



# Herefordshire Safeguarding Children Board



Annual Report - 1 April 2015 – 31 March 2016

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# 1. Foreword from the Independent Chair

I am pleased to introduce this annual report for Herefordshire Safeguarding Children Board covering the year 2015-16, at the end of my first full year as its independent Chair.

At a national level, the year began with a revised version of the statutory guidance within which all Safeguarding Children Boards operate - 'Working together to safeguard children', and concluded with the publication of the Wood review of LSCBs, which heralds significant changes in the safeguarding landscape for the future. These changes took place against a backdrop of rising demand, reducing resources, and pressures across the system for partners to do more with less. The implications of these are still being worked out, but have already resulted in and will continue to result in structural changes and altered working arrangements, which bring their own risks in terms of disruption to the continuity of services for children.

In Herefordshire, the Board has worked to create stronger links across other multi-agency partnerships in Herefordshire, aligning its activities and priorities to promote the ambitions set out in Herefordshire's Children and Young People's Plan (2015-18).

This year has therefore seen considerable activity focused on coordinating and ensuring the effectiveness of arrangements to protect children who are at risk of or already experiencing sexual exploitation. At the same time, there has been significant challenge to the agencies involved in the "front door" arrangements - known locally as the multi-agency safeguarding hub (MASH) - as the Board recognised that there was insufficiently strong leadership and evidence of inconsistent responses to and outcomes for children. Part of the challenge included a focus through the Children and Young People's Partnership on strengthening arrangements to provide early help for families.

Ofsted's judgement in May 2014 that the Board 'requires improvement' has provided impetus for the Board to review its own structures and working practices, in recognition of the need to become more effective in its operation and achieve clearer impacts, whilst working hard to progress its priorities and achieve consistently good services and outcomes for children. Hence it has worked to improve and focus its quality assurance and learning activity in order to strengthen its ability to scrutinise and challenge effectively the work of the safeguarding partner organisations across Herefordshire.

The Board has revised and strengthened its membership, reviewed and reconfigured its subgroups - transferring some of these to sit within operational services - developed its engagement with front line practitioners, and improved its oversight of frontline practice. It has taken steps to engage more with children and young people, responding to their voices and stories when carrying out its work.

2015-16 has also been the first full year of operation of the joint Business Unit that was set up to support the Safeguarding Children and Adults Boards and the Community Safety Partnership. The Business Unit has worked hard to streamline its functions and improve alignment between these Boards and with the other key multi-agency partnerships operating within Herefordshire. This offers significant potential to improve efficiency and effectiveness across all the partnerships, and will be further developed now that the unit has secured permanent staffing.

Overall, the direction of travel within Herefordshire is a positive one. The quality and consistency of child protection work is improving, and there are some good examples of effective multi-agency working. Recruitment and retention of staff within the Children's Wellbeing Directorate is improving gradually as well. However, there are still areas across organisations which are in need of improvement. Wye Valley NHS Trust was inspected by the Care Quality Commission during the year, which concluded that its services were inadequate overall; in its assessment of the effectiveness of West Mercia Police in protecting people who are vulnerable and supporting victims, HMIC judged the police to be 'requiring improvement'.

There is, therefore, much still to do. Within the report, the priorities on which the Safeguarding Children Board will concentrate during the coming year are set out. This will include responding to the national changes which are expected to accompany forthcoming legislation.

Amidst all this activity, however, what does not change is the hard work, commitment and dedication of staff who work every day to support families, keep children safe and promote their well-being. This report contains examples of feedback and appreciation by some of the children and their families who have been helped, to which I add my voice.

**Sally Halls**  
Independent Chair  
Herefordshire Safeguarding Children Board



## 2. About this report

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Chapter 3, paragraph 12 of Working Together to Safeguard Children (2015), requires the Chair of the Local Safeguarding Children Board to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

This report covers the priority areas addressed by the Herefordshire Safeguarding Children through 2015-16, as well as the data and reporting provided by partner agencies regarding their performance in working together to safeguard children and young people in Herefordshire. The report also sets out how effectively the Board meets its statutory responsibilities, identifies areas for improvement, including learning from case reviews and audits, and sets out the Board's planned priority areas for 2016-18.

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This report can be downloaded from the HSCB website at: [www.herefordshiresafeguardingchildrenboard.org.uk](http://www.herefordshiresafeguardingchildrenboard.org.uk)

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### 3. Executive Summary

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This report sets out how Herefordshire Safeguarding Children Board has worked during 2015/16 to meet its statutory objectives, which are to co-ordinate local work to safeguard and promote the welfare of children and young people, and to ensure the effectiveness of that work. The report also gives detail on the priority areas addressed by the Board during this period, as well as the data and reporting provided by partner agencies regarding their performance in working together to safeguard children and young people in Herefordshire. The report also sets out how effectively the Board identifies areas for improvement, including learning from case reviews and audits, and details the Board's planned priority areas for 2016-18.

# Progress on Priorities 2015-16

Herefordshire Safeguarding Children Board's (HSCB) priority areas for 2015/16 were determined following consideration of evidence from multi-agency case audits, Ofsted inspection (2014) and the peer review diagnostic commissioned by the Board.

1) HSCB is a truly effective agent for change that has a real impact for children and young people.

3) To support increased resilience in individuals, families and communities.

2) To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people.

4) To safeguard and promote the welfare of children and young people who are abused and/or neglected.

## Priority 1: HSCB is a truly effective agent for change that has a real impact for children and young people.

Ofsted's Inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers in May 2014 included a review of the effectiveness of the Local Safeguarding Children Board, which it found to be 'requiring improvement.' HSCB developed an improvement plan in response, which focused on the four broad areas for improvement identified by Ofsted:

- Governance arrangements for the HSCB
- Policies and Procedures
- Child Sexual Exploitation and children who go missing
- Multi-agency safeguarding training

Significant progress has been made in the majority of areas. With the exception of activity in relation to multi-agency training, all areas have now been incorporated into 'business as usual' and reflected in the Board's business plan for 2016/17. The Board continues to monitor the establishment and implementation of the training pool through 2016/17.



## Priority 2: To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people.

The Board has established a CSE and Missing subgroup that oversees and challenges the work of partners to recognise and respond effectively to this issue. A CSE strategy was drawn up and signed off by the HSCB in July 2015, supported by a delivery plan. A dataset has been agreed to enable the Board to monitor the effectiveness of the response to CSE. Targeted auditing of responses to CSE has also taken place during 2015/16. The pathways for referring and responding to cases of CSE, a checklist and a CSE risk assessment tool have all been implemented.

The Board recognises that there remain areas for improvement in relation to our response to CSE in Herefordshire, and as such it continues to be a priority area for the Board in 2016/18.

Specifically the Board will be working to ensure that:

- The pathway for addressing concerns about cases of suspected CSE is clear.
- There is clear data relating to CSE risks and children missing from home
- There is good intelligence from practice to better understand the prevalence of CSE and inform responses.
- Children, families, the general public and professionals know about and understand CSE and how to respond as appropriate.
- Return home interviews are of good quality and used at an individual and strategic level to tackle risks.
- Children who have experienced CSE receive appropriate post abuse support.



## Priority 3: To support increased resilience in individuals, families and communities.

This priority area of the Board aligns with a key priority within Herefordshire's Children and Young People's Plan, and covers the whole spectrum of provision of services to children and families. The aim is always to improve the early identification and response to critical issues affecting children and young people's development.

In support of this the Board has led the development and promotion of the "Levels of Need" in Herefordshire, which acts as a guide to support professional judgement when considering help that children and families need and when to refer concerns.

The Board has also both supported and challenged the development of the Early Help Strategy and offer, which is a priority in Herefordshire's Children and Young People's Plan and is led by the Children and Young People's Partnership.

HSCB will continue to receive reports on the prevalence of domestic abuse in cases involving children and reviewing the services designed to reduce the risk of harm to children and address the impact of domestic abuse, as evidence shows that factors affecting adults can have a direct impact on the safety and wellbeing of children.

Our plan for the year 2015-16 set out some key areas where we wanted to see improvements:

- A reduction in referral and re-referral rates to children's social care.
- Improved quality of referrals to children's social care.
- An increasing percentage of professionals who report they are confident in responding to concerns in accordance with thresholds document.

Whilst re-referrals have reduced compared to the previous year they are still high and focus will remain on this area, this is being reviewed in order to better understand and then address themes or causes.

Learning from HSCB audits carried out in 2015-16 demonstrated that:

- There was good awareness of the Levels of Need Guidance but more work was needed in supporting use of this in day to day practice and decision making.
- There was limited use of any tools when practitioners were carrying out assessments or considering referrals.

HSCB will be working to ensure that:

- Effective decision making is taking place at the early stage of identification of needs.
- Common Assessments are taking place within timescales and are effective in identifying needs of children and families and planning interventions.
- Lead professionals are identified in each case deemed to be level 2 or 3.

## Priority 4: To safeguard and promote the welfare of children and young people who are abused and/or neglected.

The performance information and quality assurance established by the Board highlighted a number of areas for improvement within the child protection system. HSCB noted that the numbers of children subject of a child protection plan was high. In response, the Board commissioned an analysis of the child protection system "overheating" with a number of issues identified and actions agreed to address these.

Our plan for the year 2015-16 set out key areas where we wanted to make a difference:

- The process and decision making at the initial stages of the child protection process comply with statutory guidance, and the decisions are consistent with the levels of need in Herefordshire.
- The child protection planning and review process is truly multi-agency and consistent with guidance and procedures.
- Child protection plans are effective in reducing/eradicating the risk of significant harm to children.

This too will be a continuing theme for the Board; one of the priority areas for the HSCB for 2016/17 is assuring itself that the child's 'journey' through the child protection process results in positive outcomes for the child.



# How the HSCB has carried out its statutory functions

## a. Policies, procedures, practice guidance updates

Herefordshire commissions its multi-agency child protection procedures together with the other West Mercia LSCBs - Shropshire, Telford and Wrekin and Worcestershire - from Tri-X. There has been a project throughout 2015/16 reviewing any "local" procedures and where appropriate ensuring that they are reflected in the cross West Mercia procedures and guidance. The aim is to have agreed West Midlands procedures in place by April 2017, with an agreed process for management and review of the procedures. Until this is achieved Herefordshire will continue to maintain the joint West Mercia procedures.

## b. Training

The HSCB multi-agency training offer for 2015/16 reflects the priority areas of the Board and wider safeguarding issues. Face to face multi-agency training has included working together to safeguard children (and refresher), childhood neglect, Child Sexual Exploitation (CSE) and child protection conferences.

There has also been an on-line training offer that has included safeguarding children basic awareness, CSE basic awareness and Female Genital Mutilation (FGM).

## c. The safety and welfare of children who are privately fostered

A child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative' is deemed to be privately fostered. Private fostering is an arrangement made between a parent and a carer for 28 days or more. The council has a legal duty to make sure that all private fostering arrangements are safe and appropriate for the child. HSCB receives an annual report about private fostering in Herefordshire.



## d. Case reviews

During 2015/16 one Serious Case Review (SCR) in respect of a child was initiated. The review will be fully concluded in 2016/17.

## e. The Child Death Overview Panel (CDOP)

There were 14 deaths within the review period April 2015-March 2016, five of which are still awaiting completion of review. Of those reviewed; all were completed within six months from time of death. Of the five from the current year that are awaiting review completion two await post-mortem and possible subsequent inquest. Three have not been completed because of delayed submission of some of the statutory form Bs needed from agencies to enable the CDOP to complete the review. This has been an area of concern for some time and the matter has been escalated to the HSCB with corresponding challenge issued by letter to the agencies concerned.



# Effectiveness of agency safeguarding arrangements in Herefordshire

The Board has continued to monitor a range of performance information and carry out quality assurance activities to ascertain the effectiveness of local services. This work is set out in the Board's Learning and Improvement Framework and is primarily coordinated through the Quality Assurance and Performance (QA) subgroup. Practitioners and first line managers have been actively involved in the multi-agency case audits and this allows for a much richer discussion and exchange of views and understanding that lead to better learning.



## Section 11 audit

Partners of the Herefordshire Safeguarding Children Board completed a "Section 11" Audit Self-Assessment tool in 2015-16. Based on their self-assessment, each agency (except CAFCASS) identified actions for improvement and developed an action plan in response. The HSCB has put into place a peer challenge review of the section 11 audits, consisting of panels of Board members meeting with each representatives of each agency to seek evidence for their assessments and challenge the completion of the audits. The QA subgroup will be reviewing the progress and impact of the action plans through 2016-17.

A further full section 11 audit will take place in 2017-18.

# Development of HSCB and its effectiveness 2015-16

HSCB carries out its work primarily through its subgroups, supplemented by task and finish groups as required, and through scrutiny and challenge at Board meetings.

The Board also works with other multi-agency partnerships across Herefordshire to both scrutinise and challenge their activities and to pursue joint objectives. Overall engagement by partners in the work of the HSCB has continued to be positive throughout 2015-16. HSCB has benefitted from the creation of the joint business unit at the beginning of the year, which supports the Safeguarding Adults Board and the Community Safety Partnership as well as HSCB.



# Illustrations of HSCB challenge and impact

Throughout this Executive Summary there are details of the work of all partners in safeguarding children, and the Board's function in seeking assurance that partners are working effectively together. Examples of this activity are summarised below:



## Challenge

Improving identification of and response to CSE.

Improved consistency and quality of "front door" services.

Improving the "step down" process so it works better for children.

Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.

Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.

Audit of CSE cases to assist in improving identification & response to CSE.

Increasing the pace of the development of the early help offer in Herefordshire.

## Impact

Clear pathways and guidance and tools to support recognition, referral and response.  
Awareness raising campaigns and activities.  
An increase in cases over the 12 month period.  
Parents and children more involved in the process.

MASH Governance Group established. Clarification of agencies responsibilities in the MASH. Continued identification of areas for improvement (deep dive analysis commissioned).

Work undertaken in relation to step down process. The relationship between early help and targeted services has been picked up as an issue by the Board for coming year priorities.

Report from WVT relating to cancelled meetings. Greater scrutiny of Strategy meeting thresholds; one child protection conference chair focusing solely on initial child protection conferences. Work on threshold criteria relating to significant harm.

HSCB has included this in all Board meetings, sources of voice of the child are illustrated in this report.

Development of the work of the Operational Group to identify themes and factors relating to CSE to support disruption activity.

Detailed report on the implementation of the early help offer measures of effectiveness to be reported to the board in April 2016. Early Help is a priority area for the Board in 2016-17.

# Conclusion and priorities for 2016/18

The focus that the Board placed on Child Sexual Exploitation in 2015/16 has led to greater awareness of CSE, more robust processes in intelligence gathering and improved understanding of what this means. In the coming year the Board will want to see positive impact from recognition and responses to CSE and good reporting relationships between the CSE team, operational group and strategic group.

Early Help Services and processes continue to be developed to recognise and respond promptly to the needs of children and difficulties in families early. The Board will be expecting a report on progress and impact during 2016/17.

The Board will also continue to focus on the "front door" with the commissioning of a deep dive analysis of the MASH and subsequent monitoring of an improvement plan.

Through scrutiny and challenge the Board has been able to see positive actions in improving the child protection process by focusing on key stages in the 'child's journey'. There will be further work to monitor these areas.

There has been some awareness raising in relation to Private Fostering, though this needs a stronger focus, and the newly developed joint communications subgroup of the partnership boards will prioritise this.

There are positive indications of stability and improving outcomes for children in the looked after system. HSCB will want to continue to see a strong commitment from all agencies in seeking and taking account of the views and understanding of children and young people.

Reflecting on the achievements through 2015-16, considering data and other evidence alongside the need to ensure continuous improvement, the HSCB has set four priorities for 2016-18.

Priority 1	Priority 2	Priority 3	Priority 4
Identification, prevention and response to Child Sexual Exploitation/ children who go missing.	The child's journey through the child protection process ensures effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm.	Identification and response to childhood neglect.	The early help services effectively identify needs and concerns relating to children and families, and services address these needs through effective planning and interventions to enable families to function effectively and children's needs are met and they are supported to achieve their full potential.





## 4. The Local Context

The latest (mid-2014) estimate of Herefordshire's resident population is **187,200**; 0.6 per cent higher than the year before.

Almost uniquely in England, Herefordshire's population is scattered right across its 842 square miles. Just under a third (60,000 people) lives in Hereford city and just over a fifth (40,500) in one of the five market towns, but over two-fifths (79,400) lives in areas classified as 'rural village and dispersed'.

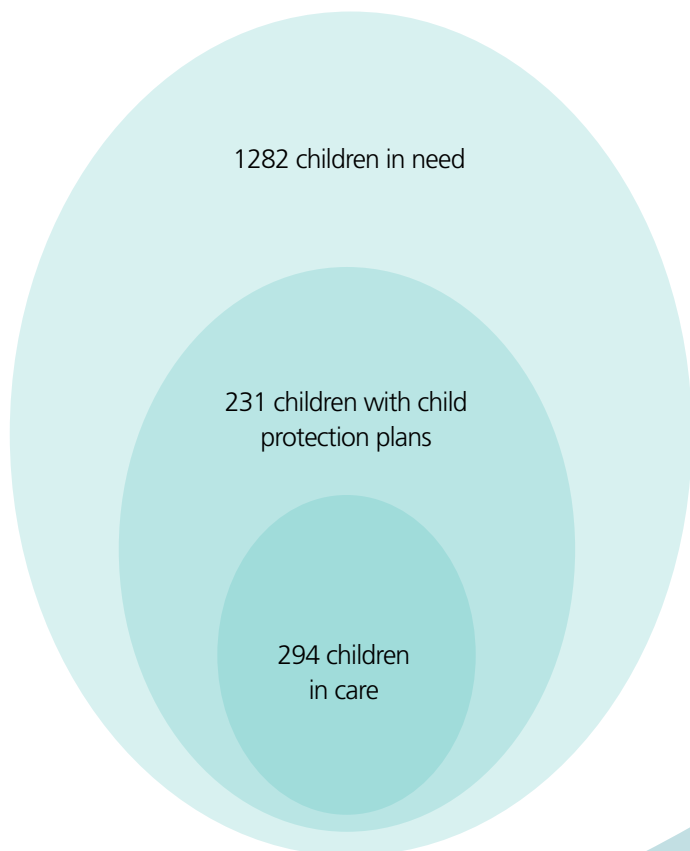
There are 40,000 (21%) children and young people (aged 0 to 19) living in Herefordshire, of whom:

- 9,900 (5%) are aged under five
- 21,800 (12%) are aged 5-15 years
- 8,400 (5%) are aged 16-19 years and

There are also

- 11,600 (6%) aged 20-25 years old.

Below is an illustration of the numbers of children assessed as in need, numbers of children with a child protection plan and numbers of children in the care of the Local Authority as at 31st March 2016.



## 5. Progress on Priorities 2015-16

Herefordshire Safeguarding Children Board's (HSCB) priority areas for 2015/16 were determined following consideration of evidence from multi-agency case audits, Ofsted inspection (2014) and the peer review diagnostic data commissioned by the Board.

1) HSCB is a truly effective agent for change that has a real impact for children and young people.

2) To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people.

3) To support increased resilience in individuals, families and communities.

4) To safeguard and promote the welfare of children and young people who are abused and/or neglected.

## Priority 1: HSCB is a truly effective agent for change that has a real impact for children and young people.

Ofsted's Inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers in May 2014 included a review of the effectiveness of the Local Safeguarding Children Board, which it found to be 'requiring improvement.' HSCB developed an improvement plan in response, which focused on the four broad areas for improvement identified by Ofsted:

- Governance arrangements for the HSCB
- Policies and Procedures
- Child Sexual Exploitation and children who go missing
- Multi-agency safeguarding training

Significant progress has been made in most areas, and is detailed elsewhere in this report. With the exception of activity in relation to multi-agency training, all areas have now been incorporated into 'business as usual' and reflected in the Board's business plan for 2016/17. As the HSCB training pool (see below for details) becomes more fully established and supported in 2016-17 this area will be signed off by the Board along with other areas as now being core business rather than part of an improvement plan.

## Priority 2: To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people.

### What we have done

The HSCB has established a CSE and Missing subgroup that co-ordinates, oversees and challenges the work of partners to recognise and respond effectively to this issue. A CSE strategy was drawn up and signed off by the HSCB in July 2015, supported by a delivery plan that sets out the expectations of what needs to be done in Herefordshire to address CSE. Work was commissioned from West Mercia Police and Public Health to develop a local problem profile. This continues to develop.

A dataset has been agreed to help the HSCB monitor the effectiveness of services to respond to CSE. It was a difficult process to draw together the data from different agencies. However, by early 2016 the HSCB had a comprehensive score card to assist in identifying risk and providing assurance. This has been supplemented by targeted auditing to assess awareness of and responses to CSE risks and harm.

The pathways for referring and responding to cases of CSE, a checklist to help partners identify CSE concerns and better refer, and a CSE risk assessment tool to assist the MASH (multi-agency safeguarding hub) team, have all been implemented in 2015/16.

The Family Support Team Manager, Early Help, Intensive Support team, manages all the "Return Home Interviews" of children who go missing, and liaises closely with the CSE Coordinator who was appointed in 2015/16 by the local authority.

There has been a significant amount of awareness-raising undertaken with both children and adults. This included a coordinated approach by key agencies in raising the issue on 18th March 2016 - National CSE Awareness Day. HSCB has also made positive links with the Licensing services to raise awareness and responses from taxi services and other areas of the night time economy. This is an initiative that the HSCB will be taking forward in 2016-17.

### What have we learned and what difference we have made

Our plan for the year 2015-16 set out some key areas where we wanted to make a difference:

- An increased number of schools delivering safe and healthy relationship information to pupils.
- Percentage increase in the number of welfare return interviews completed
- Increase in the disruption and/or prosecution of perpetrators

In the 4th quarter (Jan-March 2016) of 2015/16 32 risk assessment tools were completed by staff in the MASH on referrals concerning possible CSE and of these 27 were deemed low or medium risk and 3 were assessed as high risk. Most cases (24) were of children living at home. The table below gives details by age and gender:

Age	Male	Female
12		1
13	1	3
14		6
15	1	5
16	1	8
17		6

The increase in CSE referrals that have then been risk assessed is an encouraging indication of increased awareness of CSE and the need to refer. Data for the same period in 2014/15 shows 14 risk assessment tools were completed, with the age and gender breakdown as follows:

Age	Male	Female
13		4
14		0
15		3
16	1	3
17		3

10 cases were deemed low/ medium risk and 4 high risk.

On 21st March 2016, in collaboration with Hereford Academy, HSCB arranged for the staging of the production of "Chelsea's Choice" (a CSE Awareness raising theatrical production) at The Hereford Academy which was seen by children and young people from 4 schools across Herefordshire, along with a presentation from West Mercia Police about Sexting (which has been rolling out to schools across the County).



*Chelsea's Choice production held at The Hereford Academy 21st March 2016*

The production was extremely well received, with a sample of responses given below:

#### Academy Vice Principal:

*"We are very grateful for you allowing us to host the play here. It went very well indeed and though I have now seen it 3 times, it is incredibly powerful. The Interim Principal has tweeted about it and we have put an article on our web page. The students have been really thoughtful about it and have been discussing with some staff. We have followed up with some RS/ PSHE lessons. I had a great lesson with Year 9 this morning about negative relationships as a follow on and we referred to the play constantly. They were really shocked by it and some have said they are going to be more careful on line. I really wish all teenagers could see it"*

#### What Young people said about Chelsea's Choice:

*"I am now more aware of who people might be, and not to message anyone I don't know"*

*"This covered a lot of detail about different aspects of exploitation and grooming. As its true, it kind of makes you think this can actually happen"*

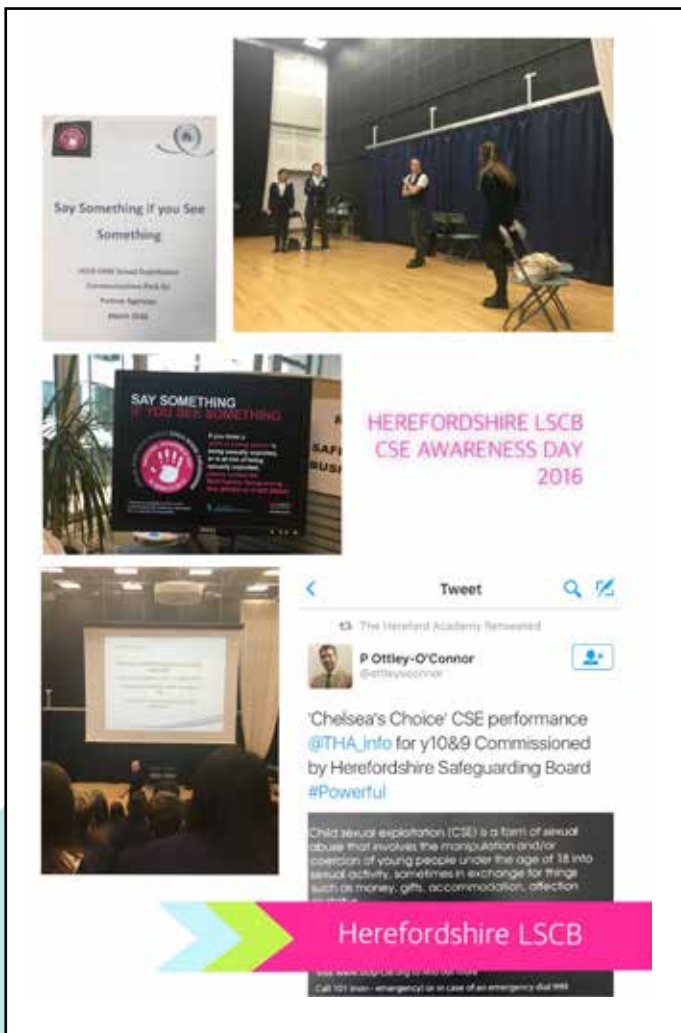
*"It shows what can happen if you trust or communicate with a stranger"*

*"This made me aware of how manipulative people can be"*

As well as commissioning the Chelsea's Choice production, HSCB took part in the NWG #Thunderclap initiative during CSE Awareness Day in March 2016, and arranged a screensaver takeover in Herefordshire Council and our NHS Trust partners. A Communications Pack for all partner agencies was developed and distributed, encouraging their support. A multi-agency "Tackling CSE" Conference was scheduled for 27th April 2016, with key speakers including Dr Peter Unwin and Lorin La Fave from The Breck Foundation.



The NWG Annual Conference Awards displayed the images below to highlight the work done in Herefordshire.



A CSE case audit carried out by the HSCB identified that not enough information was being shared and analysed to assist in the disruption of CSE. The “CSE Operational Group”, whose role this is, has taken account of the findings and as a result will be reporting to the CSE subgroup on findings and action taken. A good example of improved intelligence is the “soft information” gained from return home interviews of missing children that is now fed in to the Operational Group. Information such as postcode areas and schools attended is also now reported on, which in turn will enable improved and more targeted responses.

HSCB also became aware via its audit activity that referrals relating to CSE were often considered via a strategy meeting (see below for information about strategy meetings), and challenged this practice: this has changed as a result and these cases are more often considered through a risk management meeting process, which involves parents more fully.



### What we will do next

HSCB will be working to ensure that:

- The pathway for addressing concerns about cases of suspected CSE is clear.
- There is clear data relating to CSE risks and children missing from home.
- There is good intelligence from practice to better understand the prevalence of CSE and inform responses.
- Children, families, the general public and professionals know about and understand CSE and how to respond as appropriate.
- Return home interviews are of good quality and used at an individual and strategic level to tackle risks.
- Children who have experienced CSE receive appropriate post abuse support.

HSCB will want to see a reduction in the numbers of children going missing and the numbers of missing episodes; that return home interviews take place in all cases, consistent with the guidance and procedure; and evidence of increased disruption and/or prosecution of perpetrators.



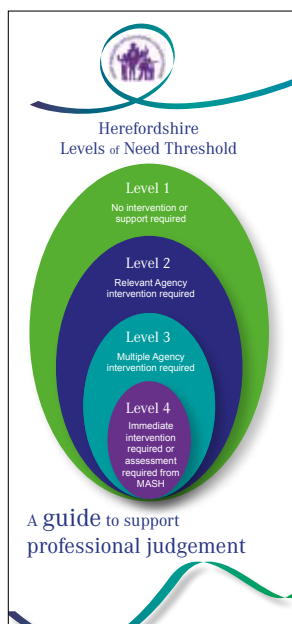
## Priority 3: To support increased resilience in individuals, families and communities.

This priority area of the Board aligns with a key priority within Herefordshire's Children and Young People's Plan, and covers the whole spectrum of provision of services to children and families. The aim is always to improve the early identification and response to critical issues affecting children and young people's development.

### What we have done

#### a) Thresholds for intervention

HSCB has led the development and promotion of the "Levels of Need" in Herefordshire, which acts as a guide to support professional judgement when considering help that children and families need and when to refer concerns.



#### b) Early help

HSCB has both supported and challenged the development of the Early Help Strategy and offer, which is a priority in **Herefordshire's Children and Young People's Plan** and is led by the Children and Young People's Partnership.

The approach to early help in Herefordshire has continued to be developed throughout 2015/16, including the following:

- Revision of the Common Assessment Framework (CAF) assessment form (consistent with Families First eligibility criteria; Herefordshire Outcome Framework; ensuring assessment of all family members; Single Assessment process) to help professional assess how best to help families.

- Multi Agency Group (MAG) meetings continue to be held on a 6 weekly basis in 9 localities in Herefordshire to co-ordinate activity to support families. Emphasis is being placed on "step down" cases from child protection plans and those cases deemed to be at risk of "step up" to Social Care.

The Early Help team has continued to provide an Early Help Directory of Services. A new site - "Wellbeing and Signposting for Herefordshire" (WISH) - has also been launched which provides access to information and advice as well as information about services and activities.



At Level 2 and 3 of the Levels of Need, professionals adopt a 'pre-assessment checklist' and where appropriate complete an assessment with the family and other agencies using the Common Assessment Framework to determine the needs of children and families and the best way to intervene and offer support to address identified needs. Below is information about case activity through common assessments:

Average number of active Common Assessments (CAs) 2015:	497
Total number of new CAs in 2015:	313
Of which number of step down CAs:	152 = 49%
Total number of closed CAs:	360

There is a need to improve the completion of closure information for Early Help services; currently this is done in a third of cases. An increasing source of pressure for the Early Help services is the rise in the numbers of cases which are "stepped down" from more intensive interventions. The figure for January-March 2016 was 93, compared with 152 for the whole of 2015.

Whilst there is a process for quality assuring Common Assessments the service, due to limited resources, does not carry out case audits. As part of its plans for 2016 onwards the HSCB will be including Early Help in its quality assurance audit programme.

### c) Multi-agency safeguarding hub (MASH)

Contacts and referrals for services are received in the MASH, where decisions are made about the level of response that is required, and further enquiries initiated as required. Governance and oversight of the MASH sat originally with HSCB, and was transferred into operational services at the beginning of the year. The Board has continued to closely monitor the effectiveness of the MASH.

### d) Domestic abuse

Evidence shows that factors affecting adults can have a direct impact on the safety and wellbeing of children. Such factors include parental mental ill health and substance misuse, and exposure to domestic abuse.

**Appendix 3** shows data, sourced by West Mercia Women's Aid and West Mercia Police, that indicates the numbers of children in Herefordshire exposed to domestic abuse. Whilst a drop is indicated in the number of children exposed to domestic abuse, analysis suggests that this may be due to a change in the electronic recording system and further work will be needed on this indicator and viewed over time.

Notifications from the police regarding incidents of domestic abuse where children may be affected are a significant proportion of the total number of contacts received by MASH. The MASH team is in the process of reviewing the triage of these cases and the HSCB will monitor the effectiveness of this.

Herefordshire's Multi-Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The MARAC facilitates, monitors and evaluates effective information sharing to enable actions to be taken to increase public safety. MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of services for all those involved in a domestic abuse case: victim, children and perpetrator.

West Mercia Women's Aid provides a service working with children and young people through the Children's Independent Domestic Violence Adviser (CIDVA) service. **Appendix 4** shows the numbers of children involved with this service in 2015-16, and their age categories.



Below is some feedback from children, families and professionals about the CIDVA service:

*"I would like to have more talks. I would like my mum to be happy. I would like my dad to be happy. I would like to do more stuff with [the CIDVA worker]."*

*"The Children really enjoyed their time with [CIDVA worker] and really looked forward to the sessions. I feel these have been helpful for them. Thank you. A valued service."*

*"The boys really enjoyed using the puppets and asking how we are feeling and why. It was really good and I enjoyed bonding with the boys, we all feel we can express our feelings."*

*"Sessions are calming and positive for pupils" from school.*

*"Supports students and helps with a positive outlook for the future, the students enjoy being listened to by someone who understands" from school.*

HSCB will continue to receive reports on the prevalence of domestic abuse in cases involving children, review the quality and availability of services designed to reduce the risk of harm to children and address the impact of domestic abuse. The Board will also want to see increased availability and use of effective voluntary programmes for perpetrators.



## What we have learned and what difference we have made

Our plan for the year 2015-16 set out some key areas where we wanted to see improvements:

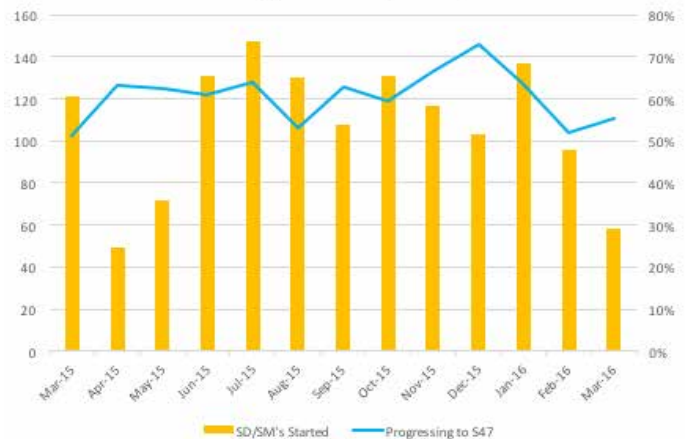
- A reduction in referral and re-referral rates to children's social care.
- Improved quality of referrals to children's social care.
- An increasing percentage of professionals who report they are confident in responding to concerns in accordance with thresholds document

The chart below illustrates the volume of contacts received in the MASH, and the percentage of these which proceeded to be referred to children's social care for further assessment and service.



Contacts received in the reporting year have reduced by 19% from last year. There is a higher percentage of contacts progressing to referral (42.6% as opposed to 31.9% in 2014-15), which is positive. 96.7% of the contacts were screened within one working day. This is the correct "direction of travel" in terms of data, reflecting the aim of ensuring the most appropriate referrals go to the MASH. However, the referral rate per 10,000 population is still higher than the English average and statistical neighbours, and the reason for this is unclear. Whilst re-referrals have reduced compared to the previous year they are still high and this is being reviewed in order to better understand any themes or causes.

Strategy Discussions/Meetings



A strategy meeting is convened to decide whether enquiries under section 47 of the Children Act 1989 (regarding safeguarding concerns) need to be initiated. The numbers of strategy meetings/ discussions convened during the year have reduced, whilst the number of Section 47 investigations has remained similar to the previous year. This indicates an improving direction of travel in that strategy meetings are being appropriately convened.

Prompted by concerns that the MASH was not functioning as effectively as it could and the volumes of child protection activity did not reflect Herefordshire's population and statistical neighbours, HSCB commissioned an initial analysis of the MASH by the Head of Adult Safeguarding and received a short report in January 2016. This highlighted a number of issues regarding quality and consistency of practice and led to a further 'deep dive' review being commissioned which forms the basis of an improvement plan through 2016/17 that the Board will review.

Learning from HSCB audits carried out in 2015-16 demonstrated that:

- There was good awareness of the Levels of Need Guidance but more work was needed in supporting use of this in day to day practice and decision making.
- There was limited use of any tools when practitioners were carrying out assessments or considering referrals.

## What we will do next

HSCB will be working to ensure that:

- Effective decision making is taking place at the early stage of identification of needs, and appropriately directed to WISH, Early Triage (MAG) or referred to MASH
- Common Assessments are taking place within timescales and are effective in identifying needs of children and families and planning interventions (with clear multi-agency engagement in this process)
- Lead professionals are identified in each case deemed to be level 2 or 3.

## Priority 4: To safeguarding and promote the welfare of children and young people who are abused and/or neglected.

### What we have done

With regard to the Child Protection process, the performance information and quality assurance established by HSCB highlighted a number of areas for further work and enquiry. HSCB noted that the number of children subject of a child protection plan was high. This had been a continuing trend since December 2014, and higher than comparator authorities. In response, the Board commissioned an analysis of the Child Protection System "overheating" with a number of issues identified and actions agreed to address them. These included:

- Greater scrutiny being applied in MASH in convening strategy meetings;
- The interim implementation of a conference chair focussing solely on Initial Child Protection Conferences (ICPC's) to ensure consistency of decision making and provide a higher level of challenge and scrutiny to social work teams; and
- A more robust consideration of the threshold for significant harm at review conferences with chairs providing a steer where necessary to the multi-agency decision-making group,

These approaches are having a measurable effect on reducing the numbers of children being drawn into the child protection system.

Following anecdotal reporting by the Wye Valley Trust of meetings being cancelled the Trust was asked to carry out an audit, which took place over a 7 week period, and was reported back to the Board. It was identified that during this period seven Initial Child Protection Conferences and four Core Groups were cancelled, with varying reasons and notice.

Children subject of a child protection plan for a second or subsequent time remains low in Herefordshire, falling below 1% at the end of March 2016.



It should be noted that data indicates lower rates of children subject to a child protection plan for lengthy periods of time, with the result that in November 2015 only 12% of child protection plans were more than 12 months old

Numbers of children subject to a CP plan by category as at the last day of each quarter 2015/16.

	Q1	Q2	Q3	Q4
<b>Emotional Abuse</b>	96 (49%)	122 (50%)	152 (55%)	136 (59%)
<b>Multiple Abuse</b>	0 (0%)	0 (0%)	1 (0%)	0 (0%)
<b>Neglect</b>	71 (37%)	85 (35%)	83 (30%)	71 (31%)
<b>Physical Abuse</b>	11 (6%)	13 (5%)	18 (7%)	12 (5%)
<b>Sexual Abuse</b>	16 (8%)	23 (9%)	20 (7%)	12 (5%)

In line with the national trend, Emotional Harm remains the primary category for a children becoming the subject of a child protection plan. In addition, apart from in the 4th quarter there were more children subject of a child protection plan under the category of sexual abuse than physical abuse, which is not necessarily the case nationally.

The Office of the Children's Commissioner committed to a two year enquiry into intrafamilial child sexual abuse (IFCSA), prompted by findings from the study Child Sexual Exploitation in Groups and Gangs. The report found that little is known about the experience of the victims of IFCSA; there was concern that children were not being listened to in planning to protect them and the criminal justice system may be inflicting further harm; there were concerns also that there are key gaps in understanding the prevalence of IFCSA. The full report "It's a Lonely Journey: A Rapid Evidence Assessment on interfamilial child sexual abuse can be accessed here.

An audit of cases of children subject of a child protection plan was reported to the HSCB in April 2015. This audit found that for 109 children from 53 families their care was compromised by domestic abuse. In March 2014 the percentage of children in this cohort was similar at 54%.

## What we have learned and what difference we have made

Our plan for the year 2015-16 set out some key areas where we wanted to make a difference:

- The process and decision making at the initial stages of the child protection process (strategy meetings/ section 47 investigations) comply with statutory guidance, and the decisions are consistent with the levels of need in Herefordshire.
- The child protection planning and review process (child protection conferences/ core groups) are truly multi-agency and consistent with guidance and procedures.
- Child protection plans are effective in reducing/ eradicating the risk of significant harm to children.
- the low rate of children who are subject to a Child Protection Plan for the second or subsequent time suggests that the child protection planning process is effective in addressing risks to children.

The Board has received evidence during the year that children and parents/ carers involved with the child protection system are having positive experiences.

Below are some responses of children and young people and parents about their experiences of working with people as part of the Child Protection plan.

2. Draw a circle around the faces that show how you felt about having a support worker.

Really sad   Really happy   Sad   Scared   Angry   Confused / worried   Happy   Okay

it helped me to tell mummy my true feelings.

2a. If there is anything else you would like to tell us about how you felt, please write it here:

I felt comfortable working with

6. Which areas of support did you feel were most helpful for you and why?

Information - how to step back during argument and think is best way using

6. Which areas of support did you feel were most helpful for you and why?

relationships and keeping safe

6. Which areas of support did you feel were most helpful for you and why?

about child safety on the internet when you put something on the internet you can't delete it

4. What difference has having a support worker made to you? (You can circle all answers that fit)

1. I generally feel happier ✓	2. I have more people to confide in if I need to	3. I get on better with my mum / dad or carers
4. I feel like people listen to me ✓	5. I get on better at school/college/work	6. I feel less angry
7. Nothing has really changed	8. I feel happier at home ✓	9. I don't feel as anxious

### Comments from parents included:

#### Female Carers:

3. Please tick the relevant boxes below to tell us what you thought of our service.

	Very Good	Good	Okay	Poor	Terrible
1. Your relationship with the worker	✓				
2. How often you had contact with your support worker	✓				
3. Time of visits	✓				
4. Advice given to you	✓				
5. Practical help / support given to you	✓				

3a. If you would like to provide any other comments about the above topics please let us know this in the space provided below. It would be very useful for us to find out if any specific areas were particularly helpful to you i.e. visits scheduled around your other commitments or to fit in with the support needed e.g. evening routines; practical support; your relationship with the worker etc.:

I found the advice really informative and useful and will continue to use the book. I was brilliant and someone that I felt ~~was~~ listened and was very approachable

3. Please tick the relevant boxes below to tell us what you thought of our service.

	Very Good	Good	Okay	Poor	Terrible
1. Your relationship with the worker	✓				
2. How often you had contact with your support worker	✓				
3. Time of visits	✓				
4. Advice given to you	✓				
5. Practical help / support given to you	✓				

3a. If you would like to provide any other comments about the above topics please let us know this in the space provided below. It would be very useful for us to find out if any specific areas were particularly helpful to you i.e. visits scheduled around your other commitments or to fit in with the support needed e.g. evening routines; practical support; your relationship with the worker etc.:

All visits were when I was free and worked around me and the children.

5. Which of these areas did you feel that the support worker was most helpful with and why?

Substance Misuse.

Family Relationship.





Comments from parents included:  
Female Carers:

5. Which of these areas did you feel that the support worker was most helpful with and why?  
*Behaviour Management. The work I did on Trip P printing with has been very helpful to me and helped me to look at things in a different way.*

3. Please tick the relevant boxes below to tell us what you thought of our service.

	Very Good	Good	Okay	Poor	Terrible
1. Your relationship with the worker	<input checked="" type="checkbox"/>				
2. How often you had contact with your support worker	<input checked="" type="checkbox"/>				
3. Time of visits		<input checked="" type="checkbox"/>			
4. Advice given to you	<input checked="" type="checkbox"/>				
5. Practical help / support given to you	<input checked="" type="checkbox"/>				

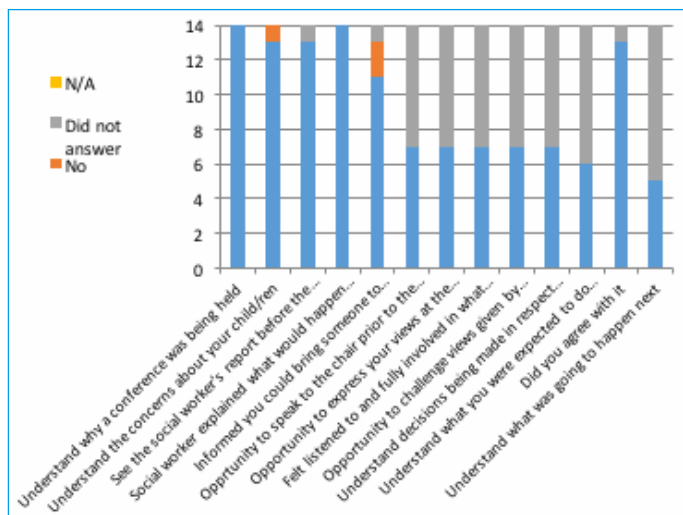
4. Which areas did you and the support worker focus on?

1. Behaviour management	<input checked="" type="checkbox"/>	2. Parenting (basic care; supervision)	<input checked="" type="checkbox"/>	3. Routines	<input checked="" type="checkbox"/>	4. Substance Misuse	<input checked="" type="checkbox"/>	5. Accessing other services	<input checked="" type="checkbox"/>
6. Relationships	<input checked="" type="checkbox"/>	7. Domestic Abuse	<input checked="" type="checkbox"/>	8. Home Safety	<input checked="" type="checkbox"/>	9. Home Conditions	<input checked="" type="checkbox"/>	10. Housing	<input checked="" type="checkbox"/>
11. Keeping Safe	<input checked="" type="checkbox"/>	12. Mental Health	<input checked="" type="checkbox"/>	13. Physical Health	<input checked="" type="checkbox"/>	14. Budgeting	<input checked="" type="checkbox"/>	15. Future aspirations	<input checked="" type="checkbox"/>
16. Jobs	<input checked="" type="checkbox"/>	17.	18.	19.	20.				

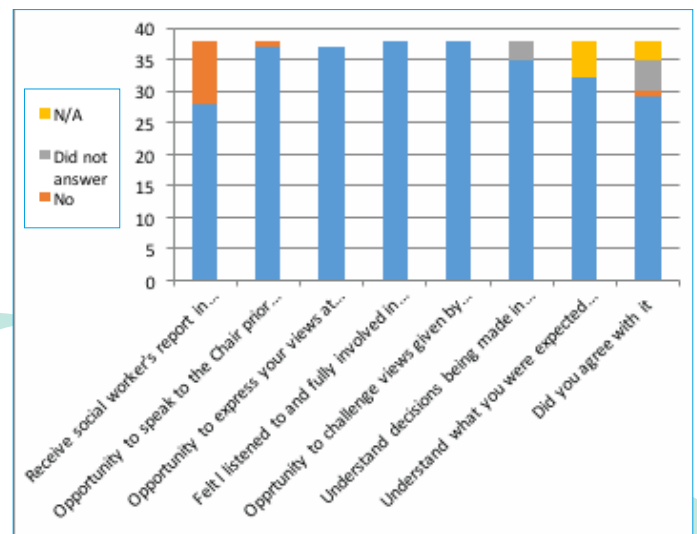
5. Which of these areas did you feel that the support worker was most helpful with and why?  
*parenting - helped me learn and develop more as a dad*

Parental feedback regarding their experience of child protection conferences (CPC), from a data set that covers the period June 2015 – January 2016, was received, which demonstrates both positive experiences and areas for improvement, the latter particularly applying to initial child protection conferences. A total of 52 forms were completed, 14 in respect of Initial CPCs and 38 regarding Review CPC, a summary of which is given in the tables below.

Responses from parents following an initial child protection conference



Responses from parents following an initial child protection conference



There will be follow up of the responses relating to receiving the social worker's report "in sufficient time". Reviewing and improving the seeking of parental views about CP conferences will be considered in 2016-17, as well as exploring ways of getting children and young people's views.

What we will do next

One of the priority areas for the HSCB for 2016/17 is assuring itself that the child's 'journey' through the child protection process results in positive outcomes for the child. The Board will be scrutinising this area and this will include Board members observing child protection conferences to establish the quality of multi-agency working to safeguard children.

HSCB will also be working to ensure that:

- The process and decision making at the initial stages of the child protection process (strategy meetings/ section 47 investigations) comply with statutory guidance, and the decisions are consistent with the levels of need in Herefordshire.
- The child protection planning and review process (child protection conferences/ core groups) are truly multi-agency and consistent with guidance and procedures.
- Child protection plans are effective in reducing/ eradicating the risk of significant harm to children.
- children have their needs addressed earlier so that few are drawn into the child protection system.

## 6. How the HSCB has carried out its statutory functions

LSCBs have a number of statutory functions in addition to their objectives of:

- *Co-ordinating what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area, and*
- *ensuring the effectiveness of what is done by each such person or body for those purposes.*

This section of the report refers to wider significant areas of safeguarding children in addition to the priority areas for 2015/16.

### a. Policies, procedures, practice guidance updates

Herefordshire commissions its multi-agency child protection procedures together with the other West Mercia LSCBs - Shropshire, Telford and Wrekin and Worcestershire - from Tri-X. There has been a project throughout 2015/16 reviewing any "local" procedures and where appropriate ensuring that they are reflected in the cross West Mercia procedures and guidance. A report to the Policy and Procedures subgroup in November 2015 noted that the regional West Mercia Procedures located on the Tri-X system were updated on 30 October 2015. Prior to the update, local procedures were located on both the HSCB Website and the Tri-X site under 'local' procedures. This led to practitioner confusion as to where to go to access the correct procedure and led to duplication of procedures and poor version control, with a number of out of date procedures being located on both sites. These issues have all been addressed.

The Policy and Procedures subgroup has led on this work and specific procedures that have been developed, reviewed or updated in this year include:

- Protocol for children who go missing
- Children missing education, and elective home education
- Female Genital Mutilation and Forced Marriage
- Serious Case Review Procedures
- Violent extremism and PREVENT Strategy
- Persons who pose a risk to children
- Substance misuse guidance updated to include misuse during pregnancy.
- Policies on Child Working and Animal Abuse
- Multi-Agency Overarching Information Sharing Policy developed
- Revision of the Common Assessment Framework and "step down" guidance
- Local Authority Designated Officer
- Child Abuse & Info Technology
- Safeguarding Children who may have been Trafficked, Safeguarding Children from Abroad
- West Mercia Joint Protocol for Reporting Missing Children & Young People.

Herefordshire has also been involved in the West Midlands Regional Procedures Innovation Project, which aims to develop a set of procedures that are common across the West Midlands region. The Project has developed levels of procedures to assist in planning the work of the project:

Level A: Child Protection Procedures

- *These are the overarching core child protection procedures drawn from key national documents (e.g. Working Together) and include clear shared definitions.*

These have been produced and widely circulated and have been agreed by HSCB.

Level B: Guidance

- *Level B contains the agreed regional guidance on these procedures.*

A list of procedures and guidance that come under this heading has been established and plans need putting in to place to review and agree across the region.

Level C: Area Specific Information

- *Level C contains area specific information.*

This will include information such as local referral procedures and pathways, local threshold guidance, contact details. The aim is to have agreed West Midlands procedures in place by April 2017, with an agreed process for management and review of the procedures. Until this is achieved Herefordshire will continue to maintain the joint West Mercia procedures.

## b. Training

### Multi-agency training

The HSCB multi-agency training offer for 2015/16 reflects the priority areas of the Board and wider safeguarding issues. The plan going forward also reflects the priority areas for training 2016/17. Face to face multi-agency training has included:

- Working together to safeguard children
- Working together refresher
- Childhood Neglect
- Child Sexual Exploitation (CSE)
- Child protection conferences

Each of the courses under these topics has been reviewed in order to reflect changes, updates, research findings and local learning.

There has also been an on-line training offer that has included:

- Safeguarding children basic awareness
- CSE basic awareness
- Female Genital Mutilation (FGM)

These and a range of other courses around topics relating to safeguarding children have been provided by the Virtual College and accessed through a Herefordshire based service, Hoople, that operates the Continuous Professional Development (CPD) on line service. This is also where the face to face courses are accessed and booked.

The Workforce Development subgroup has developed a model for carrying out a training needs analysis of agencies to identify numbers of staff and training needs at different levels. Work has also taken place to develop a multi-agency training pool. There have been colleagues, mainly from health and social care, who have contributed to the delivery of some training, but the numbers involved have not been high and it has not been well coordinated. Through promotion and development the numbers now beginning to engage in the training pool have increased. Regular support and review sessions are planned with the aim of having a well-functioning training pool in place from September 2016.

### Numbers attending HSCB multi agency training courses 2015-16

Course	Numbers
Targeted Working Together to Safeguard Children, 1 day	189
Targeted Working Together to Safeguard Children half day refresher	46
Targeted Course Understanding Neglect	64
Child Sexual Exploitation, half day	30
Child Protection Conferences	22
Domestic Abuse 3 day course	70
HSCB/HSAB Practitioner Forums	109

412 professionals also accessed the E learning courses relating to safeguarding children, basic awareness; child sexual exploitation; safeguarding and leadership; hidden harm. With the development of the training pool and review of the courses the aim will be for increased number attending the multi-agency child protection training courses in 2016-17.

The evaluations of the courses were positive:

*"Multiagency group was very helpful and interesting. Great to hear information and share experiences with different agencies"*

*"It is always good to refresh Knowledge and issues surrounding safeguarding. I felt the Daniel Pelka case study was very powerful"*

*"Was very useful to use a case study to highlight where children and young people have "fallen through the gaps" and use this reflection to strengthen our own service".*

*"Reviewing review cases and looking back at previous case records. This is an aspect that all professionals neglect, looking deeper into previous events, to learn from mistakes".*

*"I have a better knowledge of the resources and tools available to facilitate a good quality assessment".*

*"Understanding of the case conference process and who has what role within it. Particularly good to clarify where GPs fit into this"*



In the coming year we will be implementing a more comprehensive evaluation of the HSCB training and its impact. This will include:

- Reaction - end of day satisfaction with learning questionnaire either online or by using feedback sheets.
- Learning – 2 weeks after the training a dip sample of learners across all agencies / learning activities will be identified to secure feedback on the learning from the training through an online survey – this might for example be driven by the need to assess new training provision or a new trainer.
- Behaviour and Results - 1-3 months after the learning activity a sample of managers will be sent a questionnaire to evaluate the impact the training has had on the delegate's behaviour, skills, practice and performance.

The HSCB practice audits will also play a part in assessing whether best practice is being applied.

### Single agency training

Data analysis found that available on-line training was not being utilised as fully as it could. In addition, the HSCB reached a decision that the Board could not continue to fund universal training for single agencies (the Board had previously funded the e-learning). This means that individual agencies are expected to take responsibility for the training of their staff at the universal level. HSCB will continue to provide content for single agency training to ensure consistency.

Whilst the Board is not continuing to fund e-learning, the HSCB website will provide signposting to free e-learning opportunities, eg for CSE, FGM, Prevent and Radicalisation, as well as to some E-learning opportunities that have a cost. The HSCB will also be reviewing and updating a Safeguarding Children Basic Awareness training pack that single agencies can use.

### Practitioner Forums

The HSCB has established a series of multi-agency "Practitioner Forums" aimed at front line practitioners and managers. The aims of these forums are:

- To support practitioners to take professional judgement-based approach to safeguarding rather than a purely process driven approach;
- To share good practice across agencies to improve standards;
- To share learning from audits, investigations and serious case reviews
- To act as a conduit for the HSCB to share key messages and information with front line practitioners, and to receive feedback so that the voice of the practitioner is taken into account in the work of the HSCB

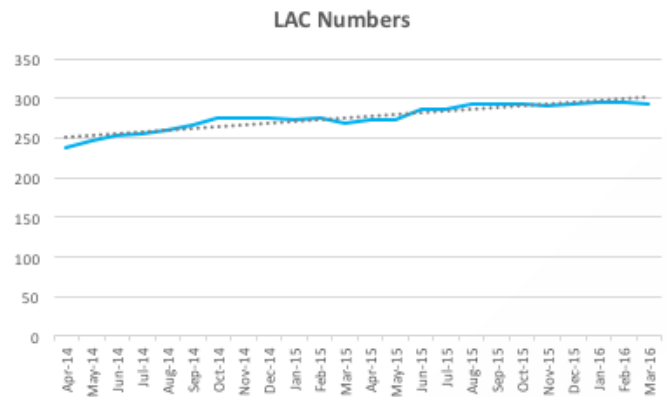
A number of these forums have been run jointly with the Adult Safeguarding Board. Topics have included:

- Domestic abuse, including the work of the Multi Agency Risk Assessment Conference in Herefordshire.
- Levels of Need, and understanding the impact of adult factors (mental ill health; domestic abuse; substance misuse etc.) on children's wellbeing and safety.
- Information sharing.

As these forums have developed, the numbers and range of agencies attending has increased. These forums will continue throughout 2016/17, and will be attended by HSCB members in order to enhance direct dialogue with practitioners.

## c. Children in Care

Although the local authority has the lead responsibility for children in care, many more agencies have the responsibilities of being a 'corporate parent.' These children are reliant on the effective working together of many universal and more specialist services, and their outcomes are too often poor. There has been a steady increase in the number of children in the care of the local authority. The HSCB will be monitoring this in comparison with statistical neighbours to ascertain whether there are trends to be concerned about and investigate more closely.



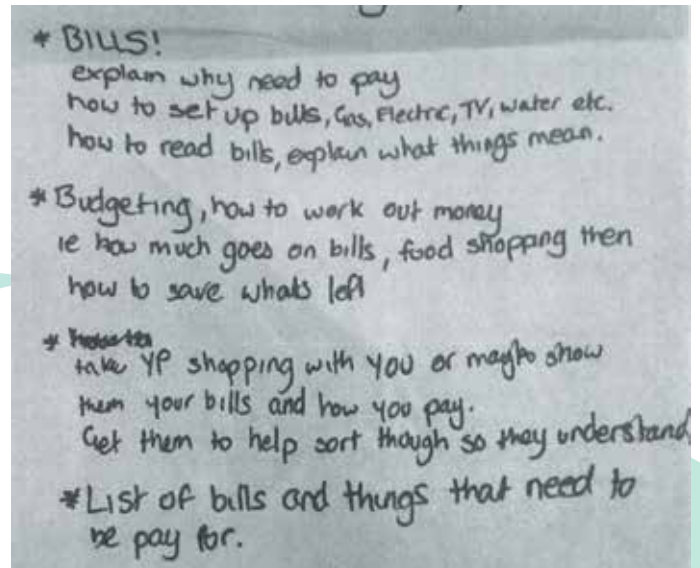
In terms of placement stability there is a positive picture, with only 2.4% of children in care having experienced three or more placements.

With regard to care leavers, a manual analysis of the electronic social care records indicates that at the end of the year there was one 19 year old in unsuitable accommodation, and 16 not in suitable education, employment or training. At the end of March 2016 there were over 90% of care leavers with pathway plans. This is an improvement on previous performance, although the target remains 100%.

The Children in Care Council (CICC) has been active in promoting the voice of the child in terms of views about services and being listened to in individual cases. The CICC priorities for 2015 included:

- **To improve No4 (where CICC meets) for children and young people** – including provision of laptops for children and young people at No4 - It was felt that the computers at No4 were not 'fit for purpose' and they would really like laptops which they could use at No4 and also when out doing interview panels and PEEPs (see appendix 4) training – CICC to look at funding options – achieved.
- **To review the rules for children and young people in Foster Placements** – CICC questioned the rules within Foster placements and how they impact on them socially – for example; when they aren't allowed to play the same computer games as their peers. CICC to meet with Fostering and Corporate Parenting Panel
- **Why do we have so many changes of social workers – how can we change this?** CICC to meet with Corporate Parenting Panel to discuss - virtual academy to come to talk to CICC
- **Our lives as Looked After Children and Young People in film** – Children's Rights and Participations officer to approach local film companies – funding application on hold as Apprentice left.
- **Delegated Authority form** – can we make the form look better, why are the words so complicated, when do we get to see the form and review it? Why doesn't the form mention our privacy/ curfew and why are we never seen as a person in control of any of the issues?
- **Choosing foster carers/ supported lodgings providers for us** – what do you tell them about us and what do you tell us about them – and why?
- **What are our rights in foster care and supported lodgings** – do all Looked After Children and Young People know about the guidance about pocket money and clothing allowance? If not why not?
- **Do you know what we really need to know for moving onto independence?**
- **How are foster carers trained to support Looked After Children and Young People alongside their own birth children – can we help you?**
- **Getting foster carers to get us!!!**

A theme that emerged regarding helping young people with greater independence was a better understanding of bills and finances:



With regard to changes of Social Workers the CICC advised that children and young people just wanted people to say goodbye and to know that there would be a change, if one had to happen. The CICC gave an indication from their experiences of the number of Social Workers they have had whilst in care;

- 6 in 5 years
- 4 in 2 months
- 9 in 17 years
- 3 in 2 years
- 6/7 in 5 years

The CICC advised that they felt a good social worker was someone who:

- visited often
- was always on time
- always tried their best
- was committed
- wanted to form a good relationship with you
- had an interest in you
- spoke to you away from your foster carer

Below is a collection of what some young people had to say about the difference that being in care has made to them.

Below is a collection of what some young people had to say about the difference that being in care has made to them.

**Ben is 20 years old and he has been in care for 17 years**

"I like volunteering at British Heart Foundation. I like gaming, going out with my mates. I want a job, house and family in the future. When I first moved in with my foster carers I felt nervous and uncomfortable, but they made me feel safe in the house which made me feel relaxed and ready to live. They bought me things that made me feel valued. They helped with a lot of benefits and to budget which is good because I buy expensive stuff. I think people should be foster carers as it enables them to speak to young people from different backgrounds who have been affected by not so good things. So foster carers - we need you"



**Sasha is 12 years old and she has been in care for 6 years**

"I like playing football and going to police cadets. I want to be a police officer. My foster carers treat me like I am their daughter and they keep me safe. They give me the right stuff when I need it. They are awesome in every way. They have taught me to become a better person."

Things don't always go so well, however. Below are some extracts from the "Journey of a Looked after Child."

**Journey of a looked after Child (with thanks to the young person who provided this)**

We were placed at an emergency placement by a random worker (who obviously had something else to do!)  
(NOBODY WAS TAKING CONTROL)

My stuff had already been packed!! (WHO HAS BEEN TOUCHING MY STUFF – I BET THEY WERE JUDGING ME!)

My brother text me to say that the carer had been through my stuff!!! My room was trashed! (NOBODY CARES, NOTHING IS PRIVATE, NOBODY TRUSTS ME, ONCE AGAIN THE FUTURE IS UNCLEAR!)

Guess what – they moved us to our Aunty's – I never went – I ran!! I was picked up 2 days later by the Police – what have you done young man?? (WHY IS IT ALWAYS MY FAULT??)

I met my brother at a building I didn't recognise – we were told that we were moving again! (GREAT!!!) But this time not together – I was going to Shropshire and my brother to another County! (IT WAS THE END OF EVERYTHING! I WAS LEAVING EVERYTHING I KNEW!)

When I went to this new placement in Shropshire the Social Worker forgot my name when she introduced to the carers! She then said she would let my Social Worker know that the move had gone smoothly – Smoothly for who?? – I never heard from my worker for days!

When I tried to get in touch with someone in Hereford, I was told that my Social Worker had left – thank s for saying goodbye!!

Nobody would tell me where my brother was!! I have spent all of my life looking out for him and YOU have even taken this away from me!

Oh and I am sorry that I am not engaging with education at the moment – my head is a bit f\*\*\*\*\*!!

These are strong messages for everyone working with children and young people from whatever agency and at whatever level. There are plans for the coming year to develop projects to improve the voice of the child, such as children chairing their own reviews. The "Voice of the Child" will be a key topic at one of the HSCB practitioner forums, and will be a standing item whenever the Board meets.



## d. Allegations concerning persons who work with children

HSCB has in place safeguarding procedures which include comprehensive procedures to manage allegations against adults who are employed to work with children or who work with children in a voluntary capacity. These procedures are in line with other key statutory documents including the DfE statutory guidance, Keeping Children Safe in Education (2015), a new version of which will take effect in September 2016.

The Local Authority Designated Office, (LADO) is responsible for the management and oversight of all investigations in to allegations against those working with children within Herefordshire. The LADO produces an annual report which is scrutinised by HSCB.

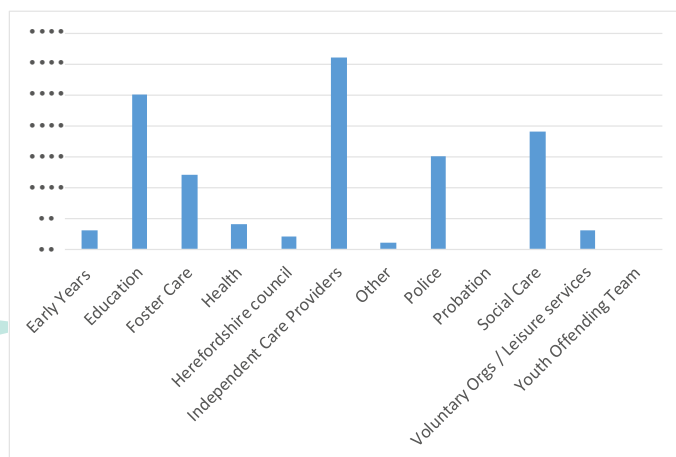
The duties of the LADO in relation to managing allegations are to:

- Manage individual cases
- Provide advice and guidance
- Liaise with the police and other agencies
- Monitor the progress of cases for timeliness, thoroughness and fairness

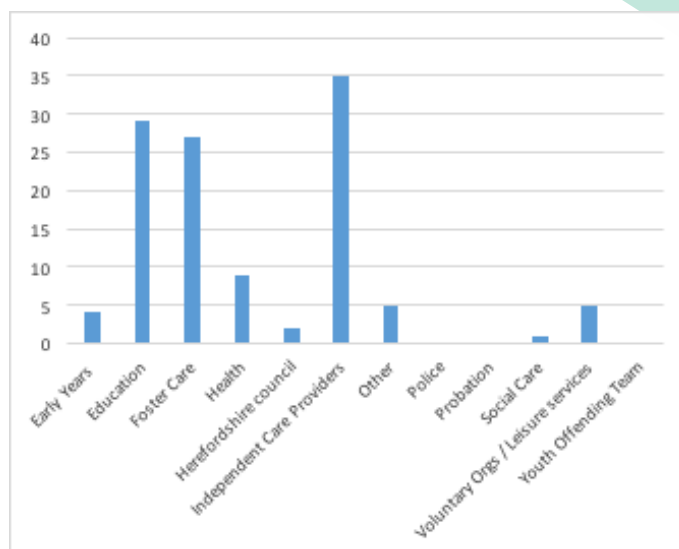
Between 1st April 2015 and 31st March 2016 a total of 117 allegations against professionals were managed by the LADO, compared to 175 in 2014/15. Although this suggests a downward trend, figures for the preceding six years show a discernible fluctuation and the total for 2015/2016 is not significantly lower than the mean for the past seven years (139). The number of referrals averaged 9.5 per month in 2015/16.

Working Together 2015 sets the expectation that 80% of cases should be resolved within one month of referral, 90% within three months and all but the most exceptional cases within twelve months (measured as number of days from referral to case closure). In 2015/2016, 25% of cases were resolved within one month, 33% were resolved within three months and 42% were open for longer than three months. Even when taking into account the preservation of criminal proceedings in some cases and some data inaccuracies, performance in this area has been poor. Factors that have impacted on this are changes in Electronic Social Care recording systems and from a multi-agency partner perspective, delays in requested actions being completed by employing agencies.

The graph below shows referring agencies to the LADO for 2015/16

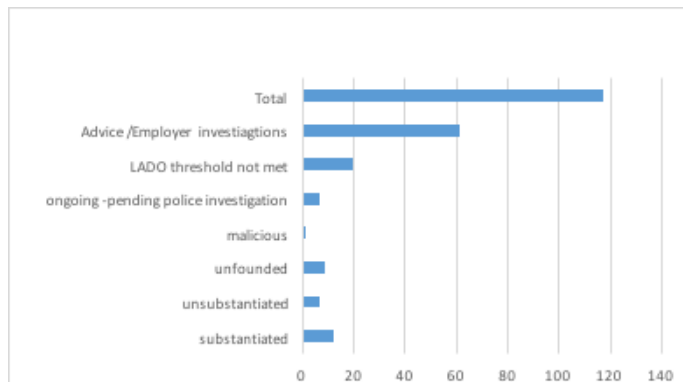


The graph below shows referring agencies to the LADO for 2015/16



Education and independent care providers continue to make the highest percentage of referrals to LADO. Youth offending services are highlighted again this year, as in the previous five years, for not having made any referrals or having an employee who is the subject of any referrals. The LADO will be meeting with other agencies to explore their agency's awareness of the allegations management process. Social care, fostering services, education and independent care providers continue to constitute the vast majority of referring agencies, which indicates a good understanding of procedures within these key agencies.

## The graph below shows outcomes of referrals 2015/2016



Priorities for 2016/17 include:

- Collection of accurate data and evolution of the existing LADO processes that removes the need for secondary recording systems and allows for accurate analysis. This is required to evidence outcomes for children.
- The time taken to resolve cases must improve in line with Working Together guidelines. This will be achieved through a more robust chasing of investigation outcomes with employers where there is delay, and supported by a monitoring and tracking spreadsheet which has now been implemented.
- Awareness raising is arguably the most crucial factor of the LADO role, as appropriate action can only be taken if employers are aware of and adhere to LADO processes. This will be achieved through briefings to key teams across social care and partner agencies.

## e. The safety and welfare of children who are privately fostered

A child under the age of 16 (under 18 if disabled) who is cared for by someone who is not their parent or a 'close relative' is deemed to be privately fostered. Private fostering is an arrangement made between a parent and a carer for 28 days or more. The council has a legal duty to make sure that all private fostering arrangements are safe for the child, that they are being looked after properly, that appropriate arrangements are agreed between parties and that everyone involved knows who to ask for help if advice or support is needed.

HSCB receives an annual report about private fostering in Herefordshire.

In 2015/16 only three private fostering arrangements were notified to the local authority. This number is low. There is concern that other children and young people are living in private fostering arrangements that have not been assessed and this could leave children vulnerable. There is a need for on-going work to raise awareness within the community and amongst professionals to identify children who may be privately fostered and of their responsibility to notify the Council if they believe a child is living in such an arrangement.

There have been and continue to be a range of campaigns and strategies to raise awareness of private fostering, for example a radio campaign in Jan/ Feb 2015. The HSCB Joint Communications subgroup has included this in its priority areas for 2016/17.

## f. Case reviews

LSCBs are required to undertake reviews of serious cases, determining and communicating lessons to be learned in order to improve practice.

HSCB, Herefordshire's Adult Safeguarding Board and the Community Safety Partnership have a Joint Case Review (JCR) subgroup which commissions and oversees any formal Case Reviews as well as identifying other learning opportunities from cases brought to the group's attention.

During 2015/16 one Serious Case Review (SCR) in respect of a child was initiated. This case initially commenced as a learning review following issues being identified through HSCB case audits, but as further information emerged a decision was made that it met the criteria for a SCR. The review will be fully concluded in 2016/17.

The JCR Group has implemented a Practice Learning Review Model for use when reviewing cases that may fall below the criteria for a SCR but where it is identified that there is learning that would benefit future practice and multi-agency working. One case has commenced using this approach which will be concluded and reported in the 2016-17 annual report.

The Business Unit of the HSCB through the relevant subgroups and partner agencies will be sharing the lessons and messages about practice. The individual and multi-agency action plans that stem from these reviews are monitored by the Joint Case Review Group and reported to the Board. An element of the quality assurance framework of the HSCB will be to include factors from these reviews into the case audit programme to identify improvements.

## g. The Child Death Overview Panel (CDOP)

Chapter 5 of Working Together to Safeguard Children sets out the responsibilities of the Local Safeguarding Children Board “for ensuring that a review of each death of a child normally resident in the LSCB area is undertaken by a CDOP”. The CDOP has a fixed core membership drawn from organisations represented on HSCB. CDOP provides an annual report to HSCB.

There were 14 deaths within the review period April 2015-March 2016, five of which are still awaiting completion of review. Of those reviewed; all were completed within six months period from time of death. Of the five from the current year that are awaiting review completion two await post-mortem and possible subsequent inquest. Three have not been completed because of delayed submission of some of the statutory form Bs needed from agencies to enable the CDOP to complete the review. This has been an area of concern for some time and the matter has been escalated to the HSCB with corresponding challenge issued by letter to the agencies concerned.

CDOP considered the learning from this and recommended the following:

- Professionals are made aware of their role through the development of a pathway which is on the LSCB website
- A good practice guide and sample is posted on the web to assist with understanding
- The Director of Children Services, as the accountable officer for one of the agencies, has been alerted to take the appropriate action.
- A communication item on the CDOP agenda to agree dissemination of learning, with responsibility for this to the Communications sub group.

The impact of actions taken in response to these recommendations will be monitored by HSCB in 2016/17.

There were no serious case review referrals made from CDOP during the year.

In addition to complying with statutory guidance, CDOP has identified key learning in the following two areas:

- **Support for and involvement of families.**

Local and national (Bliss 2016) feedback has recommended improved engagement with families. Locally the NHS team have evidenced the need for the development of an end of life individualised care plan and pathway to ensure seamless service between acute services and home.

- **Group B strep sepsis (GBS)**

A death associated with the group B streptococcus occurred during the year. This highlighted the continued national concern over the screening for this condition. Current studies show that in the UK it affects around 1 per 1,000 births. Early administration of antibiotics is extremely effective but this depends on early clinical diagnosis.

A new method of testing for this infection during pregnancy is available but is only available privately. NICE have reviewed the need for screening although this has not been recommended. There are national campaigns on this subject, and there is still ongoing debate of cost benefit for the screening. Implementation of this learning will also be monitored by HSCB during 2016/17.





# 7. Effectiveness of agency safeguarding arrangements in Herefordshire

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to safeguard and promote the welfare of children. LSCBs have a responsibility to monitor how effectively they do this.

HSCB monitors a range of performance information and carries out a range of quality assurance activities to ascertain the effectiveness of local services. This work is set out in the Board's Learning and Improvement Framework and is primarily coordinated through the Quality Assurance and Performance (QA) subgroup. Case reviews in respect of both children and vulnerable adults are coordinated by the Joint Case review (JCR) subgroup, and details about this are given elsewhere in this report.

QA activities include:

- Review of external inspections of Herefordshire services and oversight of the delivery and impact of action plans;
- Discussion and analysis of a multi-agency core data set at each QA meeting;
- A monthly meeting to examine the data, ensure end of year target trajectories are on track and identify and remedy any deviation through operational leads;
- Multi-agency case audits;
- Consideration of data on family violence provided by the Domestic Abuse forum;
- Discussion of emerging local issues and trends arising from the data and identification of areas of strategic importance, which are reported to the LSCB for direction or further work;
- Regular assurance reporting from individual agencies and sectors;
- A regular 'section 11' audit of single agency contributions to safeguarding children.

A learning log has been created to capture the learning from case audits and Serious Case Reviews and is used regularly to inform training and forward planning.

Practitioners and first line managers have been actively involved in the multi-agency case audits and this allows for a much richer discussion and exchange of views and understanding that lead to better learning.

## Section 11 audit

Partners of the Herefordshire Safeguarding Children Board completed a "Section 11" Audit Self-Assessment tool in 2015-16. The tool is designed to facilitate reflection and challenge in order to improve safeguarding within services and therefore improve outcomes for children in Herefordshire. Agencies that completed the audit included:

- Herefordshire Clinical Commissioning Group (HCCG)
- Herefordshire Council's Homes and Communities Services (H&C Services)
- Herefordshire Council's Children's Well Being Directorate
- CAFCASS
- West Mercia Police
- West Mercia Probation Trust (NPS)
- West Mercia Youth Offending Service
- Wye Valley NHS Trust
- West Midlands Ambulance Service\*
- Warwickshire and West Mercia Community Rehabilitation Company (WWM CRC)
- British Transport Police

Based on their self-assessment, each agency (except CAFCASS) identified actions for improvement and developed an action plan in response. Some of the main themes from the audit included:

- Ensuring that single agency policies and procedures were fully up to date and regularly reviewed, taking in to account national and local changes, and that staff were aware of changes and how to access policies, procedures and guidance.
- With regard to staff, issues included ensuring safeguarding children is reflected in all job descriptions; establishing specialist posts or elements in posts to support safeguarding activity; implementing reflective supervision and auditing that supervision is taking place.
- As well as ensuring that staff received the relevant safeguarding training respective of their role, there were common issues of raising staff awareness and understanding of radicalisation and the PREVENT strategy, and child sexual exploitation.
- Continued awareness raising through e-learning regarding safe recruitment and safe working practice, including safeguarding questions in all job interviews.
- Continued promotion of the HSCB levels of need guidance and understanding of the MASH.

The HSCB has put into place a peer challenge review of the section 11 audits, consisting of panels of Board members meeting with each representatives of each agency to seek evidence for their assessments and challenge the completion of the audits. The QA subgroup will be reviewing the progress and impact of the action plans through 2016-17.

A further full section 11 audit will take place in 2017-18

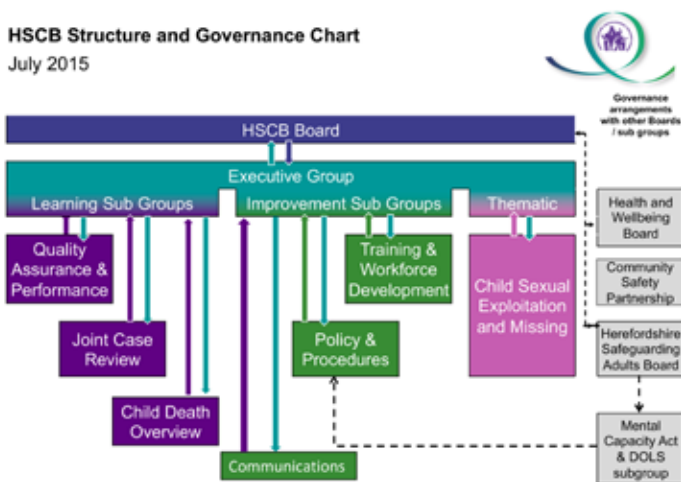
## 8. Development of HSCB and its effectiveness 2015-16

HSCB carries out its work primarily through its subgroups, supplemented by task and finish groups as required, and through scrutiny and challenge at Board meetings.

The Board also works with other multi-agency partnerships across Herefordshire to both scrutinise and challenge their activities and to pursue joint objectives. In 2015 a regular forum was established between the Chairs of the two safeguarding boards (adults and children), the Health and Well Being Board, the Children and Young Peoples Partnership and the Community Safety Partnership, underpinned by a partnerships protocol, to clarify leadership and roles in key areas, ensure identification of common themes, align priorities and principles, and avoid duplication of activity.

The structure and governance arrangements for HSCB are set out below.

**HSCB Structure and Governance Chart**  
July 2015



The attendance of partners at the HSCB Board meeting is set out in appendix 1.

Overall engagement by partners in the work of the HSCB has continued to be positive throughout 2015-16. Member reviews with the Independent Chair have ensured that agency representatives understand their role and responsibilities as Board members. There have been a few occasions when performance has dipped, for example early in 2015-16, when membership of the Workforce Development subgroup had reduced in membership. These issues are addressed as they emerge so that remedial action can be taken and the work of the subgroups is not compromised.

HSCB has benefitted from the creation of the joint business unit at the beginning of the year, which supports the Safeguarding Adults Board and the Community Safety Partnership as well as HSCB. This is jointly funded by partners, and details of the budget, contributions and expenditure are included in **appendix 2**.

The Unit consists of:

- Business Unit Manager
- Learning and Development Officers X 3
- Business Support Coordinator X 3
- Training officer (p/t)

Each of the Learning and Development officers takes lead responsibility for one of the partnership boards and for particular areas that allow for cross cutting themes and shared work streams.

A protocol was put into place to support the efficiency of the business support process and also act as a mechanism for supporting and prompting partner agencies in respect of their contribution to the work of the HSCB and multi-agency working.

The Training Officer post has been vacant throughout most of 2015-16 and the budget for 2016-17 will be reviewed to consider whether this post can be filled in the future.

Towards the end of 2015-16 a review of the business activity between the HSCB Strategic Board, the Executive and the subgroups led to a decision to refine the process. The Executive group now consists primarily of the chairs of the subgroups. The function of the Executive is to coordinate, support and drive the business of the subgroups on the Board's priority areas and reporting to the Board to allow for reflection and a strategic steer.

The progress and effectiveness of the Unit in supporting the HSCB has been reviewed by all the Boards and it is felt to be a positive model.

The two Lay members of the HSCB have continued to attend Board meetings regularly and are valued contributors. One lay member also attends the Communications subgroup. Both attended the Executive lay member Group but will not be involved in this meeting in the future in order to release capacity to contribute elsewhere. Plans are to involve Lay Members in areas such as the Section 11 audit peer challenge; 'voice of the child initiatives' and bringing a community perspective to the Board.



### Illustrations of HSCB challenge and impact

Throughout this annual report there are details of the work of all partners in safeguarding children, and the Board's function in seeking assurance that partners are working effectively together. Examples of this activity are summarised below:

Challenge	Impact
<p>Improving identification of and response to CSE.</p>	<p>Clear pathways and guidance and tools to support recognition, referral and response. Awareness raising campaigns and activities. An increase in cases over the 12 month period. Parents and children more involved in the process.</p>
<p>Improved consistency and quality of "front door" services.</p>	<p>MASH Governance Group established. Clarification of agencies responsibilities in the MASH. Continued identification of areas for improvement (deep dive analysis commissioned).</p>
<p>Improving the "step down" process so it works better for children.</p>	<p>Work undertaken in relation to step down process. The relationship between early help and targeted services has been picked up as an issue by the Board for coming year priorities.</p>
<p>Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.</p>	<p>Report from WVT relating to cancelled meetings. Greater scrutiny of Strategy meeting thresholds; one child protection conference chair focusing solely on initial child protection conferences. Work on threshold criteria relating to significant harm.</p>
<p>Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.</p>	<p>HSCB has included this in all Board meetings, sources of voice of the child are illustrated in this report.</p>
<p>Audit of CSE cases to assist in improving identification &amp; response to CSE.</p>	<p>Development of the work of the Operational Group to identify themes and factors relating to CSE to support disruption activity.</p>
<p>Challenge regarding the pace of the development of the early help offer in Herefordshire</p>	<p>Detailed report on the implementation of the early help offer measures of effectiveness to be reported to the board in April 2016. Early Help is a priority area for the Board in 2016-17.</p>



## 9. Conclusion and future priorities

The focus that the Board placed on Child Sexual Exploitation in 2015/16 has led to greater awareness of CSE, more robust processes in intelligence gathering and improved understanding of what this means. The arrangements in place for responding to concerns about CSE are now more effective with the CSE checklist and assessment screening tool in use, and an increase in referrals. In 2016-17 the Board will want to see a positive impact from the recognition and responses to CSE and good reporting relationships between the CSE team, operational group and strategic group.

The balance of resources to support Early Help on the one hand and respond to concerns about children at risk of harm on the other is a complex one. Services and processes continue to be developed to recognise the needs of children and difficulties in families early, to best target resources and prevent situations escalating to a point where children may be at risk. The Board is aware of work underway regarding continuing development of the Early Help offer in Herefordshire, to achieve the vision set out in the Children and Young People's Plan that all children and young people in Herefordshire have the best start in life and grow up healthy, happy and safe within supportive family environments. The Board will be expecting a report on the progress of this initiative during 2016/17 and the plans for implementation. This will include the quality of engagement by universal and specialist services across Herefordshire.

The Board will also continue to focus on the "front door" with the commissioning of a deep dive analysis of the MASH and subsequent monitoring of an improvement plan.

Through scrutiny and challenge the Board has been able to see positive actions in improving the child protection process by focusing on key stages in the 'child's journey'; referral, strategy discussions, Initial Child Protection Conferences and thresholds for significant harm. It is noted that there have been higher numbers of children subject of a child protection plan in Herefordshire compared with similar authorities, albeit the initiatives put in place do appear to be addressing this. As is illustrated in this report however, there is also a pressure on the early help services from "step down" cases from child protection plans. There will be further work through 2016/17 to monitor these areas, and the initiatives that are being put in place, given the obvious relationship between the two. This will include observations of child protection conferences by Board members.

There has been some awareness raising in relation to Private Fostering, though this needs a stronger focus, and the newly developed joint communications subgroup of the partnership boards will prioritise this.

There are positive indications of stability and improving outcomes for children in the looked after system. Both in terms of children in care and children on a child protection plan there are some positive messages from the voice of the child in terms of the services they received. HSCB will want to continue to see a strong commitment from all agencies in seeking and taking account of the views and understanding of children and young people about their lived experiences, as well as the views of parents. There will be an expectation of reporting to the Board and demonstrating how these views are identifying good practice and supporting improvements. Given the OCC report in to IFCSA, the Board will consider how the voice of the child in such circumstances is captured and understood.

The work that has taken place in 2015-16 in relation to the multi-agency training pool is a very positive development for opportunities to expand the multi-agency training offer and this initiative should be fully supported in the coming year.

Reflecting on the achievements through 2015-16, considering data and other evidence alongside the need to ensure continuous improvement, the HSCB has set four priorities for 2016-18. These are detailed below:

### Priority 1.

Identification, prevention and response to Child Sexual Exploitation/ children who go missing.

### Priority 2.

The child's journey through the child protection process ensures effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm

### Priority 3.

Identification and response to childhood neglect

### Priority 4.

The early help services effectively identify needs and concerns relating to children and families, and services address these needs through effective planning and interventions to enable families to function effectively and children's needs are met and they are supported to achieve their full potential.

These have been identified by the HSCB partners as priority areas for seeking assurance of improving services and positive outcomes for children, drawn from knowledge and understanding developed through audits, review and reporting.

They also reflect the priorities set by the Health and Wellbeing Board (Priority 2 addresses the importance of keeping children safe), and the Children Young Peoples Partnership; Priority 4 of the Children and Young People's Plan is "Children and young people in need of safeguarding", and includes expectations in relation to effective early intervention, identifying children at risk of sexual exploitation, a reduction in the number of children subject of a child protection plan and looked after, and support for children with enduring needs particularly in relation to transition in to adult life.

The full Children and Young Peoples Plan can be found here. The HSCB will have a reporting cycle that includes detailed reports on one of the priority areas each quarter, using a focused scorecard, with exception reporting on any issues identified through the Quality Assurance and Performance subgroup of the HSCB. Along with this reporting there will be findings from multi agency case audits set around the priority areas, together with data and qualitative information from other areas including:

- Single agency audit activity, findings, analysis and actions
- Board members observations of Child Protection Case Conferences
- Board members visits to front line services
- Audit of agencies responses to identified actions to improve safeguarding practice through Sec 11 Children Act 2004, Sec 175/157 Education Act 2002 audits.

In addition, the HSCB will be seeking reports and assurances from partner agencies about other safeguarding children matters throughout the year. These will include:

#### Safeguarding area

Looked after children

Female genital mutilation (FGM)

Prevention of radicalization and extremism

Health Services assurance reporting

Public Protection assurance reporting

Education assurance reporting

Child Death Reviews

Serious Case Reviews and other case reviews that the Board have identified should take place

Private Fostering

Adult Factors that impact upon the safety and wellbeing of children



# Appendix 1

## Attendance of agencies at HSCB Board meetings\*

Agency / person	Board meeting 22/4/15	Board meeting 20/7/15	Board meeting 19/10/15	Board meeting 27/1/16
Independent Chair	•	•	•	•
Lay Member 1	•	•	•	•
Lay Member 2	•	•	•	•
HC Children's Well Being	•	•	•	•
HC Adult Safeguarding	•	•	•	•
2Gether NHS Trust	•	•	•	•
Wye Valley Trust (WVT)		•	•	•
Clinical commissioning Group (CCG)	•	•	•	•
National Probation Service		•		•
Youth Offending Service	•	•	•	•
West Mercia Police		•	•	•
CAFCASS	•	•	•	•
Lead Member Children's Well Being	•	•	•	•
Education representative	•	•	•	•
Voluntary and community representative		•	•	

\* In most instances agencies are represented by more than one person attending from an organisation. Herefordshire Council (HC) representation has included the Director and Assistant Director of Children's Well Being; Head of Additional Needs; Head of Quality and Review; Public Health; Health representation has included Head of Safeguarding CCG; Designated Doctor CCG; Deputy Director of Nursing 2Gether Trust; Director of Nursing and Quality WVT; Executive Nurse Quality and Safety CCG; Director of Nursing Taurus; Designated Nurse WVT. Education representatives have included representatives from the Early Years sector, Primary Schools, Secondary Schools, Special Schools and FE Colleges.



# Appendix 2

## Partnership Boards budget\*

Agreed budget for 2015/16	
Children's Wellbeing	130,028
Adults Wellbeing	103,000
Other Council Dept	7,365
CCG	80,186
Police	53,510
Probation	8,181
CAFCASS	550
YOS	1,144
<b>TOTAL GROSS BUDGET</b>	<b>383,964</b>



Final 2015-16 expenditure statement		
Category	Actual spend to date	Notes and comments
Salary Costs	198,209	
Agency staff costs	91,165	
Other direct employee costs	314	
Transport costs	1,027	
Independent chair costs	34,728	
Serious Case Review costs	21,488	
Training expenses	15,900	
Office expenses	51,323	Includes end of year recharges for council back office services of £36,224
Training income	-14,900	
Additional income	-15,290	
<b>TOTAL</b>	<b>383,964</b>	

\*Note: this budget also covers the support of the Herefordshire Safeguarding Adults Board and the Community Safety Partnership

# Appendix 3

## Children exposed to domestic abuse MARAC data, sourced by WMWA

	Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	
Number of unique children - quarterly totals	284	376	243	273	-35%
Number of children exposed to DA crimes and incidents	300	298	298	315	9%
Children exposed to DA three or more times	36	26	26	26	8%
Number of children exposed to DA as recorded by: Children's Social Care	93	79	79	32	-59%

# Appendix 4

Numbers of children and young people involved with Children's Independent Domestic Violence Adviser 2015-16

17. IDVA SERVICE USER CHILDREN DATA	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
No. of service user children recorded at the end of previous period	22	14	22	31	25	31	27	20	21	19	27	13	272
No. of new service user children recorded during the month	9	17	13	15	18	23	14	18	16	18	12	8	181
No. of service user children closed during the month	17	9	4	21	12	27	21	18	17	10	26	8	190
TOTAL NO. OF CHILDREN ASSOCIATED WITH SERVICE USERS EACH MONTH	31	31	35	46	43	54	41	38	37	37	39	21	453
TOTAL NO. OF UNIQUE SERVICE USER CHILDREN RECORDED DURING THE YEAR	31	17	13	15	18	23	14	18	16	18	12	8	203
19. CIDVA SERVICE USER CHILDREN AGE	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
<1	1	3	0	0	4	0	1	1	1	1	0	1	13
1-4	10	2	2	3	4	6	1	6	4	7	0	1	46
5-9	9	3	3	7	5	7	7	6	5	7	7	3	69
10-14	2	7	5	1	4	6	3	4	2	3	3	3	43
15-18	9	2	3	4	1	4	0	1	3	0	2	0	29
Unknown	0	9	0	0	0	0	2	0	1	0	0	0	3
Total	31	17	13	15	18	23	14	18	16	18	12	8	203



# Appendix 5

## PEEPs training (definition):

Provide opportunities for professionals to understand the experiences of young people

Encourage professionals to consider and reflect on the assumptions made about care experienced by young people

Empower professionals to build on important skills that are needed when working with children and young people (Active Listening, Effective Communication, Observation and Record Keeping)

Promote the involvement of young people within all decisions that affect them, the delivery of services and importance of working together

Support learning around the importance of Children's Rights and Advocacy



# Appendix 6

## Single agency assurance reporting

This section includes reports direct from each of the statutory agencies involved with the HSCB.

### a. West Mercia Police.

The Alliance has provided training to promote safeguarding issues, with 9031 e-training Public Protection packages completed during the last three years. These included five separate modules one of which was Child Protection. The Alliance utilises and has as mandatory the 13 strands of Public Protection training as provided by the National College of Policing. All new to role staff have an input on safeguarding.

During the period 2015/16 all officers within a Child Protection Unit were required to be trained detectives and attend a 2 week Specialist Child Abuse Investigator Course.

The Alliance is at the forefront nationally regarding the development of a course for all established front line officers and staff to look at 'professional curiosity', recognising the need to address vulnerability in a more holistic way. A pilot for 'Vulnerability' training has taken place in the Telford area, consisting of both e-learning and work with an external drama group. This pilot has been evaluated by Worcester University, and as a result a larger pilot is due to take place, with the long term aim of rolling the training out across the entire Alliance. This will mean that non specialist departments will also be provided with training on a variety of aspects of vulnerability including child protection matters. The ethos which has been promoted is that safeguarding children is a core responsibility for all and is everyone's business, not just that of specialist departments.

With the introduction of the 'pathfinder' model (further details in point 2 below) there is recognition that investigators will continue to require the same level of training to maintain their skill levels.

The Alliance document, 'Looking to 2020' sets out the vision for the future of policing, and highlights that 'Protecting people from harm' is at the core of everything we do. The overriding ambition over the next five years is to become 'great' at protecting the most vulnerable from harm.

There has been significant re-structure, with the Protecting Vulnerable Persons (PVP) department initially retaining and recruiting additional staff, whilst developing the delivery of services to communities and partner agencies. In the restructure the impact of the redesign on safeguarding, all vulnerable persons including children was paramount.

The restructure across the Alliance introduced a new 'Pathfinder' model. It is a single CID model which incorporates within it existing members of specialist PVP teams thereby retaining those specialist staff but spreading them out across the larger teams to share that expertise and experience. There is an expectation that traditional non PVP detectives will be exposed more to PVP related crimes with the knowledge and experience of those around them to support their development. It is intended that this will up skill all Detective Officers in dealing with PVP related crimes as well as other crime types thus making protecting vulnerable people everyone's business and in line with the Alliance vision to be great at protecting the vulnerable. The increased teams will identify appropriately trained staff to deal with Child Protection issues and require outstanding actions to be passed to those remaining on duty to complete. This will appropriately expedite investigations. The Pathfinder model is in the phased process of rolling out across the alliance. Operational staff have continual access to safeguarding processes, information and supervision.

The Alliance is committed and are currently actively planning an increase over the next two years in PVP related training courses to ensure that officers have the knowledge and training to complement their new role. Additional courses will take place from June 2016, which includes two new courses – Serious Sexual Assault Investigative Development Programme (SSAIDP) and Professional Curiosity. The issues of Child Protection and vulnerability are threaded throughout the content of other courses currently delivered.

The Alliance has introduced new working practices, with permanent dedicated teams to proactively target individuals involved in possession and sharing of Indecent Images of Children (IIOC) and online Child Sexual Exploitation (CSE).

Although the Pathfinder model is commencing across the Alliance, there remains a Strategic PVP team to ensure a full overview of policy, procedure, communication and leadership, along with corporacy and consistency.

Service delivery is also developed through engagement in Serious Case Review processes across the Alliance. A dedicated Detective Inspector for Strategic Safeguarding is responsible for thematic reviews of SCR learning across the Alliance to ensure service delivery takes into account the lessons to be learnt & ensure action plans are seen through to conclusion.

During this period there has been the introduction of 5 Multi Agency Safeguarding Hubs (MASH) groups across the Alliance covering Herefordshire, North & South Worcestershire, Telford & Wrekin, Shropshire and Warwickshire. These co-located multi-disciplinary teams will enable improved oversight of the quality and flow of information between agencies, resulting in the ability to safeguard the vulnerable and provide the right response as quickly and efficiently as possible.

To facilitate joint working, the forces have developed a new shared vision and set of values. These provide a unified purpose for the two organisations and a clear direction to our workforce and our stakeholders as to how the forces will operate.

**Vision** - Protecting people from harm

**Values** - We will:

1. Take pride in our professionalism and standards of behaviour
2. Listen and engage
3. Use professional judgement and be courageous in making decisions
4. Seek out better ways of working
5. Lead with confidence and do the right thing
6. Work in partnership to provide the best service we can

Our vision and values form the basis of the alliance's organisational culture - a set of shared attitudes, goals, practices and aspirations.

## b. The National Probation Service (NPS)

1. Hereford NPS has conducted an audit to ensure that all children's safeguarding checks are requested within 24 hours of NPS case allocation. The protocol agreed is that children's services respond within 48 hours. In the rare event of a late return NPS staff will pursue the response. Results of the audit were that returns are requested by NPS and then completed by children's services in timely fashion in almost all cases. A quick phone call to children's services has secured achievement of this target in the remainder of cases.
2. NPS offender managers are required to attend child protection conferences and strategy meetings in all cases where there is NPS involvement. Indications currently are that we achieve this expectation. An audit in respect of this is at the planning stage.

3. NPS Offender Managers prioritise Multi Agency Referral form (MARF) and PPRC2 (person posing a risk to children) completion where indicated and identify this task in risk management plans. As a result of Hereford MAPPA meetings, NPS offender managers often take action points to complete a MARF in cases where for different reasons a MARF has not already been completed. (e.g. disclosure that there is a child at risk which NPS has not previously been aware of). In these cases a MARF is completed immediately and the completion of the action point communicated to the MAPPA team.

### Case examples:

**CASE 1:** MAPPA 3 sex offender nominal, the NPS Offender Manager was tenacious in communicating with children's services and in ensuring a strategy meeting and then child protection meeting was convened.

**Case 2:** (MAPPA 2 nominal) a MARF was completed in respect of disclosed Child Sexual Exploitation

4. Similarly, NPS plays a very pro-active role in MARAC which, of course, frequently contributes to child safeguarding. NPS is also a key player in Integrated Offender Management in which forum child safeguarding is a priority.
5. Currently Hereford NPS team is also developing a close working relationship with Troubled Families through regular liaison/case discussions regarding cases supervised by NPS. This adds to intelligence regarding children who may be at risk and raises NPS awareness of families who may be in difficulties in parenting their children so that this can be addressed on a multi-agency basis.





## c. Warwickshire and West Mercia Community Rehabilitation Company (WWM CRC)

Warwickshire and West Mercia Community Rehabilitation Company is one of the 21 Community and Rehabilitation Companies (CRCs) across England and Wales. We cover Warwickshire, Herefordshire, Shropshire, Worcestershire and Telford & Wrekin.

CRCs were formed as a result of the government's Transforming Rehabilitation programme which split the existing 35 Probation Trusts into two parts - a National Probation Service and 21 CRCs. Warwickshire and West Mercia merged to become Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC).

We aim to work closely with partner organisations across Herefordshire.

Warwickshire and West Mercia CRC work directly with offenders to tackle the causes of their offending behaviour and help them to stop re-offending. Our aims are to:

- Protect the public
- Reduce reoffending
- Ensure proper punishment of offenders in the community
- Ensure that offenders are aware of the effects of crime on the victims and the public
- Rehabilitate offenders

### Safeguarding Children

WWMCRC continue the approach taken by West Mercia Probation Trust in holding annual audits on issues relating to safeguarding children as a way to assure the quality of this element of its work in house and to partners and to highlight its importance generally.

WWMCRC recognises its responsibility to ensure that staff are aware of and responsive to issues of safeguarding children, and that this should be one of the underpinning elements of all aspects of service delivery for the purpose of safeguarding and promoting the welfare of children in the local area.

### Inspections and Audits

WWM CRC Child Safeguarding Audit: Spring 2015

This audit was undertaken in the context of a thematic inspection of Safeguarding work in six former Probation Trusts which was published in 2014 and highlighted a range of issues for improvement.

Although neither of the CRC's predecessor trusts were part of the inspection, its findings appear to have general relevance and have therefore led to an action plan for the CRC to target the highlighted issues. The inspection finding of a generally poor quality in assessments of risk to children in domestic abuse cases is the basis for the theme of this audit.

A list was generated of offenders with a register for domestic abuse on their case record who also show as having "parental responsibilities" within their latest Offender Assessment System review. From that a random sample of 20% per office was selected and Senior Probation Officers completed an audit checklist to assess specific elements of assessment and casework as good, adequate or needing more work and to record a commentary on the reasons for that assessment.

### Findings

Despite some good practice across the organisation, the findings of this audit largely reflect those of the Thematic Inspection in these respects:

- No routine use of home visits to inform safeguarding assessments
- Inaccurate assessment of risks to children in relation to domestic abuse
- No sharing or alignment of assessments and plans between Probation staff and Children's Social Care staff.

In addition, as had already been identified within a recent Serious Further Offence investigation, practice in relation to the use of Spousal Abuse Risk Assessment (SARA) is not consistent. Concerns have also arisen in relation to the management of standalone Unpaid Work (UPW) requirements which involve a risk of domestic abuse. The positive evaluation of the ongoing work to reduce risk to children is encouraging.

### Actions

- CRC to agree a protocol for SARA completion with the National Probation Service
- Learning and Development staff to include SARA training as an ongoing element in training planning
- Offender Managers (OM's) to be provided with places on the Freedom Programme training
- Safeguarding Procedures and training to be rolled out to all OM's, including specific input on home visiting.
- Senior Probation Officers (SPOs) to undertake structured reviews of one domestic abuse case per OM per quarter.
- LDU meetings to continue to monitor home visit rates.

#### Further actions prompted by this audit:

- SPOs and Unit Performance Officer's (UPO's) to review the allocation of domestic abuse cases against the Role Boundaries agreement.
- SPOs to decide on need for and format of any extra briefing on SARA use.
- Senior Managers to decide on how and when to issue guidance for the management of standalone UPW requirements with a domestic abuse risk.
- SPOs to decide on how to use the findings of this audit as a means to focus and develop practice locally.

#### Learning and Development

All new staff completes the mandatory e-learning course Awareness of Child Abuse & Neglect. This course covers:

- What to look out for and how to respond in situations where child abuse or neglect are suspected
- Recognise the signs of, and be able to respond appropriately to physical abuse, sexual abuse, emotional abuse and neglect.
- Know what to do if abuse or neglect are suspected.

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All Probation Service Officers (PSOs), POs & SPOs then attend a multiagency event run by the Local Safeguarding Children Boards. Additionally, within Herefordshire there are further courses/training offered and the expectation is that staff will complete these:

- Working Together to Safeguard Children
- Understanding Neglect
- Child Sexual Exploitation
- Training for Practitioners involved in Child Protection Conference
- Domestic Abuse Awareness.

In order to improve our overall response to public protection in general, and safeguarding children and adults in particular, there is:

- An urgent need to ensure effective join up or access to Police information systems
- A need to engage with Police on their change programme review of public protection and IOM and
- Develop and implement plans for co-location with the Police and MASH

### d. West Mercia Youth Offending Service

In 2015/16 the service was subject to a SQS inspection by HMI Probation. The inspection found some weakness in the assessment and planning processes and the management oversight of these. Work commenced following the inspection to make improvements in the quality of both assessment and risk plans, and monthly audits have confirmed continuing improvement in these areas of work. Work in 16/17 will continue to improve assessment and planning, in particular through the implementation of both a new case management system and a new assessment framework. The service will also transfer to the Office of the West Mercia Police and Crime Commissioner and be subject to a re-structure.

The new assessment framework includes a single assessment and integrated plan for the risk areas of re-offending, harm to others and the safety and wellbeing of the subject. All practitioners will undertake a foundation course in assessment and planning and attend further training on the assessment framework and the case management system. Through the restructure of the service there will be increased support for managers in providing oversight of case work and quality assuring assessments and plans through the establishment of senior practitioner posts within the area based teams of the service.

The service will continue to undertake critical learning reviews when young people under the supervision of the Youth Justice Service commit defined serious further offences or where they have died, attempted suicide or been a victim of serious offence. The Youth Justice Service will identify learning points from these reviews and communicate the findings and resulting actions to the LSCB through the annual assurance report. Following a recommendation from a thematic inspection report (which did not include West Mercia) the service will work towards making the serious incident review process more multi-agency where relevant.

## e. Herefordshire Clinical Commissioning Group

Herefordshire Clinical Commissioning Group (CCG) brings together GP practices in Herefordshire to buy and shape health and care services for the people of Herefordshire. It achieves this by putting patients at the heart of everything it does.

The CCG contributes significantly to the work of the LSCB, including providing leadership in the Board's committees and subgroups. We are committed to working in partnership with other agencies and services in order to improve the health and welfare of all children and young people in Herefordshire. We do this by ensuring that all CCG contracts include safeguarding standards such as policies, staff training and supervision. We also hold provider organisations to account for the quality of services delivered by talking to children and young people to ensure that services meet their needs. We also monitor the work of providers regularly, ensuring that safeguarding standards are met.

As part of their commitment to improve services the CCG is supporting a national campaign 'Speak out Safely.' The CCG believes that members of the public and staff should feel able to raise concerns about wrongdoing or poor practice and are confident that their concerns will be addressed in a constructive way...

The CCG has worked hard with the community to improve the lives for children/young people across Herefordshire in 2015 and will continue to do so in future years.

## f. 2Gether NHS Foundation TRUST

2GetherNHSFT provides a range of mental health services for children, young people and adults. This includes a range of services for adults with learning disabilities. The Trust is fully committed to collaboration and partnership working with all partners including the Herefordshire HSCB (and HSAB). The Trust has played a key role in improving the outcomes for children and young people in Herefordshire through strengthened relationships and collaboration during the last 12 months.

For example, 2GetherNHSFT have worked to improve the training of the 'Think Family' approach to safeguarding children; have learnt from single and multi-agency audits with particular reference to capturing and sharing information; worked closely with the MASH to improve communication channels with mental health services and have fully participated in all Board activity at all levels. 2GetherNHSFT believes that it has been a diligent and active partner in the last years HSCB work plan.

Looking towards 2016/17 the Trust is keen to assist in participating in the HSCB's joint work on improving services and outcomes for children and families. The Trust's safeguarding priorities remain aligned to the HSCB business plan. 2GetherNHSFT will also be paying particular attention to learning from Serious Case Reviews; building on and improving the quality of recording safeguarding information with particular reference to parents with mental health issues whilst improving access to training for professionals in this area. In addition, we will focus to improve safeguarding practice and partnership working specifically around Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE), Prevent; Domestic Abuse and Sexual Violence (DASV).

The Trust is keen to ensure continual learning and improving practice during 2016/17 thus safeguarding the needs of children and young people in Herefordshire.



## g. Wye Valley NHS Trust (WVT)

Wye Valley NHS Trust is the provider of healthcare services at Hereford County Hospital, which is based in the city of Hereford, along with a number of community services for Herefordshire and its borders. We also provide healthcare services at community hospitals in the market towns of Ross-on-Wye, Leominster and Bromyard. We work hard to deliver across traditional boundaries to provide integrated care in order to deliver a standard of care we would want for ourselves, our families and friends.

The Trust works collaboratively to support the business of the HSCB in a number of ways, aligning safeguarding children priorities to those of the HSCB business plans and contributing to the work of the board and subgroups for example during 2015-16 WVT supported the work of the board in the development of policy and the development and delivery of multi-agency training on behalf of the board.

WVT has been in special measures since June 2014 following a Care Quality Commission (CQC) inspection rating of inadequate. Since this time a quality improvement programme has been in place and significant improvements have been made. A re-inspection in September 2015 found improvement was required to ensure services are safe and responsive to patient's needs. Overall the services at the trust were judged as good for caring. Patients were treated with dignity and respect and were provided with appropriate emotional support. Caring in community adult services was rated outstanding. The trust remained in special measures. With specific reference to safeguarding children key findings were:

### Outstanding Practice

- The young people's ambassador group - a group of children aged 11-16 years who meet regularly and are consulted on changes and developments, e.g. they have recently introduced a 'Saturday club' and have been involved in the ED Patient-Led Assessment of the Care Environment audit (PLACE) redesign of the children's waiting area; also they are involved in interviews for new staff in community children's services.
- A number of health visitor led projects were highlighted as good practice together with recognition of a national award for a school nurse in relation to a domestic abuse peer support model.

### Practice in accordance with expectations

- Staff in ED and MIU's knew when and how to make safeguarding referrals and a review of records found appropriate safeguarding documentation.
- Generally robust arrangements for safeguarding children and adults in maternity services.
- Within community health services for children the inspectors found that there were clearly defined and embedded systems and processes to keep children and young people safe and safeguarded from abuse. Staff received up to date training; and took steps to prevent abuse from occurring, and responded appropriately to any signs or allegations. There was active and appropriate engagement in local safeguarding procedures and effective working with other relevant organisations.

### However, areas of concerns were highlighted which included:

- Safeguarding referrals were not always made when required by paediatric ward staff, although staff could articulate the types of situations when they would refer.
- The trust was not meeting its 90% compliance rates for Levels 1-3 safeguarding children training within a number of services.
- Lack of a paediatric liaison post and delays in sending out notifications to health visitors and school nurses about ED attendances
- Out of hours delays in obtaining a mental health assessment which led to delays in children receiving appropriate support.
- Safeguarding children caseloads within midwifery were not always consistent with level of experience/ job banding of midwife
- Concerns were raised about some environmental risks on the paediatric ward; however the outside play area improvements undertaken since the last inspection were deemed safe.

Following inspection findings a Quality Improvement Programme for safeguarding Younger people was put in place. This forms part of the overarching "Quality Improvement Plan" and is monitored by the trust's safeguarding committee and reported through the trust's governance structures to board. Action plans will be monitored externally by the trust development authority and Herefordshire Clinical commissioning group (HCCG.)

A re-inspection of services is planned for July 2016. The WVT report back regularly to HSCB regarding the progress of the Quality Improvement Plans.

## h. Education and Schools

Schools are critically important partners in our shared responsibilities towards safeguarding children. Herefordshire schools continue to fund 1.5 education officers in the Multi Agency Safeguarding Hub. The education officers form an integral part of the MASH in the gathering and dissemination of information to and from education partners. In addition, the MASH education officers offer advice, support and training to schools to assist with the development of best practice and statutory compliance.

The academic year 2015/16 has seen significant changes in schools as we continue to shape our work in response to new and challenging circumstances. Various, this has included: the development of policy and practice in the light of the Savile inquiry; the participation of professionals in Workshops to Raise Awareness of Prevent; Learning from inquiries into Child Sexual Exploitation and Trafficking; the audit of our practice with regard to Keeping Children Safe in Education (KCSiE). Responses to the audit have been encouraging, but a renewed focus on this work is required with support for those schools and governing bodies who are yet to sign off completed audits.

2016/17 will be no different as, collectively, we address our policy and practice in response the updated version of KCSiE, 5th September 2016. We anticipate further change, for instance, with the opportunity and duty to meet the needs of Unaccompanied Asylum Seeking Children and to participate in the safe settlement of Syrian refugee families.

The HSCB has been monitoring key indicators in education during 2015-16:

### **Children Missing from Education (CME)**

The tracking down of children referred as 'missing from education' has been increasingly successful over the past 3 years, with fewer children remaining as 'missing' from one quarter to the next. During 2015-16, fewer than 10 children reported missing in each quarter remained missing from education by the end of that quarter (with the exception of quarter 2). There has been a steady improvement in the tracking and location of CME year on year.



### **Elective Home Education (EHE)**

2015-16 saw a further increase, from 102 to 118, in the numbers of children known to the local authority who are educated at home. There were 85 children educated at home 2011-12. It is likely that the proportion of parents registering children as Electively Home Educated with the local authority is increasing, in addition to a growth in this parental choice. The EHE officer continues to offer guidance and to make robust monitoring visits about outcomes for children. The feedback from parents who receive advice and guidance from the EHE officer remains overwhelmingly positive.

### **Reporting by schools of bullying and racist incidents**

Reported incidents of bullying have reduced significantly compared to the previous year. However, there has been a slight increase in the reporting of racial incidents in schools. Whilst there has been an improvement, in recent years, in the number of schools complying with the request to submit a return, further work is required around the number of schools providing nil returns, i.e., no reported incidents. There would appear to be too many nil returns relative to what is known about the expected incidence of bullying. This area of work will require proactive planning ahead of the expected arrival of Syrian refugees and unaccompanied asylum seeking children during 2016/17.

## i. Herefordshire Council: Children's Wellbeing Services

In March 2015, the Minister lifted the intervention notice which had been in place since the Ofsted judgement in September 2012 that services were inadequate, and the further period of consolidation and improvement subsequent to the May 2014 Inspection when a 'Requires Improvement' judgement was made. The minister confirmed that, 'Herefordshire has made good progress since the September 2012 inspection. I want to congratulate you and acknowledge the hard work of staff, leadership and partner organisations in bringing about this change...embedding and sustaining these improvements will require a continued sharp focus. I understand that these requirements are captured in your improvement plan and that you and children's services leadership and staff are dedicated to achieving 'good' or better for your provision'.

During 2015 – 16, the Service has consolidated its leadership through the appointment of permanent Heads of Service for Fieldwork and Looked After Children and a new permanent Assistant Director from January 2016. This has provided significant clarity and strategic focus, leading to a sharpening of expectations around the application of thresholds for social care intervention and greater consistency as to decision making.

### Social Care Workforce

There has been a significant increase in the percentage of permanent Social Workers in the establishment, building on the success of the Social Work Academy by increasing the number of Newly Qualified Social Workers joining the organization and reducing our agency dependency. There are currently 9.0 SW posts vacant and filled by agency staff therefore, albeit these posts are in the critical MASH and CiN areas of the service. A revised recruitment and retention strategy has been endorsed to ensure that the offer to new staff considering joining Herefordshire is both competitive financially, and critically offers a career development path with workers enabled to ensure their continuous professional development. The most significant challenge in recruitment terms has been to secure permanent team managers across our CiN service, where agency dependency continues currently.

During the course of 2015/16, there has been a strengthening of the quality assurance framework, in particular the development of an audit cycle and associated targeted improvement activity. A good example of the impact of this has been the continued concern as to the quality and consistency of reflective supervision being offered to social work staff, which has been identified. This has triggered a thematic audit of staff supervision records, a revision of our supervision policy and targeted training being delivered by the NSPCC in September 2016.

It is also gratifying to note that audit activity is reporting a much more consistently positive recognition of the voice of the child being listened to, recorded and impacting on plans, and indeed a growth in the number of commendations received where the work of social care staff has been positively praised or recognized.





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