



**Annual
Report**

**2013 -
2014**

Herefordshire
Safeguarding Children Board

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About the Board and the Annual Report

Herefordshire Safeguarding Children Board (HSCB) includes appropriate senior representatives from a range of key partner agencies and organisations including schools, colleges, health service providers, children's social care and the police.

The Annual Report provides an assessment of safeguarding in the County and an analysis of the Board's activity during the year. It is written by the Board's Business Manager in collaboration with the Independent Chair. Members of the Strategic Board are then asked to finalise and approve the report before its publication in September. Organisations and sectors represented on the Board are expected to distribute the Annual Report to the appropriate officers within their organisations and the report will also be available on the Board's website at www.herefordshiresafeguardingchildrenboard.org.uk.

More information can be found on the Board's website or on request from the Business Unit. The Business Unit can be contacted via email at admin.hscb@herefordshire.gov.uk or by phoning on 01432 260100.

More details about the Board, its membership and its Business Unit are available on our About HSCB webpage¹.

¹ Available for download from the [About HSCB](http://www.herefordshiresafeguardingchildrenboard.org.uk) page at www.herefordshiresafeguardingchildrenboard.org.uk.

Introduction

What Annual Reports should do?

Working Together to Safeguard Children² is a document which outlines how the government expects all organisations working with children and young people in an area to co-operate to ensure children are kept as safe as possible in England. It governs the work of local safeguarding children boards including setting out the requirements for our Annual Report.

Working Together, updated in 2013, states that our Annual Report should:

- ✎ Assess the effectiveness of child safeguarding and the promotion of the welfare of children in the local area.
- ✎ Provide a rigorous and transparent assessment of the performance and effectiveness of local safeguarding arrangements.
- ✎ Identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.
- ✎ Include lessons from reviews undertaken within the reporting period.
- ✎ List the contributions made to the local safeguarding children board (LSCB) by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

Herefordshire Safeguarding Children Board also uses its Annual Report to demonstrate what it is doing to:

- ✎ Develop policies and procedures for safeguarding and promoting the welfare of children.
- ✎ Communicate to persons and bodies in Herefordshire the need to safeguard and promote the welfare of children, raise awareness of how this can best be done, and encourage them to do so.
- ✎ Collect and analyse information about the deaths of all children in Herefordshire.
- ✎ Provide assurance that procedures are in place for co-ordinated responses by the authority, their Board partners and other relevant persons into any unexpected death of a child.

How Annual Reports should be used?

Organisations working with Children and Young people can use this report to develop their understanding of safeguarding in Herefordshire and the work Herefordshire Safeguarding Children Board is doing to support them and to be aware of the critical safeguarding issues relevant to their organisation.

The public can use this document to develop their understanding and see how there can be wider community engagement in safeguarding issues.

The annual report is published in relation to the preceding financial year in order to influence local agencies' planning, commissioning and budget cycles for the forthcoming financial year.

It is submitted to the Chief Executive of the Local Authority, Leader of the Council, the Local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

² Working Together to Safeguard Children can be downloaded from www.workingtogetheronline.co.uk

The Board's Vision, Mission and Values

The Board works to the following shared vision, mission and values.

Our Vision

Children and young people in Herefordshire grow up in an environment in which their well being needs are met and they are safe from harm.

Our Mission

To work together effectively, as organisations and with children and families, to ensure that local services and arrangements are effective in promoting the well being of children and young people in Herefordshire and keeping them safe from harm.

Our values

- 🧵 The impact on the well being and safety of children and young people in Herefordshire will be at the centre of all HSCB activity.
- 🧵 We will learn and be willing to develop, responding to evidence and best practice.
- 🧵 We will work in an open and honest manner with children, young people, their families and with each other.
- 🧵 We will address the well being needs of children and young people at the earliest opportunity and prevent the need for later child protection intervention whenever possible.
- 🧵 We will challenge each other and be ready to receive challenge as we work together in a spirit of mutual respect.

Reviewing the Year: April 2013- March 2014

This year has been a positive and significant one in terms of the progress of safeguarding children services in Herefordshire. There needed to be considerable improvement in the way in which children are safeguarded in the county, recovering from a long period during which they have not been good enough. This Annual Report sets out the wide range of activity that has taken place in the last twelve months with the express intention of enabling Herefordshire Safeguarding Children Board (HSCB) to ensure that what is done in Herefordshire to safeguard and protect children has been both well co-ordinated between all of the relevant organisations and effective.

The publication of this Annual Report and the Business Plan for the Board in the year 2014-15 has deliberately been delayed because HSCB was subject of a Review by Ofsted as part of its inspection of safeguarding arrangements in Herefordshire in May. Such inspections provide invaluable insight into how Board plans are progressing in terms of effectiveness and informing the development of those plans, so the Ofsted conclusions are reflected in both documents.

The key building block of good safeguarding practice is the effectiveness of all aspects of work to protect children suffering or at risk of significant harm.

How we know what practice is like – Audit and Review

In order to be fully aware of how effective day-to-day work is, an ambitious audit and review programme examining front line child protection practice was managed through the year by the Board's sub groups including:

- ✎ Eight thematic reviews of specific areas of work undertaken by the Quality Assurance and Evaluation sub group totalling forty cases (see page 15);
- ✎ Four multi-agency individual case audits undertaken by the Quality Assurance.
- ✎ Four significant case learning processes facilitated by an independent author including one Serious Case Review undertaken by the Joint Case Review group (see page 18); and
- ✎ Five child death reviews undertaken by the Child Death Overview Panel (see page 23).

This provided the board with an accurate view of how well child protection work was being managed. The picture was one of steady improvement, but with more than isolated examples of inadequate work and insufficient consistently high quality practice being evident. In September 2013, upon the request of Herefordshire Council, a 'Peer Review' process was instigated with experienced professionals from a range of agencies in other areas coming in and scrutinising how local organisations were working together to protect children. This team provided some useful support in assisting HSCB to make the step change in performance that has been required for us truly to develop the consistently high quality child protection service that Herefordshire children deserve. The Ofsted Inspection Team later found that since the Peer Review, the speed of improvement has accelerated. This pace of improvement is very positive and needs to be sustained. Crucially, the Ofsted Inspection Team, which examined circumstances of many children in local safeguarding processes, found no cases in which children were suffering continuing harm.

Knowing whether children are being supported by the right services at the right time

High quality child protection practice is reliant on those having contact with children having a clear joint understanding of the thresholds at which agencies respond to meet the needs of those children.

It also relies on the main agencies sharing information effectively and appropriately and co-ordinating their activity to ensure that each child in need receives services tailored to their particular circumstances. In June 2013, Herefordshire implemented a 'Multi-Agency Safeguarding Hub' (MASH), in which identified representatives of all the main organisations (police, social care, health, education and the voluntary sector) work in the same place, receive reports of concerns about children, share information appropriately, make informed and co-ordinated decisions on what needs to be done and provide advice and support as required. The implementation of the MASH was managed in a staged manner and was not without its challenges. Evidence from the Board's own audit activity, and external review, including Ofsted's inspection, show that it is now effective in delivering better co-ordination between relevant organisations and more children receiving the services that they need.

The Voice of Children and Families

The HSCB is clear that it wants to ensure that the voice of children and families is heard, and that this is used to improve how services work and the impact they make. During the course of the year, the HSCB received evidence to show that representatives of all the organisations working with children and families engage with them and listen to their experiences. However, the accounts of those experiences are not cohesively recorded, analysed and then used to assess and develop safeguarding services. This was a key priority for HSCB over the last year and there has been disappointing progress with this.

Cooperation and Coordination between Partners

There have been notable strides forward in how organisations work together. In addition to the implementation of the MASH, most of the groups of HSCB have been well supported and Ofsted recognised the engagement of multi-agency partners. The management of the ambitious local audit framework, serious case reviews and the reviewing of child deaths as a means of learning and improvement have all benefited from good multi-agency support. Safeguarding children is a priority for all HSCB partner organisations. Issues such as Child Sexual Exploitation and Trafficking have been the subject of focus led by HSCB with workshops spreading awareness.

Strategically, Ofsted recognised that HSCB does meet its statutory responsibilities. Governance arrangements are well established, with appropriate links to other strategic bodies locally. My independence as Chair was recognised. An increasing readiness to challenge is apparent across the board, which is becoming more hard edged and prepared to hold member organisations to account. There is a core of excellent lay members who represent the views of our communities thoughtfully and assertively.

Safeguarding Training

HSCB delivers a range of safeguarding training. Training of our workforce and awareness raising among the local population must be further developed to ensure that children whose welfare is being compromised are recognised and well supported. The Training and Workforce Development sub-group, although well led, is insufficiently supported and this agenda is suffering further through not having a training co-ordinator because of delays recruiting to this position in The Business Unit.

Data and Intelligence

Although the use by HSCB of performance information has improved this year, it is relatively dependent on performance information provided by Herefordshire Council Children's Social Care, and despite much remedial work having been done, data provided during the year

Herefordshire Safeguarding Children Board: Annual Report 2013-2014 remains too often inaccurate and unreliable. Although most recently there has been evidence of improvement, the Board wishes to see this become consistent in the long term

As confidence in local child protection work rises, there must be a wider focus by HSCB, for example on how well families are supported to prevent children slipping into the child protection arena. The Board needs to become better at examining and measuring the impact of work that is being done to further improve the maturity of its learning and development. This must include actively listening to the voices of children, families and the people working with them. There must be a particular emphasis on looking at the welfare of disabled and deaf children and those from diverse backgrounds to ensure that they are being supported appropriately and not disadvantaged. Children who go missing from their carers must be responded to so as to better mitigate their vulnerability. All these issues are priorities within next year's Business Plan.

Although it is important to acknowledge that HSCB has travelled a long way in the right direction over the past year, it must be recognised that it still has a very long way to go before it can be content that safeguarding services are functioning fully as they need to be. HSCB needs to further influence other strategic bodies to prioritise the safeguarding of children. Action Plans must be relentlessly followed through. Training of our workforce and awareness raising among the local population must be further developed to ensure that children whose welfare is being compromised are recognised and well supported. The Training and Workforce Development sub-group, although well led, is insufficiently supported and this agenda is suffering further through not having a training co-ordinator because of delays recruiting to this position in The Business Unit.

The HSCB Business Plan for 2013-14, formulated in line with agreed strategic development priority areas, was ambitious and far reaching. This Annual Report documents that much of the planned activity was delivered successfully and my thanks go to all those who worked tirelessly to achieve this. HSCB is now considerably better placed to understand the quality of safeguarding work that is being done in the county, there is a significant drive to develop that quality and the co-ordination in the way it is being managed is also considerably improved. This is explicitly recognised in the recent Ofsted Inspection.

Finally, as the work of HSCB has gathered pace and volume, it has created additional pressures on the Business Unit that supports and co-ordinates that work. This pressure is exacerbated by the unit having also to support a similarly burgeoning Safeguarding Adults Board agenda. If the current momentum is to be maintained, it relies on that unit having additional capacity to continue to provide that vital support. Options to resolve this issue are currently under consideration.



Dave McCallum, Independent Chair

How effective are our local Safeguarding arrangements?

All agencies and organisations that work with children and young people should have appropriate safeguarding arrangements in place. This expectation was made a legal requirement through Section 11 of the Children Act 2004³ for a range of public agencies. Through engagement of organisations directly, or through sector representatives, Herefordshire Safeguarding Children Board reassures itself that these arrangements are in place.

Ofsted's Review of Herefordshire Safeguarding Children Board in May 2014⁴, stated that:

- 🔗 *"Safeguarding is appropriately prioritised by partner agencies and this is confirmed through the safeguarding audits that agencies completed in 2013, under Section 11 of the Children Act 2004".*
- 🔗 *"Partners from all agencies are well-represented at the right level on the Board and its sub-groups. Strong commitment and enthusiasm to work collaboratively to improve safeguarding services is now evident."*
- 🔗 *The Board "has undertaken regular multi-agency audits of safeguarding practice" and "also considers performance information from partner agencies".*

These comments demonstrate how Herefordshire Safeguarding Children Board is now much better placed to assess the effectiveness of local multi-agency safeguarding arrangements and illustrate the significant improvements made since 2012 when Ofsted commented that the Board was not *"sufficiently effective at either identifying deficits or improving practice within child protection services"*.

Staffing Resources and Quality of Practice

A key concern for Herefordshire Safeguarding Children Board are our comparatively high rates of children who are on Child Protection Plans or who become Looked After in Herefordshire. While these may be concerning in their own right, these elevated numbers also put additional pressure on staff involved with safeguarding across agencies and especially in children's social care.

The Board's audit and quality assurance work has consistently told us that generally, the right children are getting the right level of support for their current situations. The local authority has undertaken a significant piece of work over the past six months to reduce the caseloads of its social workers through some targeted additional input to improve the situations of a number of children so that they can be supported appropriately without the need for a child protection plan.

Significant demands from the child protection system have also placed strain on other agencies. For example, during the year, the Board received a report from Public Health who had recently become the commissioners of the school nursing service in Herefordshire and who were unable to meet the increasing demands. More information about this is given in Section A *Evaluating the effectiveness of Child Safeguarding through performance monitoring..*

Audit work also tells us that in the main, agencies work well together to safeguard the children they work with. During the year, schools funded a post within the Multi-Agency Safeguarding Hub (MASH) to manage the interface of schools with the MASH safeguarding professionals, and increase communication with safeguarding leads in schools. This reflects similar

³ The Children Act 2004 can be access at www.legislation.gov.uk

⁴ The full report is available at www.ofsted.gov.uk/local-authorities/herefordshire

arrangements made by police, Herefordshire Council and health partners to resource their involvement in the MASH.

Interagency Challenge and Cooperation

Herefordshire Safeguarding Children Board has also developed its *Three Steps to Safeguard Children*⁵ and have promoted this in a number of communications during the year. The rationale behind this is to support practitioners to use informed professional judgement to take action in response to safeguarding concerns, make referrals to the MASH appropriately in line with Herefordshire's Levels of Need and to and to empower them to escalate their concerns should there be professional case disagreements. Escalations of case disagreements support the development of improving services as well as progressing work in individual cases. The Board monitors all escalations which reach senior management level and during 2013-2014 there were only two escalations which have reached this level. Single agency audit work indicates that the majority of case disagreements are effectively resolved prior to the level at which they need to be reported to the Board indicating that joint working and challenge between agencies is effective.

In order to ensure greater learning from the monitoring of escalations, Herefordshire Safeguarding Children Board has revised its Escalation processes to capture learning at an earlier stage and the new process will be implemented during 2014-2015.

The range of information available to the Board suggests that safeguarding arrangements are generally more effective and organisations do work together to support children in receipt of their services. However, the Board is aware that further improvements do need to be made to ensure children in receipt of child protection and safeguarding services consistently receive the best possible support.

To this end, during 2013-2014, Herefordshire Safeguarding Children Board identified further areas for development in addition to its 3 year strategic priorities agreed in 2013. These additional priorities, listed below, are included within its 2014-2015 Business Plan:

- ✚ Private Fostering
- ✚ Governance arrangements between the Board and the Improvement Board
- ✚ The capacity of the Business Unit
- ✚ Evaluation of training provided by the Safeguarding Board.

⁵ More information is available from the [Three Steps to Safeguard Children](http://www.herefordshiresafeguardingchildrenboard.org.uk) page at www.herefordshiresafeguardingchildrenboard.org.uk.

The Board's ongoing improvement journey

Over the past two years Herefordshire Safeguarding Children Board has pursued the following key areas of our development through our Business Plans and associated work.

Here, observations made by Ofsted regarding the local safeguarding children board (LSCB) in their inspections in 2012 and 2014 are mapped against those key areas. The Board's work in these areas is also highlighted throughout the annual report.



The context of safeguarding children in Herefordshire

Herefordshire is a rural county with a population of 184,900⁶, approximately, 36,100 of whom are under 18 years old.

The County's Integrated Strategic Needs Assessment, Understanding Herefordshire⁷, provides an evidence base to inform commissioning decisions, particularly those relating to priority setting and resource allocation. Using a wide range of data, Understanding Herefordshire identifies the most significant concerns for the county as well as noting performance against historical issues of concern.

Overall, there are few concerns being highlighted by Understanding Herefordshire around the safety and well-being of children indicating that Herefordshire continues to be a safe and supportive place for children to grow and develop. Furthermore, the assessment shows that there have been improvements in a range of components that affect the wellbeing of children including the standard of housing in Herefordshire over the past 10 years, road safety over the past 15 years and in the proportion of children reaching expected levels of attainment in reading, writing and mathematics in primary schools.

Understanding Herefordshire does however highlight the following areas of concern around the safeguarding and wellbeing of children:

- ✎ The rate of child protection referrals is above national average.
- ✎ The rate of children in poverty in Herefordshire has increased slightly although it is significantly below the national average.
- ✎ The rate of repeat instances of domestic abuse is high compared to the national average.

Following concerns raised by Herefordshire Safeguarding Children Board (HSCB) and the Children and Young People's Partnership that Understanding Herefordshire was not adequately focussed on the needs of children and young people, Public Health led a Children's Integrated Needs Assessment during the year. Interim results, presented to Herefordshire Safeguarding Children Board's Strategic Board meeting in April, raised the following specific concerns:

- ✎ Inequalities in health, education and safety exist within the county and some cohorts of children are more likely to experience these including:
 - Children in receipt of disability living allowance
 - Children who are carers; 301 are currently on the carers register
- ✎ Herefordshire has a higher rate of first time entrants to the youth justice system than the regional or national figures. There were 176 first time entrants into the youth justice system in 2013-2014. The latest national comparator data (up to September 2013) converts the numbers into a rate-per-10,000-population for comparison. Herefordshire's rate was 589 compared to the national rate of 464.
- ✎ Herefordshire has a higher rate of homelessness than national and statistical neighbours and 201 children are part of homeless families.
- ✎ Data quality continues to be a concern within safeguarding case management systems with reasons for safeguarding intervention not easily reportable.

⁶ 2012 Population & household estimates for Herefordshire
(<http://factsandfigures.herefordshire.gov.uk/1847.aspx>)

⁷ Understanding Herefordshire is available at <http://factsandfigures.herefordshire.gov.uk/1922.aspx>

Herefordshire Safeguarding Children Board is also aware of these issues and is working with partners who are working to reduce these concerns. Where appropriate they have been included within the Board's Business Plan priorities or Risk Register for action and monitoring.

The Board's understanding of the context of safeguarding in Herefordshire is developed through its [Learning and Improvement](#)⁸ processes including its quality assurance programme. The programme includes regular submissions of data about safeguarding themes from a range of agencies as well as themed and case audits throughout the year. More information on these themes is available in Section A *Evaluating the effectiveness of Child Safeguarding through performance monitoring*.

Herefordshire Safeguarding Children Board continues to engage in external scrutiny and governance processes to support its ongoing improvement agenda including working with the Health and Wellbeing Board, Herefordshire Council and Herefordshire Safeguarding Adults Board. In addition, during 2013-2014, the Board was involved in a Peer Review and continues to work closely with the Herefordshire Supporting and Protecting Children Improvement Board.

Levels of Need, Co-ordinated Early Help and Referrals to Social Care

Herefordshire Safeguarding Children Board, in cooperation with its regional partners, maintains multi-agency procedures⁹ to safeguard and promote the welfare of children and with the aim of encouraging close working between agencies to facilitate early intervention and support to meet the needs of children, young people and their families.

These are supplemented locally by The Herefordshire Levels of Need and Service Response Guidance¹⁰ which gives all practitioners across partner agencies clear guidance as to when they should be providing appropriate responses on their own; engaging the early help services of a range partner organisations through use of the Common Assessment Framework and Herefordshire's Multi-Agency Groups and when it is appropriate to make a referral to Social Care.

Embedding the Levels of Need guidance into practice across the children's workforce remains a focus for Herefordshire Safeguarding Children Board. During the year, the Levels of Need have been promoted across the Board's newsletters, promotional materials and website. The Board's audit work has suggested that the Levels of Need are being used more consistently by partner organisations and within the MASH, although its performance management analysis suggests that there are still inconsistencies within this. For that reason, the Board is undertaking a redevelopment of the Levels of Need during 2014-2015 which will further support professional decision making by the children's workforce and bring greater clarity for families and the public.

⁸ More information is available from the [Learning and Improvement](#) page at www.herefordshiresafeguardingchildrenboard.org.uk.

⁹ <http://westmerciaconsortium.proceduresonline.com/index.htm>

¹⁰ Available for download from the [Policies and Procedures page](#) at www.herefordshiresafeguardingchildrenboard.org.uk.

What have we done to improve the effectiveness of child safeguarding in Herefordshire?

a. Evaluating the effectiveness of Child Safeguarding through performance monitoring.

A significant amount of data is received and analysed by the Quality Assurance and Evaluation sub group in the form of reports on the safeguarding performance for member organisations and on specific safeguarding themes. The Quality Assurance and Evaluation sub group analyses the data presented in the reports, where possible triangulating that against data and intelligence derived from other quality assurance activity and identifies areas of concern for further monitoring or investigation. Performance Reports received by the group include the following quarterly reports:

- ✎ Children's Social Care and Early Intervention
- ✎ Health
- ✎ Police
- ✎ Youth Offending Service
- ✎ Domestic Abuse
- ✎ Safeguarding in Education (Termly)
- ✎ Effectiveness of Child Protections Conferences
- ✎ Case Escalations
- ✎ Safeguarding Training and Development

In addition, the following annual reports are also received by the Quality Assurance and Evaluation sub group:

- ✎ Sexual Assault Referral Centre
- ✎ Missing Children
- ✎ Private Fostering
- ✎ Local Authority Designated Officer (LADO)
- ✎ Independent Reviewing Officers (for children's social care)
- ✎ Sexual Exploitation and Trafficking
- ✎ Multi-Agency Risk Assessment Conference (MARAC)
- ✎ Education
- ✎ Multi-Agency Public Protection Arrangements (MAPPA)
- ✎ Youth Homelessness

It is expected that Herefordshire Safeguarding Children Board members from the above organisations maintain ongoing processes to monitor and quality assure their own safeguarding activity. The nature of that monitoring is set out in the internal safeguarding practice presentations, which were refreshed during 2013-2014 and which form part of the Board's Commitment to Safeguarding document¹¹.

¹¹ Available for download from the [About HSCB](http://www.herefordshiresafeguardingchildrenboard.org.uk) page at www.herefordshiresafeguardingchildrenboard.org.uk.

Performance
Monitoring

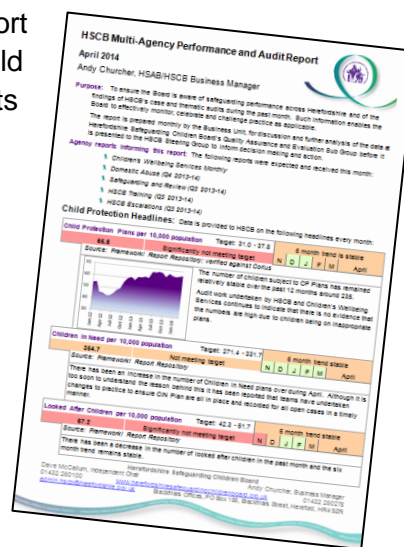
Voice of the
Child

The ongoing monitoring of performance data through quarterly reports enables Herefordshire Safeguarding Children Board to challenge partners where analysis of the data identifies safeguarding concerns. The Quality Assurance and Evaluation Sub Group undertake the initial analysis of the performance data and communicate this analysis to members of the Strategic Board (via the Steering Group) to enable holding to account.

To ensure the effectiveness of this process during the year Herefordshire Safeguarding Children Board developed a Performance Highlight report communicating monthly data and analysis around ten Child Protection Headlines, areas of concern from quarterly reports and the findings of the Board's audits.

The ten Child Protection Headlines are:

- 🔗 Child Protection Plans per 10,000 population
- 🔗 Children in Need per 10,000 population
- 🔗 Looked After Children per 10,000 population
- 🔗 Contacts processed within 24 hours
- 🔗 Conversion Rate of Contacts to Referrals
- 🔗 Timeliness of Assessments
- 🔗 Timeliness of Child Protection Visits
- 🔗 Timeliness of Looked After Children Visits (two measures)
- 🔗 Percentage of Child Protection Plans lasting 24 months or more



October's Performance Highlight Report highlighted a concern around data from West Mercia Youth Offending Service (YOS) showing, that while there is long term ongoing decline of First Time Entrants to the Youth Justice System, our numbers are still higher than the newly available comparator data. Concern over this resulted in the Youth Offending Service making a specific presentation to the Board's Steering Group which then directed Police and YOS to work together to test the hypothesis given as to why this is the case.

Furthermore, this data then informed a wider discussion about the potential effect on Safeguarding of service redesign and cuts within multi-agency universal and early help services. Agencies agreed that they will inform Herefordshire Safeguarding Children Board, the Children and Young People's Partnership and the Health and Wellbeing Board when they are reducing or redesigning their services so that these proposals can be scrutinised by partners.

As a result, the Board's Steering Group received a report from Public Health around the current capacity of School Nursing services who were taking responsibility for meeting a specific area of health providers' statutory duties. The report asked the Board to agree to proposed changes to the service. The Steering Group challenged Public Health about their understanding of their statutory responsibilities and that these shouldn't be compromised within any service redesign. Public Health reported back to the Board, outlining the way in which they had rectified the issues to ensure children could continue to access appropriate safeguarding services from them which may otherwise have been reduced.

Voice of the
Child

Developments for the Board or its partners has not progressed as expected and will be carried through into 2014-2015.

**Performance
Monitoring**

**Voice of the
Child**

An area that has not been developed as planned at the beginning of the year is the Board's commitment to understanding the way that partner agencies listen to and use the voice of children in receipt of their services as a significant indicator of quality and to inform improvements. Each reporting agency, listed above, is expected to report how they seek and take account of children and families in their service delivery. Reporting during 2013-2014 was inconsistent, highlighting the relatively under-developed processes used by partners. The Board is also aware of the fact that it also needs its own mechanisms for understanding the voice and experience of the child and has included this within its 2014-2015 Business Plan.

Wye Valley NHS Trust and YOS have processes which are beginning to inform service design and all partner agencies see the development of their work in this area as a priority. Herefordshire Safeguarding Children Board will also develop its own processes to seek the views of children and young people through 2014-2015.

Through developing its ability to test, triangulate and analyse performance data, Herefordshire Safeguarding Children Board is now more empowered to identify concerns around data quality. Children's Wellbeing Services, who provide the majority of data around child protection processes are undertaking a significant transformation project of its electronic case recording system. By the end of 2013-2014 the Board was more confident in certain data items being provided and this project is continuing into 2014-2015. Data quality across partners has been identified as an action area for development within the 2014-2015 Business Plan.

**Performance
Monitoring**

The Board, now more able to test data presented is aware of inconsistencies in data quality and are seeking to improve this.

The Board's Learning and Improvement Framework has been developed to combine performance monitoring with a programme of case and thematic audits to ensure the best possible understanding of the effectiveness of safeguarding services in Herefordshire.

The Board proposes themes for thematic audits in advance; including the scheduling of quarterly review audits approximately 6 months after the initial audit is carried out to identify how learning has made an impact on practice. The programme of thematic audits began in April 2013 and during 2013-2014 the Board undertook the following review audits.

Thematic audits take an in depth and searching review of practice in the cases audited. It should therefore be noted that this approach means that sample sizes are small and some care must be taken when extrapolating findings across cohorts. This is only done when triangulated against other supporting evidence such as the analysis of performance data.

Thematic and Review Audit of the Children's Social Care front door

Following multi-agency audits of referrals made to children's social care (April 2013) and Strategy Discussions/Meetings (May 2013) the Board undertook a review audit of both elements in October 2013. The following overarching learning was identified and impact of progress checked:

Initial Finding (April/May)	Review Finding (October)	Impact Assessment
The quality of some referrals was compromised through empty sections of the form. An action was agreed to update the Multi	An updated MARF was used for the majority of the referrals audited and no sections were left empty.	By updating the MARF there has been an increase in the quality of information included in some referrals.

**Performance
Monitoring**

**Voice of the
Child**

Initial Finding (April/May)	Review Finding (October)	Impact Assessment
Agency Referral Form to remind referrers to note Not Known if that is the case to improve the quality of information within referrals and ensure gaps are not left unnecessarily.	Where appropriate a note was made that specific information was not known or not relevant.	Higher levels of confidence can be placed on initial screening decisions and strategy discussions where there is an increased level of assurance that key information is not missing.
The Levels of Need were not consistently complied with by the referrer or the team receiving the MARF within children's social care. Therefore the guidance was reissued and promoted heavily by HSCB across all communications channels and training and development opportunities.	Cases audited in October all showed greater alignment to the Levels of Need Guidance in the referrals and within the MASH where they were received.	A targeted campaign to increase knowledge and use of the Levels of Need guidance has increased the appropriateness of responses by agencies to safeguarding concerns. Further work is needed and is ongoing in HSCB's the Levels of Need refresh programme.
One agency was using a standardised form to make referrals which risked wrong information being included within the MARF and jeopardised the quality of decision making at initial screening.	Referrals from the agency involved were in the correct format and assurance given that the standardised form is no longer being used.	The robustness of referrals made by the agency has increased as the standardised form has been removed from use.
Concerns were raised about the consistency of the quality of Strategy Discussions and their compliance with Working Together. The Safeguarding and Review Service were required to assure the Board of how they would increase levels of quality.	The review audit showed similar inconsistencies within the practice of strategy discussions within the MASH and that work to increase the quality of Strategy Discussions had not been successful at this stage.	These further findings concurred with the findings of the Peer Review, undertaken at around the same time, and since then the quality of Strategy Discussions and the recording of them has improved as noted through further audit and QA work.
There was little evidence of the voice and experience of the child being captured adequately in strategy decisions. HSCB highlighted the need to increase the level of use of the voice of the child within referrals and decision	Cases audited showed an increased level use of the voice of the child within referrals which was then reflected in part within the recorded strategy decisions.	While work with the voice of the child is ongoing and improvements need to be made, decisions are being made with greater emphasis on the voice of the child in case

Performance Monitoring	Voice of the Child	
Initial Finding (April/May) making within its work programme.	Review Finding (October)	Impact Assessment assessments.

Thematic and Review Audit of Child Protection Conferences

Building on learning from thematic audits of ICPCs (July 2013) and RCPCs (September 2013) Herefordshire Safeguarding Children Board undertook a review audit of all conferences in February 2014. The following overarching learning was identified and impact of progress checked through this process:

Initial Finding (July/September)	Review Finding (Feb)	Impact Assessment
Multi-agency involvement (attendance and submitted reports) in conferences is not consistent enough. Safeguarding and Review were asked to investigate the length of notice given to agencies invited to ICPCs and propose actions for improvements.	Audit findings suggest that invites to agencies are being sent with an increased period of notice and conferences are more likely to go ahead as planned without last minute rescheduling.	While improvements have been made in process to support greater engagement by agencies, performance information suggests little improvement in attendance and reports submitted to conferences. Further work is underway to improve this.
Inconsistencies in the quality of conferences was raised as an issue with specific concern around the management of invites and minutes. HSCB agreed to support Safeguarding and Review in the development of resources for Chairs and attendees at conferences.	Overall, the audit identified a greater level of consistency in the quality of conferences from the previous audits, notably in the quality of chairing and clarity in decision making. Distribution of minutes remained a concern.	The quality of multi-agency decision making seems to have improved at conferences at the same time as the audit identified greater levels of consistency in the quality chairing and recording within minutes.

Herefordshire Safeguarding Children Board is aware that its programme of audits is very ambitious and, as observed by Ofsted in May 2014, is probably too ambitious to be able to ensure all learning generated through them is converted into improvements in safeguarding practice or the supporting frameworks. During 2014-2015 the Quality Assurance and Evaluation sub group, under the governance of the Steering Group, will develop its auditing processes to ensure more time is given to ensuring improvements are planned and actioned.

**Audit and Case
Analysis**

HSCB will now be reviewing and developing its audit processes to ensure all learning is converted into improvement.

b. Learning and Improvement through Case Reviews.

The Joint Case Review (JCR) group oversees learning and improvement through case reviews by providing advice and management of Serious Case Reviews for both adult and children’s safeguarding boards and domestic homicide reviews (DHR). The group makes initial decisions about multi-agency reviews into cases where multi-agency failings may have contributed to someone experiencing significant harm and makes a recommendation to the Independent Chair of Herefordshire Safeguarding Children Board on cases involving children who has the final decision on the review process in each case. Following new guidance released in Working Together to Safeguard Children (April 2013)¹², the group also makes decisions about undertaking reviews for cases which do not meet the criteria for an SCR but which do merit review.

During 2013-2014, the Joint Case Review Group has developed processes for the undertaking of reviews in Herefordshire. The Significant Incident Learning Process (SILP) has been used to date on four occasions by Herefordshire Safeguarding Children Board, including in undertaking its serious case review, and the process has been evaluated by those involved. In addition, the Board has also developed a Herefordshire Evaluation and Learning Process (HELP) which incorporates key activities from established learning processes. The HELP methodology has so far not been used to review cases from the Children’s Board. It is currently being used to review two cases by Herefordshire Safeguarding Adults Board.

Outcome of Referral to JCR	Children	Adults	DHR
Referrals Received	7	3	1
Serious Case Reviews	1 (SILP)	0	0
Independently chaired multi-agency review	2 (SILPs)	2 (HELPS)	0
Internally chaired multi-agency review	0	0	0
Single Agency Review	1	0	0
Did not meet criteria for review	3	1	1
Reviews completed during the year following referrals made in 2012-2013	1	0	0

The Joint Case Review Group had eleven cases referred to it during the year in comparison to seven in 2012-2013 reflecting the new guidance.

A key theme that has been common in two independently chaired multi-agency reviews undertaken by Herefordshire Safeguarding Children’s Board, and also identified in a number of its case audits is that of neglect. The effect of the neglect is different within the two reviewed cases, but it had a significant role in the final outcomes of both. As a result, neglect has become a priority action area of the Board’s 2014-2015 Business Plan and new guidance and training will be developed during the year to

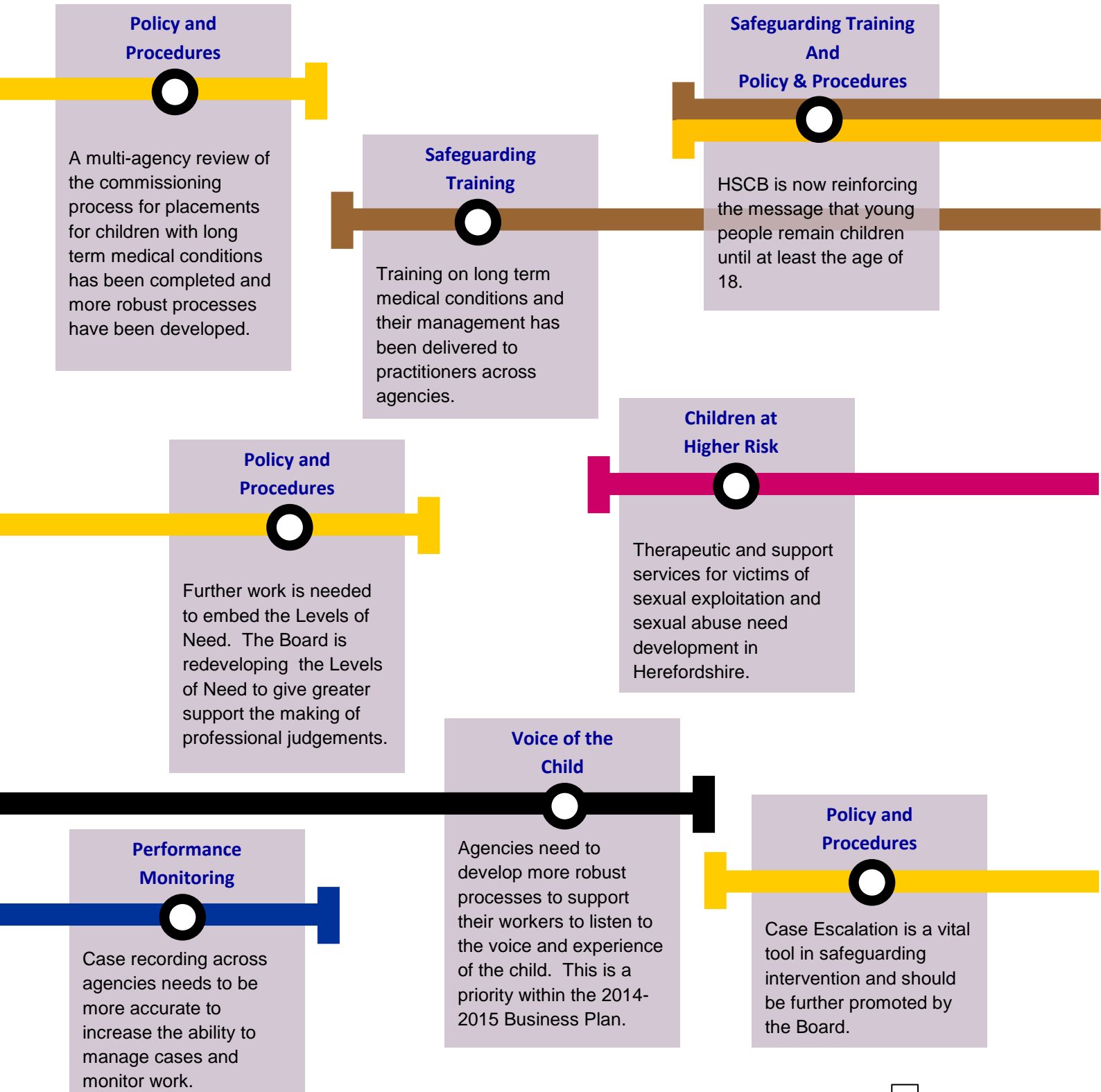
**Safeguarding Training
And
Policy & Procedures**

HSCB is now developing new guidance on neglect which will be supported by training.

¹² Working Together to Safeguard Children can be downloaded from www.workingtogetheronline.co.uk

ensure the workforce are more able to identify neglect and understand the potential additional risks that it can have on children.

The Board maintains a composite learning and improvement action plan, overseen by its Steering Group, which includes all the agreed actions arising from the recommendations made through case reviews alongside those which have resulted from the Board's thematic and case audit programme. Some of the additional actions resulting from the Board's Case Review processes are outlined below:



c. Workforce Development: Training and Communication.

Herefordshire Safeguarding Children Board communicates with organisations across Herefordshire through it's:

- 🔗 Membership from partner organisations
- 🔗 Newsletter
- 🔗 Business Plan
- 🔗 Training
- 🔗 Events
- 🔗 Website

The Board progresses the County's joined-up approach to safeguarding in Herefordshire by bringing together directors and strategic leaders across organisations working with children. Organisations represented include:

- 🔗 Herefordshire Council, incorporating Children's Social Care, Education Services, Housing and the Community Safety Partnership
- 🔗 NHS Herefordshire
- 🔗 West Mercia Youth Offending Service
- 🔗 West Mercia Probation Trust (superseded in June 2014 by the National Probation Service and the West Mercia Community Rehabilitation Company)
- 🔗 Herefordshire Voluntary Organisations Support Service
- 🔗 Hoople
- 🔗 Wye Valley NHS Trust
- 🔗 2gether NHS Foundation Trust
- 🔗 Education establishments
- 🔗 West Mercia Police
- 🔗 Children and Family Court Advisory and Support Service (CAFCASS)
- 🔗 Strategic Health Authority

Further third sector organisations are represented as appropriate within the Board's sub groups. Members of the Board and its sub groups have a range of responsibilities as laid out in its Constitution¹³ including representing the Herefordshire Safeguarding Children Board within their organisation, and ensuring that the organisation is meeting its obligations to safeguard and promote the welfare of children.

Therefore, members of the Board have a responsibility to ensure that their organisations understand what the Board is doing and is working towards the priorities of the Board.

The development and publishing of the Board's Business Plan also supports members in ensuring the Board's priorities are promoted among partner agencies. In 2013-2014 the Board produced its poster of priorities for practitioners working in Herefordshire as



¹³ Available for download from the [Policies and Procedures page](http://www.herefordshiresafeguardingchildrenboard.org.uk) at www.herefordshiresafeguardingchildrenboard.org.uk.

an aide memoir to the need to safeguard and promote the welfare of children.

Through meeting its statutory responsibility to ensure the availability of inter-agency safeguarding training, and through providing additional training and e-learning to meet the needs of Herefordshire, Herefordshire Safeguarding Children Board maintains an on-going line of communication to front line staff across the children's workforce in Herefordshire.

Inter-agency safeguarding training was delivered through the Board to 1583 practitioners during the year, which includes a number of people who have been trained to deliver training within their own organisations. The main purpose of all of this training is to ensure all partners understand the most effective ways to promote the safety and welfare of children and young people. Training courses delivered have focussed on a range of safeguarding themes including:

- ✚ Universal Introduction to Safeguarding
- ✚ Universal and Specialist Sexual Exploitation and Trafficking
- ✚ Targeted Multi-Agency Working Together to Safeguarding Children
- ✚ Specialist Safer Recruitment and Designated Member of Staff Training for Education
- ✚ Specialist Safeguarding in Leadership

Sexual Exploitation and Trafficking was identified as a key development area for Herefordshire Safeguarding Children Board in the 2013-2014 Business Plan based on intelligence gathered by partners during the previous year. One element of the action plan was to raise awareness across the children's workforce and as part of those activities the Board provided the following learning opportunities:

In June 2013 Herefordshire Safeguarding Children Board held two half day multi-agency events (with 249 attendees) to raise awareness of the issue with speakers from Barnardo's, the Police, the third sector and children's social care. All Herefordshire's secondary schools and further education colleges sent attendees and all attendees were given resources to take back to their workplaces to provide information to colleagues.

- ✚ At the events the Board launched its Universal Sexual Exploitation and Trafficking e-learning which, by the end of Q4 had been undertaken by 177 practitioners.
- ✚ The Board has developed a Sexual Exploitation and Trafficking module within all our Targeted Working Together Training since June 2013 which by the end of Q4 had been delivered to 212 practitioners.
- ✚ Bi-monthly Specialist Sexual Exploitation and Trafficking Training courses have been commissioned by the Board and provided at subsidised rates to members of children's workforce. 5 courses were delivered to 77 trainees during 2013-2014 and these are continuing into 2014-2015.

Attendees at all of these learning events receive information including copies of Herefordshire Safeguarding Children Board's Signs and Indicators poster which can then be displayed within the workplace.

Of the 77 trainees on the Specialist Sexual Exploitation and Trafficking training during 2013-2014, twenty-two secondary schools, secondary pupil referral units and further education

**Safeguarding Training
and
Children at Higher Risk**

The Board committed significant resource to raising awareness of Sexual Exploitation and Trafficking through training and events.

colleges have been represented and those who have not been represented have now received targeted communications from the Board to encourage engagement:

Having undertaken a review of comments from education staff within their course evaluations it is clear that the course content has been sufficiently engaging to ensure wider dissemination of learning across the establishments they represent. Areas identified as key learning within those evaluations include:

- ✎ The fact that sexual exploitation is an issue, “even in Herefordshire”;
- ✎ The importance of information sharing, especially in regard to safeguarding children and young people from sexual exploitation;
- ✎ Specific vulnerabilities of children including those at higher risk and the signs and indicators staff should be looking for;
- ✎ The legal framework supporting intervention work;
- ✎ How to speak to young people effectively to support them in understanding and communicating if they are being exploited.

The following specific comment was made by a member of staff at one of Herefordshire’s further education colleges and highlights how the training has supported an increase in the identification of cases of children and young people affected by sexual exploitation and how the workforce is being supported to act appropriately to it:

“The signs of trafficking was especially useful. During a de-brief on the training to colleagues later that week, a member of staff recognised a situation with a student and we acted on our suspicions and the case was accepted.”

All trainees from education who completed evaluations stated that the content was pertinent and that they would be sharing learning within their establishments to other staff. Some trainees also stated that they would be using some of the learning to raise awareness among their students.

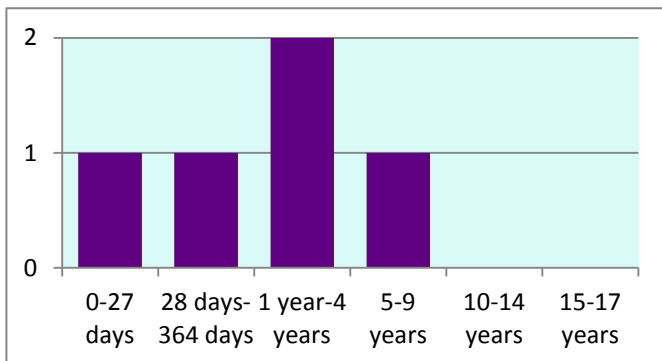
During the year Herefordshire Safeguarding Children Board has launched a termly Safeguarding Leads in Education Forum to ensure a regular two way conversation is facilitated between the Board and education providers to increase the effectiveness of safeguarding work.

The Board’s Accommodation Providers Safeguarding Forums have been attended by representatives from the county’s fostering agencies, residential schools and looked after children’s homes. They have focussed on a range of safeguarding issues including sexual exploitation and trafficking due to the evidenced increased risks to children in the looked after system, children missing from care and developing processes for notification of new placements in line with new statutory guidance introduced in 2014. It is vital that the Board accommodation providers within its work as there are over 200 looked after children who have been placed in the care of these providers by other local authorities.

d. Learning and Improvement through reviews into Child Deaths.

Herefordshire Safeguarding Children Board hosts the Child Death Overview Panel (CDOP) which reviews all child deaths in Herefordshire whatever the cause of death. CDOP is a multi-agency panel led by Public Health and includes members from health services, Children’s Social Care, the Police and the Coroner’s Office. They determine whether deaths were preventable and whether there are any lessons to be learnt or issues of concern.

There were a total of eleven deaths of Herefordshire children from April 2013 until the end of March 2014. Of those, CDOP was able to complete its reviews of 5 of them during the year, three male and two female. The graph shows the ages of those children where the reviews of the deaths concluded during the year:



Of the five cases, CDOP concluded that one of the deaths could potentially have been prevented¹⁴ and there were factors identified which, if modified, could help to prevent similar deaths in future

Whilst it is positive that the county has few child deaths, it is not possible to draw any meaningful analysis or conclusions to determine emerging themes in relation to

causes of death. Herefordshire Safeguarding Children Board therefore shares its CDOP information with regional partners to identify any specific learning.

Lesson Learnt	Action Taken by HSCB
Co-sleeping was a factor in a child death although numbers have continued to reduce.	Education for all of recommendations for safe sleeping (co-sleeping death) and ensuring information is readily available.
Following a child deaths in 2012-2013 and 2013-2014 where the children had different long term health conditions, the need for specific training was identified.	Continued Education and professional development of health professionals and across agencies in the management of long term health conditions and the medications involved.
Referral pathways for vulnerable young adults were not clear and there was evidence that agencies were unclear on when young people should be counted as adults in the planning and delivery of services.	Clear guidance has been reissued making it clear that all young people under the age of 18 should be supported as children within health services. Referral pathways have also been reviewed and updated.

¹⁴ Section 5.8 of Working Together to Safeguard Children 2013 states that preventable child deaths are defined as “those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths”.

e. Developing and maintaining Policies and Procedures¹⁵.

During 2013-2014, Herefordshire Safeguarding Children Board identified the need to extend its processes for maintaining its policies and procedures which at the time were the responsibility of its Steering Group. While the majority of these are shared with regional partners in West Mercia there is significant work to do to keep the policies fit for purpose and, with an increasingly demanding role for Steering Group, the Board decided to re-establish its Policy and Procedures sub group.

In response to inconsistencies in practice identified through the Board's learning activities, the following policies and procedures have been developed during 2013-2014:

- 🔗 Herefordshire Safeguarding Children Board's Risk and Resilience Assessment Tool;
- 🔗 The standard script and supporting documentation for Strategy Meetings;
- 🔗 Minimum Standards for Supervision across agencies;
- 🔗 Guidance for members of Child Protection Core Groups

**Policy and
Procedures**

The following policies and procedures are scheduled for development during 2014-2015:

- Levels of Need & Service Response Guidance
- Suite of Assessment/conference policies/procedures
- Pre-Birth Planning Processes
- Risk for Adolescents Policy
- Neglect Guidance
- Quick Guide to CP Procedures

¹⁵ All policies and procedures mentioned are available to view through the [Policies and Procedures page](#) at www.herefordshiresafeguardingchildrenboard.org.uk.

2013/14 Strategic Priorities

The Herefordshire Safeguarding Children Board's (HSCB) Business Plan 2013/14 set out the Board's strategic aims and specific objectives. The strategic priorities were based on the Board's analysis of priority areas for development and improvement. This section describes the progress made against these specific priorities.

Priority Improvement Area 1

We said we would improve the experience of children, young people and families when they are supported in safeguarding systems (i.e. CAF, Social Care).

How we said we would achieve this:

- ✎ Ensuring all agencies improved the way they listened to and used the voice of children in receipt of their services
- ✎ Improve the quality of reflective supervision and the involvement of management in case decision making.
- ✎ Implement changes in safeguarding practices and HSCB functioning to meet the statutory changes within Working Together

What did we do?

- ✎ Required all partner agencies to regularly report to us how they listened to children and families in receipt of their services and what that was telling them.
- ✎ Developed a shared minimum standard for supervision to ensure managers are involved in case decision making.
- ✎ Increased the number of in depth case reviews that we undertake to ensure an greater amount of inter-agency learning is generated to inform service improvements.

What difference has this made?

- ✎ This accountability mechanism has encouraged agencies to develop their services through decisions, in part informed by the experiences of children and families.
- ✎ Frontline workers who are supporting children and young people are supported to make more empowered decisions.
- ✎ Direct improvements in the knowledge of the workforce with regard to long term health conditions, referral pathways and needs of children and young people placed in specialist care.

Priority Improvement Area 2:

We said we would improve multi-agency case work.

How we said we would achieve this:

- ✎ Improve multi-agency case decision making.
- ✎ Improving multi-agency case assessments within Children's Social Care.

What did we do?

- ✎ Ensured that agencies not in on-going support relationships with children and families were inputting effectively into early help assessments (e.g. Common Assessment Framework and Multi-Agency Groups).
- ✎ Fully implemented Herefordshire's Multi-Agency Safeguarding Hub.
- ✎ Understood how agencies were involved in Strategy Discussions/Meetings and ensured that the MASH supported these.

What difference has this made?

- ✎ Increased multi-agency involvement in early help and initial decision making ensures the most appropriate packages can be put in place for children and families in need of support.

Priority Improvement Area 3:

We said we would tackle evidenced safeguarding issues in Herefordshire

We said we would achieve this by improving the quality of multi-agency work with:

- ✎ Children affected by Domestic Abuse
- ✎ Children affected by Sexual Exploitation and Trafficking
- ✎ Children Missing from Care
- ✎ Children Placed in Herefordshire by Other Local Authorities.

What did we do?

- ✎ Developed our understanding of Domestic Abuse through additional focusses on this area within our audit and performance monitoring processes.
- ✎ Influenced the partnership in Herefordshire to put additional emphasis on Domestic Abuse and influenced the commissioning of additional services.
- ✎ Raised the profile of sexual exploitation in Herefordshire, developing support resources for professionals in order to identify and respond to children affected by it.
- ✎ Developed support processes for those who have been involved in sexual exploitation.
- ✎ Ensured accommodation providers understand the responsibilities they have which support multi-agency safeguarding frame works for children placed in Herefordshire and those who go missing from care.
- ✎ Developed the Board's Missing Children Action Plan with the aim of reducing incidences of children going missing and reducing the safeguarding impact on them when they do.

What difference has this made?

- ✎ Additional services have been commissioned to support families affected by Domestic Abuse.
- ✎ Increased the number of referrals being made for children involved in sexual exploitation and developed more effective multi-agency interventions for such children.
- ✎ Increased the number of notifications of children being placed in Herefordshire by other local authorities so that social care and accommodation providers can work together to safeguard children more effectively.
- ✎ Improved the working relationships between police and children's social care in response to incidence of children missing.

Priority Improvement Area 4:

We said we would improve the effectiveness of the Safeguarding Children Board

How we said we would achieve this:

- ✎ Develop the culture of constructive challenge within the Board
- ✎ Develop an evidence base of safeguarding casework to demonstrate and learn from good practice
- ✎ Agree a model of SCRs and significant case reviews in Herefordshire

What did we do?

- ✎ Members of the Board were empowered to make more informed challenges of partners through the development of our monthly performance bulletin, developing training available to Board members and monitoring attendance across Board meetings.
- ✎ Processes of collating and documenting good practice and excellent outcomes were developed.
- ✎ Methodologies for undertaking significant case reviews were used and/or reviewed and a local framework was developed for use as appropriate alongside the Significant Incident Learning Process.

What difference has this made?

- ✎ Ofsted identified an appropriate level of challenge within Board meetings which over the year has ensured partners give adequate resource and support to their safeguarding responsibilities.
- ✎ Increased numbers of significant case reviews has generated a range of learning which is beginning to translate into improvements in multi-agency safeguarding case work.

Appendix 2: Herefordshire Safeguarding Children Board Structure and Attendance

	Strategic Board	Steering Group	QA Sub Group	Joint Case Review	Child Death Overview Panel	MASH Governance	T&WD Sub Group	Policy and Procedure	SET Task and Finish
HSCB (Chair and/or Lay Members)									
2gether NHS Foundation Trust									
Education Establishments									
Herefordshire Council (Elected Member)									
Herefordshire Council	Education								
	Children's social care								
	Sustainable Communities								
	Adult social care								
	Public Health								
Ministry of Defence									
Herefordshire CCG									
NHS England Area Team ¹⁶									
West Mercia Police									
West Mercia Probation Trust									
Third Sector									
Wye Valley NHS Trust									
Youth Offending Service									
CAFCASS ¹⁷									
Attendance Key	Not attended 30% or more meetings		Apologies sent and rep attended 30% or more meetings			Attended more than 70%		Not on group membership	

¹⁶⁻¹⁷ The agencies are not expected to attend all Strategic Board meetings and attendance rating is calculated on their agreed attendance.

Appendix 3: Herefordshire Safeguarding Children Board Budget Summary

Working Together states that all local safeguarding children board (LSCB) member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

The following table states how our member organisations contribute financially to the work of the Board.

Agency contributions	2013/14
Herefordshire Council	£127,016
NHS Herefordshire	£45,203
West Mercia Police	£30,165
Youth Offending Service	£645
West Mercia Probation	£4,612
CAFCASS	£550
Funding Carried Forward	£39,306
Total income	<u>£247,497</u>

Expenditure	2013/14
Independent Chair	£22,000
Business Unit Staff and Costs	£142,512
Additional Business Costs	£7,478
Training and development (including HSCB Multi-Agency Trainer)	£20,192
Independently Authored Case Reviews	£20,928
Meeting expenses	£778
Publicity, information provision and participation	£6,630
Funding Carried Forward	£ 26,979
Total expenditure	<u>£247,497</u>