others	•