Herefordshire Council

AGENDA

Health & Social Care Overview and Scrutiny Committee

Date:	**Tuesday 24 January 2017**
Time:	**9.30 am**
Place:	**Council Chamber, The Shire Hall, St. Peter's Square, Hereford, HR1 2HX**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Ruth Goldwater, Governance Services** Tel: 01432 260635 Email: councillorservices@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format, please call Ruth Goldwater, Governance Services on 01432 260635 or e-mail councillorservices@herefordshire.gov.uk in advance of the meeting.

Agenda for the meeting of the Health & Social Care Overview and Scrutiny Committee

Membership

Chairman	**Councillor PA Andrews**
Vice-Chairman	**Councillor J Stone**
	Councillor CR Butler
	Councillor ACR Chappell
	Councillor PE Crockett
	Councillor CA Gandy
	Councillor MD Lloyd-Hayes
	Councillor MT McEvilly
	Councillor GJ Powell
	Councillor A Seldon
	Councillor NE Shaw
	Councillor D Summers
	Councillor EJ Swinglehurst

AGENDA

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive details of any Members nominated to attend the meeting in place of a Member of the Committee.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interest by Members in respect of items on the Agenda.	
4.	**MINUTES** To approve and sign the minutes of the meeting held on 12 December 2016.	9 - 14
5.	**SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY** To consider suggestions from members of the public on issues the committee could scrutinise in the future. *(There will be no discussion of the issue at the time when the matter is raised. Consideration will be given to whether it should form part of the committee's work programme when compared with other competing priorities.)*	
6.	**QUESTIONS FROM THE PUBLIC** To note questions received from the public and the items to which they relate. *(Questions are welcomed for consideration at a scrutiny committee meeting so long as the question is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it* ***no later than two working days before the meeting*** *to the committee officer. This will help to ensure that an answer can be provided at the meeting).*	
7.	**HEREFORDSHIRE SAFEGUARDING CHILDREN BOARD (HSCB) ANNUAL REPORT 2015/16 AND BUSINESS PLAN 2016-18 / HEREFORDSHIRE SAFEGUARDING ADULT BOARD (HSAB) ANNUAL REPORT 2015/16 AND BUSINESS PLAN 2017-18** To provide an overview of performance of the Herefordshire safeguarding boards in order to provide assurance.	15 - 114

PUBLIC INFORMATION

Public Involvement at Scrutiny Committee Meetings

You can contact Councillors and Officers at any time about Scrutiny Committee matters and issues which you would like the Scrutiny Committee to investigate.

There are also two other ways in which you can directly contribute at Herefordshire Council's Scrutiny Committee meetings.

1. Identifying Areas for Scrutiny

At the meeting the Chairman will ask the members of the public present if they have any issues which they would like the Scrutiny Committee to investigate, however, there will be no discussion of the issue at the time when the matter is raised. Councillors will research the issue and consider whether it should form part of the Committee's work programme when compared with other competing priorities.

2. Questions from Members of the Public for Consideration at Scrutiny Committee Meetings and Participation at Meetings

You can submit a question for consideration at a Scrutiny Committee meeting so long as the question you are asking is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it **no later than two working days before the meeting** to the Committee Officer. This will help to ensure that an answer can be provided at the meeting. Contact details for the Committee Officer can be found on the front page of this agenda.

Generally, members of the public will also be able to contribute to the discussion at the meeting. This will be at the Chairman's discretion.

(Please note that the Scrutiny Committee is not able to discuss questions relating to personal or confidential issues.)

The Public's Rights to Information and Attendance at Meetings

YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.
- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.
- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.
- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage). Agenda can be found at www.herefordshire.gov.uk/meetings
- Please note that filming, photography and recording of meetings is permitted provided that it does not disrupt the business of the meeting.
- The reporting of meetings is subject to the law and it is the responsibility of those doing the reporting to ensure that they comply.
- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

HEREFORDSHIRE COUNCIL

SHIRE HALL, ST PETER'S SQUARE, HEREFORD, HR1 2HX.

FIRE AND EMERGENCY EVACUATION PROCEDURE

In the event of a fire or emergency the alarm bell will ring continuously.

You should vacate the building in an orderly manner through the nearest available fire exit.

You should then proceed to the Assembly Point which is located in the car park at the front of the building. A check will be undertaken to ensure that those recorded as present have vacated the building following which further instructions will be given.

Please do not allow any items of clothing, etc. to obstruct any of the exits.

Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health & Social Care Overview and Scrutiny Committee held at Council Chamber, The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 12 December 2016 at 2.00 pm

Present: **Councillor PA Andrews (Chairman)**
Councillor J Stone (Vice Chairman)

Councillors: CR Butler, ACR Chappell, PE Crockett, CA Gandy, MT McEvilly, GJ Powell, A Seldon, NE Shaw, D Summers and EJ Swinglehurst

Officers: **Jo Davidson, Simon Hairsnape (NHS Herefordshire CCG), Jane Ives (Wye Valley NHS Trust), Anne Owen (NHS Herefordshire CCG), Martin Samuels, Lesley Woakes (NHS Herefordshire CCG),**

119. APOLOGIES FOR ABSENCE

None received.

120. NAMED SUBSTITUTES (IF ANY)

None.

121. DECLARATIONS OF INTEREST

Cllr PE Crockett declared a disclosable pecuniary interest in item 7 as an employee of Wye Valley NHS Trust.

122. MINUTES

RESOLVED
That the minutes of the meeting held on 14 November 2016 be approved as a correct record and signed by the chairman.

123. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

None received.

124. QUESTIONS FROM THE PUBLIC

None received.

125. WYE VALLEY NHS TRUST CARE QUALITY COMMISSION (CQC) INSPECTION

Councillor PE Crockett left the meeting for this item having declared a disclosable pecuniary interest as an employee of Wye Valley NHS Trust.

The interim director of nursing, NHS Herefordshire Clinical Commissioning Group (CCG), introduced the item and explained that CCG had been working with NHS Improvement to ensure there were plans in place following the previous inspection of

Wye Valley NHS Trust (WVT). There was close working with WVT's plan to ensure continued improvement.

The managing director, Wye Valley NHS Trust, gave a presentation which highlighted the following points:

- this was the second inspection of WVT by the Care Quality Commission (CQC), the first of which took place in January 2016 with a finding of Inadequate;
- WVT had joined up with South Warwickshire NHS Foundation Trust (SWFT) to share good practice;
- the hospital and the community services gave a good impression, although it had subsequently become clear that the level of focus that WVT had devoted to the CQC inspection appeared to have distracted the organisation from robust financial management, and so the scale of the challenge was to reduce overspending by almost a half;
- management was working on agreed priorities and taking these forward;
- SWFT was a stable organisation as a result of redesign and integration of acute services, supported by collective experience and expertise, and so the intention was to draw on this expertise to support improvement by WVT;
- there was a 10-point plan, focusing on developing A&E safety and quality to bring it in line with the standards of the national A&E plan. SWFT was one of a small number of trusts nationally currently meeting this standard;
- community redesign was key to improvement, with well integrated pathways and the right capacity to meet demand for services, such as caring for people at home;
- there was close working with the council to take out duplicated processes and aligning community services

In response to a number of members' questions regarding waiting times performance, the managing director explained that some waiting times had built up, and it was necessary to address some backlogs. She recognised that this could take at least a year to resolve and that in order to meet certain targets, it was necessary to refer people to other centres. An impact of the waiting lists was that some pre-operation assessments were repeated to ensure they were up to date.

A member asked if it was a condition of special measures for WVT to form a relationship with SWFT. The managing director clarified that the relationship between WVT and SWFT was in order to ensure a positive journey towards improvement and avoiding a return to special measures. In terms of financial assurance, the two trusts were believed to have a similar demographic with significant rurality and an urban district general hospital. SWFT remained in balance, with a small surplus and there was confidence in maintaining a good level of service to South Warwickshire residents. It was possible to turn around the finances in Herefordshire but there were challenges around tariffs, which would not be achieved quickly. However, the aim was to reduce the deficit significantly within two years, although any financial intervention was for NHS England, rather than SWFT, to consider.

In answer to a question from the chairman regarding community hospitals and difficulties regarding organising home care, the managing director acknowledged that outcomes were better for people when cared for at home compared with remaining in hospital.

A member asked about bed-blocking and cross-border protocols with Wales. The managing director confirmed that there were some difficulties with discharging patients, which it was hoped would improve following work with Shropshire and Powys. Many patients could be cared for at home but the resources were currently hospital based, and this needed addressing, noting that the quality of primary care in the county was good and so local resources could be developed.

The vice-chairman observed that, as there was a high proportion of older people in Herefordshire, consideration needed to be given to complex needs of people presenting to A&E.
The managing director confirmed that the age profile was similar to south Warwickshire, although it was slightly older in Herefordshire. Outpatient waiting times were too high and needed addressing, which could be achieved through the skill mix of staff and building capacity.

It was envisaged that in quarter one of next year, it should be possible to have a financial plan. It was comparatively more expensive in Herefordshire to provide some services, such as orthopaedics, which currently was operating at a net cost to the trust. It was necessary to address patient flows to support elective work and 7-day services, and there were more efficient ways of providing services such as outpatient prescriptions.

A member noted recent news coverage about reducing agency staff, and commented that South Warwickshire and Herefordshire were not as alike as it might be thought, as Herefordshire was more rural and had a smaller population, and it was essential to recognise difficulties in getting younger workers to come to the county who were put off by its limited infrastructure and facilities. Whilst it was a good aspiration to reduce agency staff, this would not be easy.

The managing director believed that recruitment and retention could be addressed by nurturing the workforce and by providing good training and opportunities. It was essential to let people know that it could be good to work in the county and have professional and fulfilling careers. There was more to be done although this might take some time to see the results. It was not envisaged that the implications of nursing bursaries, such as graduating with debt, would have an adverse effect on recruitment as the use of bursaries meant that the number of training places had previously been capped and there had already been some recruitment into a number of specialties.

A member commented on the sustainability and transformation plan which showed a slight increase in the number of hospital beds and a reduction in community beds, and that in order to achieve aspirations to get WVT into sustainable financial position, it would accelerate the volume of discharges, such that there was a risk that the system would not be able to cope with the additional demand. The only options on discharge then would be to go home or to go a care home, which was expensive and needed funding. The situation was unsustainable and there was a question over whether SWFT has unrealistic aspirations.

In response, the managing director explained that it was about reducing whole system's costs and working together to avoid duplication. The ambition was to keep people at home whilst achieving financial balance for both health and social care.

The director for adults and wellbeing added that Herefordshire was comparatively lower than neighbours in placement rates for older people and that it was not the intention to discharge people unnecessarily, however, being in hospital reduced a person's ability to care for themselves and so they would be discharged as soon as possible when medically fit. Guidance was awaited on the better care fund, but there was opportunity to take services forward through this scheme in an integrated manner.

A member noted that the mantra of people needing to look after themselves was well used, and the success of earlier work had not been fully realised, such as falls prevention, and so the concept of self-care and prevention needed attention.
It was noted that there was much work to be brought together on this, such as development of frailty pathways. The chairman commented on an increasing

dependence on the voluntary sector, making the observation that many volunteers are elderly themselves and would not be able to take on what was expected of them.

Commenting on experience of previous public consultations, a member highlighted the importance of members having access to plans in writing in order to see the details to be able to explain them clearly to their constituents. It was also noted that there needed to be greater connection to management and for there to be sound and stable leadership in order to effect change. There was a well-established leadership within SWFT.

The chairman asked about practicalities for SWFT with the STP footprint being across Herefordshire and Worcestershire. The managing director confirmed that SWFT was committed to the STP footprint and ensuring the clinical network was robust. She added that it might be beneficial to spread services across a wider area but it was important to have services in Herefordshire. Some service models might need reviewing but there was no proposal to move services. In addition, the financial trajectory needed agreeing with NHS England.

The managing director provided assurance that SWFT's role was to help and support and to make things better. There were no plans to merge the two organisations, although there was some value in exploring corporate and back office functions sharing expertise. A member asked for details on costs for discharge pathways, commenting on ensuring they are appropriate. It was clarified that the typical cost was in the region of £2300 per week for hospital care, compared with around £150 for care at home. Experience in South Warwickshire showed that changes to discharge pathways allowed throughput to be quadrupled.

The vice-chairman added that Herefordshire's hospital services were better than might be believed, and asked what improvements could be committed to within 12 months. The managing director identified that enhanced out of hospital services would be delivered and services would feel different to the public. A member added that it was essential to engage carers at home to ensure continuity of care after discharge, but it was also important to note that pre-admission fitness was a factor in recovery time.

RESOLVED

That an update be provided to the committee in March 2017.

126. ENGAGEMENT AND CONSULTATION PROCESS FOR THE REDESIGN OF PRIMARY CARE SERVICES IN HEREFORDSHIRE

The director of primary care, NHS Herefordshire Clinical Commissioning Group (CCG), explained that the CCG's governing body was preparing to engage and consult with patients, public and wider stakeholders on the delivery of 7-day primary care medical services in Herefordshire.

Views on the redesign of the urgent care pathway had been sought and the key message was that a more streamlined pathway into care was required. There were 24 GP practices in the county plus 3 hubs provided by Taurus, and an out of hours service. There was an opportunity for redesign for a number of reasons:

- a pilot for 7-day Taurus hub pilots was coming to an end;
- funding was transferring to the CCG in April 2017;
- a new out of hours provider was in place under a new contract from November.

A timeline for the consultation process was set out, to March 2017.

The proposal centred around moving a GP practice into the walk-in centre space at Asda giving full access to primary care till 8pm, and to provide planned care through a Taurus

hub in the same facility. It also recognised that there was a need for increased primary care access in South Wye to serve an increased population.

A member commented that the current walk-in centre operated from 8am until 8pm and is used by people from all areas, not just South Wye, and gave encouragement for early consultation with community leaders. He made the point that people would not expect to have to make a 'phone call to be directed to that centre because they were used to going straight there without an appointment.

The chairman noted that there were few GP practices south of the river, and asked if the proposals meant that people outside the area would be excluded from access.
The director explained that people could go to any practice but it was necessary to tailor the primary care and to support the population that is there.

The chairman commented further that altering access to the walk-in centre would be a sensitive issue. It was noted that the service would be extended to provide planned care and walk-in facilities, along with signposting.

A member suggested that the overall object would seem to be to stop people accessing A&E inappropriately in order to take some pressure off that service, and it was not clear how successful that had been so far. It was a challenge to educate and change peoples' mind-set from making 999 calls. The director concurred that this was part of the driver for change and a consistent message was needed. Patients would be able to phone and be seen through triage and may be directed to other support such as pharmacy or nursing care, with the emphasis on clinical need.

Referring to the report, a member asked for clarification on what the end offer would look like, and the impact on minor injury units around the county. It was important to ensure the consultation was county-wide and to be clear about what was proposed in order to have meaningful consultation responses at the end of the process.

The director clarified that the consultation document was in development and more detail would be available in January. She added that the CCG had applied for support from NHS England to develop estates, technology and transformation for the development of a city hub and to develop health and wellbeing hubs. The timing was critical to align with community hospitals and the fast pace was driven by other factors in the system, so opinions were sought as early as possible.

Members identified a number of groups to include in the consultation:

- parish councils;
- community groups;
- Welsh communities who accessed Herefordshire services as these were closer;
- South Wye family centres, schools and the women's refuge

The chairman commented that more time was needed for meaningful consultation and asked about the timing for consultation with walk-in centre users. The director outlined that there would be consultation within the centre supported by a questionnaire.

The CCG accountable officer acknowledged that there was limited timing for consultation opportunities, not least because of the timing of contracts.

The vice-chairman noted the sentiments expressed regarding South Wye, which resonated with the value placed upon the community hospital by people in Leominster, where there were real examples of how the hospital had aided convalescence and avoided bed blocking in Hereford.

In answer to a question from the chairman regarding the GP hub, the director explained that the proposal was for three city practices to be relocated as one sustainable practice. There were recruitment difficulties in general practice and so it was expected that the hub and spoke model would support GPs to ensure that patients were served appropriately.

The CCG accountable officer explained that the consultation would inform and provide details for what was currently a broad proposal.

RESOLVED
That

a) **the proposal and process be noted;**
b) **the committee's suggestions regarding the consultation process as identified be taken into account; and**
c) **the matter be brought back to the committee in the new year with further detail.**

The meeting ended at 4.06 pm **CHAIRMAN**

Meeting:	Health and social care overview and scrutiny committee
Meeting date:	24 January 2017
Title of report:	Herefordshire Safeguarding Children Board (HSCB) annual report 2015/16 and business plan 2016-18 Herefordshire Safeguarding Adult Board (HSAB) annual report 2015/16 and business plan 2017-18
Report by:	Business manager, Herefordshire Safeguarding Boards and Community Safety Partnership

Classification

Open

Key decision

This is not an executive decision.

Wards affected

Countywide

Purpose

To provide an overview of performance of the Herefordshire safeguarding boards in order to provide assurance.

Recommendation(s)

THAT:

(a) the performance of the safeguarding boards be reviewed;

(b) the committee determine any recommendations it wishes to make to the boards to consider in order to secure improved performance; and

(c) any areas for further scrutiny be identified for inclusion in the committee's work programme

Alternative options

1 There are no alternative options as this is an opportunity for scrutiny to review and challenge the performance of the safeguarding boards.

Reasons for recommendations

2 To allow the committee to undertake effective scrutiny of the council's statutory functions in relation to safeguarding.

3 Key considerations

1. The information provided below in relation to the two safeguarding boards' annual reports should be considered within the context of safeguarding within Herefordshire.

2. From a children and young person's perspective the impression can be one, influenced perhaps by ongoing national coverage, that abuse is perpetrated by 'strangers', or is historic in nature. Although this is correct to an extent, the reality both in Herefordshire and elsewhere is that it is very much a current and ongoing problem, and that the vast majority of child protection issues happen within the family, and in the child's home. It is also important to recognise that the abuse can take many forms. It is not only physical and sexual abuse that the board and agencies seek to protect children from; emotional abuse and serious neglect is a very real problem in the county, as it is across the country. These forms of abuse can provide particular challenges for professionals to recognise, respond to and deal with, but can be as damaging to the child or young person's long term health and wellbeing as better recognised and understood forms of abuse. It is of note that emotional abuse and neglect are the main reasons for children being made the subject of a child protection plan. Additionally, children and young people find themselves increasingly exposed to, and at risk from, harmful individuals and material as a result of the accessibility of the internet and social media at a younger and younger age. This undoubtedly is contributing to the increase in the number of children at risk of child sexual exploitation being identified in Herefordshire.

3. From an adult perspective, the introduction of the Care Act 2014 has necessitated a new approach to working with adults at risk, with professionals having to balance the need to protect vulnerable people with the recognition that individuals are entitled to make unwise choices. The Act has also placed domestic abuse firmly as a safeguarding matter. Financial abuse is an ongoing risk to our more vulnerable Herefordshire residents particularly the elderly, and with an increasingly elderly population the challenges for partners involved in keeping residents safe from such abuse is likely to grow. In addition to these types of abuse which we know take place within the county, emerging threats such as modern slavery require a co-ordinated and multi-agency response, and these threats are particularly prevalent in areas with significant numbers of migrant workers, such as Herefordshire.

4. The work of both boards is a critical element of the ongoing challenge to keep the most vulnerable members of our Herefordshire communities safe from harm. It is well known to both the boards and the various partner agencies involved in the safeguarding of these children, young people and vulnerable adults that a number do regrettably come to serious harm. As such the importance of effective boards and the effective coordination of high quality services, as reflected in the annual reports should be recognised.

HSCB annual report 2015/16

5. The HSCB annual report details a number of developments in 2015/16 within the priorities set for that period. Key developments, impact and continuing areas for development are detailed below.

6. Priority 1 – HSCB is a truly effective agent for change and has a real impact for children and young people.

   Assessment – Mainly achieved, with effective delivery of multi-agency training the ongoing area of work.

7. During the year HSCB established a child sexual exploitation (CSE) sub-group in order to drive improvements in our collective response to this threat within Herefordshire. Further details of this work are provided below.

8. The performance information and quality assurance processes established by the board have been used directly to highlight areas for improvement then drive change which delivers better outcomes for children. An example of this was in relation to the high level of children on child protection plans. In response to this the board commissioned work which challenged decision making, the planning and review process and the effectiveness of the planning. This has led directly to a reduction in the number of children on such plans, a greater focus on early help and intervention for the child or young person, and greater opportunity to give the appropriate attention to those at greatest risk in order to keep them safe. There is however recognition that work remains within this area, and this is reflected in the 2016/18 priorities (see below).

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

   Assessment – Steady progress, but with areas for improvement remaining, particularly in relation to children who go missing, and appropriate support for those who have been subject of CSE.

10. This has led directly to clear pathways, guidance and tools to support recognition, referral and response to CSE. Extensive work has taken place over the year to raise awareness of CSE, including a multi-agency conference in March 2016, close work with the licencing authorities, and delivering key messages to children and young people. This has in turn led to an increase in the identification of cases. Further, as a result of challenge from the board, parents and children are more involved in the development of plans to keep them safe when risk is identified. The Board recognises that there remain areas for improvement in relation to our response to CSE in Herefordshire, for example to ensure return home interviews of missing children are of good quality, and children who have experienced CSE receive appropriate post abuse support, and as such it continues to be a priority area for the Board in 2016/18.

11. Priority 3 – To support increased resilience in individuals, families and communities.

    Assessment – Some progress. Future focus must now be on the early help services effectively identifying needs and concerns relating to children and families, and services then address those needs through effective planning and interventions.

12. 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.

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

14. 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.

15. Our plan for the year 2015-16 set out some key areas for improvement, for example a reduction in referral and re-referral rates to children's social care. Whilst re-referrals have reduced compared with the previous year, indicating positive outcomes for children following first referral, they are still high and focus will remain on this area. Specifically HSCB will be working to ensure that effective decision making is taking place at the early stage of identification of needs.

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

Assessment – Some progress, with continuing area of focus being the quality and effectiveness of decision making and partnership engagement within the child protection process, and that the needs of children and young people are identified and addressed earlier, to prevent them being drawn into the child protection system.

17. Details of HSCB scrutiny of a particular aspect of the child protection process has been provided above, and 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 continue to scrutinise this area and this will include Board members observing child protection conferences to establish the quality of multi-agency working to safeguard children.

18. 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.

19. Additionally, members will note the inclusion of the voice of children and young people within the annual report, and the HSCB is committed to ensuring this is at the centre of understanding the effectiveness of multi-agency safeguarding in the county.

Priorities for 2016/18

20. Reflecting on the achievements through 2015-16, and considering data and other evidence alongside the need to ensure continuous improvement, the HSCB has set four priorities for 2016-18. These priorities will ensure focus is maintained on the key areas identified in order to ensure children and young people in Herefordshire are and remain safe, and are detailed below.

- The Board will continue to seek to ensure best practice in recognising and responding to CSE, expecting good intelligence reporting to allow disruption of CSE activity, and that practitioners utilise the guidance and tools available to help recognise and respond to CSE concerns.

- The board will concentrate on the child's journey through the child protection process, to seek assurance that effective planning and intervention takes place with children and families to reduce risk. This will be considered alongside early help services and checking that help and support is continuous through "step up" and "step down" services.

- Linked to this the HSCB will be looking in 2016/17 at the early help offer in Herefordshire, that needs are identified and effectively responded to.

- A further area of priority focus in 2016/17 will be the issue of childhood neglect, and ensuring there is an effective multi-agency childhood neglect strategy in place.

21 As can be seen from the above priorities there are a number of areas of shared focus within the priorities of both the Safeguarding Children Board and Health and Wellbeing Board. Sexual Violence against women is a special consideration (Priority 6) of the Herefordshire Health and Wellbeing Strategy, which correlates with the CSE priority of the HSCB. 'Children Starting Well' is a priority (Priority 2) within the Health and Wellbeing Strategy, which supports the Early Help linked priorities of the Children's Board. Finally, tackling the issues of mental health and wellbeing (Priority 1), domestic abuse and people with disabilities and those living in poverty within special considerations (Priority 6), impact of housing (Priority 4) and alcohol abuse (Priority 7) all contribute to reducing the risk factors that can lead to childhood neglect, so supporting the associated Children's Board priority on this subject.

22 The HSCB Business Plan (attached) defines the activity to be completed during 2016/18 in order to deliver the Board's priorities. The delivery of the business plan is supported by work plans developed and owned by each of the sub groups of the HSCB.

HSAB annual report 2015/16

23 HSAB identified four priorities for the 2015/16 period. These priorities, together with examples of progress made against them and continuing areas for development are detailed below.

24 Priority 1 - Partnership working

a. Assessment – Steady progress since the Adult Safeguarding Board was placed on a statutory footing in April 2015, with future focus being on embedding the engagement of all partner agencies within Herefordshire with the Board, and promoting the importance of the adult safeguarding agenda amongst all partners.

25 This period saw adult safeguarding boards placed on a statutory footing for the first time. HSAB took this opportunity to review its meeting structure, streamline membership, and reduce meeting frequency in order to allow greater time to be spent by partners on making meaningful progress against the priorities set.

26 Herefordshire Council, in conjunction with NHS Herefordshire Clinical Commissioning Group (CCG), Police, Healthwatch and the Care Quality Commission (CQC), has introduced a new approach to the quality assurance of care and support services

offered in the county. The new quality assurance framework is designed to ensure that local services provide the appropriate care and support that individual adult's need. Continued work is now required to embed that assurance framework.

27 Priority 2 - Prevention and protection

a. Assessment – Steady progress, with the need to place further emphasis on preventing abuse across the county.

28 The structure and response of the advice and referral team has been reviewed, and there has been great emphasis on the promotion of 'making safeguarding personal' and the new deprivation of liberty standards within our workforce (further details below).

29 The work of the board and partner agencies within Herefordshire can be seen to be improving the proportion of those people who use services and feel safe and secure as a result. A government commissioned national survey showed that in Herefordshire this proportion rose from 83.90 per cent in 2014/15 to 88.00 per cent in 2015/16, which provides positive evidence of the impact of the changes being implemented.

30 Priority 3 - Communications and engagement

a. Assessment – Some progress, evidenced by the work detailed below, further work remains in relation to ensuring that we are consistently capturing the voice of the service user, and that others fully understand the work of the board.

31 The board has worked with other boards in the region to develop shared safeguarding policies and procedures. These have been adopted by the board and shared with providers and partners in order to promote a shared and consistent approach to safeguarding across Herefordshire.

32 The board has supported work to raise awareness and understanding of the law relating to mental capacity and deprivation of liberty. This has impacted significantly on the number of requests for assessment, with an increase seen, so ensuring those who most need assessment and advocacy now have access to them.

33 In February 2016 a joint communications group was established across HSAB, HSCB and the Herefordshire Community Safety Partnership. It is important that we now develop this group to ensure a co-ordinated and effective approach to our communications across the three partnerships.

34 Priority 4 - Operational effectiveness

a. Assessment – Steady progress, with a particular area for future work being to embed the 'making safeguarding personal' approach across Herefordshire to the extent it has been achieved by the local authority, supported by the development of multi-agency training for adult safeguarding.

35 During 2015/16 HSAB gave particular focus to making safeguarding personal (MSP), this being the process by which we put the adult at the centre of our work. This included the council launching an intensive training programme for staff. A review of the impact of this work conducted in April 2016 identified that as a result there was an increased proportion of service users and their representatives whose views had been sought and considered in relation to the outcomes they wanted from the

safeguarding process, and then asked at the end of the process whether they felt those outcomes had been met. This is very positive, but the board recognises that this review also showed there is further room for improvement, and as such this will remain a priority area.

36 In 2016/17 the HSAB has continued to prioritise the following areas:

- Effectiveness of partnership working (particularly promoting a shared and universal understanding of safeguarding, increased involvement of the voluntary sector, sharing the correct data, and connectedness with other boards)
- Prevention of harm and protection (particularly service user involvement, good mental health and greater focus on prevention)
- Increased communication and engagement of public and professionals (particularly understanding the work of the board, reaching out to smaller and community organisations, and continued focus on Mental Capacity Act and deprivation of liberty standards)
- Operational effectiveness (particularly challenging single agency issues, shared learning, links in commissioning and public health, embedding the competency framework and developing multi agency training).

37 These priorities were reviewed in December 2016 and will remain unchanged for 2017/18.

38 The HSAB annual report sets out work plans to deliver on the priority areas.

39 As with the priorities for the Children's Board, there is overlap within the priorities of both the Adult Safeguarding Board and Health and Wellbeing Board. The 'prevention and protection' priority for HSAB is very much supported by the focus of the Health and Wellbeing Board on the quality of life, social isolation and fuel poverty affecting older people (Priority 3) and long term conditions and lifestyles (Priority 5). Domestic abuse is an adult safeguarding matter, and is recognised as a special consideration for the Health and Wellbeing Board (Priority 6). The Health and Wellbeing Board is also committed to supporting carers who in turn support vulnerable adults, so contributing to keeping them safe and preventing abuse.

40 The HSAB business plan is contained within the annual report. However this plan has recently been reviewed and the proposed updated plan is attached as a separate document. This plan currently remains in draft form as community consultation is still to take place in relation to this latest iteration.

Community impact

41 The partners represented on the boards have statutory responsibilities for services in Herefordshire that safeguard and promote the wellbeing of children, young people and vulnerable adults. The boards have a statutory duty to scrutinise, challenge and support this work. The HSCB and HSAB are key mechanisms for challenge, supporting and promoting improvement of these services within the authority. The annual reports and priorities not only identify areas of safeguarding that require sustained focus and improvement, but also complement and support the work of the other partnerships in Herefordshire such as the Children and Young Persons Partnership focus on early help, neglect and safeguarding, and the Community Safety Partnership's focus on domestic abuse.

Equality duty

42 The safeguarding boards pay due regard to The equality duty on public bodies and others carrying out public functions, specifically that public bodies consider the needs of all individuals in their day to day work. This is particularly evident for example through the work of HSAB in embedding the ‘making safeguarding personal’ approach within Herefordshire, so tailoring the service delivered to the individual’s particular wants and needs, and ensuring that the voice of the adult informs decisions. A similar example within the HSCB is that there is a particular emphasis on ensuring that the child and parent(s) have the appropriate opportunity to express their views within child protection conferences so their needs can be fully considered within the decision making.

Financial implications

43 The safeguarding boards receive contributions from partner agencies to fund the organisation and work of the boards. A budget is set out and reviewed throughout the year and any risks identified.

Legal implications

44 The statutory functions of the safeguarding boards are found under the 1989 and 2004 Children Acts. There should be a clear framework to allow the HSCB to monitor the effectiveness of local services.

45 Section 13 of the Children Act 2004 requires each local authority area to establish a safeguarding board and specifies who should be represented on the board.

46 The statutory objectives and functions of the HSCB as set out in Section 14 of the Children Act 2004 are:

- To coordinate 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
- To ensure the effectiveness of what is done by each such person or body for those purposes

47 Regulation 5 of the LSCB Regulations 2006 sets out the functions of the Safeguarding Boards in relation to the above objectives.

48 Each local authority must establish a safeguarding adults board. The board has three core duties:

- To develop and publish a strategic plan;
- To provide an annual report of how effective the local services have been; and
- Commission safeguarding adults reviews (SARS).

49 Under statutory guidance each of the safeguarding boards has a duty to produce annual reports on the effectiveness of safeguarding children and adults respectively in the area. The reports should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should also identify weaknesses, causes of these and action to be taken to address them.

Risk management

50 There are a number of identifiable risks associated with a reduction in the effectiveness of either or both boards. Both boards have a statutory responsibility to ensure the effectiveness of safeguarding arrangements within Herefordshire. Ineffective safeguarding arrangements directly increase risk to the most vulnerable members of our community; this risk being both high in probability and impact on individuals, evident from previous high profile cases in other areas, which in turn carries legal, political, reputational and financial risks to the partner agencies involved.

51 The current identifiable risks to the effectiveness of the boards are the ongoing threat to the appropriate resourcing of the boards' work inherent in the financial challenges facing the contributing partners, organisational changes within partner agencies which can on occasions also be linked to those ongoing budget reductions, partners disengaging from the work of the boards as a result of reduced management resilience within their own agencies, uncertainty of future board structure and role as a result of ongoing reviews and scrutiny (for example the recent Wood report on safeguarding children boards) and increased demand for safeguarding services through greater awareness of safeguarding and increased public confidence to report.

52 The two boards and the Community Safety Partnership run a joint risk register in order to monitor and manage these risks where appropriate, and this is subject to regular review.

Consultees

None

Appendices

Appendix 1 – HSCB Annual Report 2015/16

Appendix 2 – HSAB Annual Report 2015/16

Appendix 3 – HSCB Business Plan 2016/18

Appendix 4 – HSAB Business Plan 2015/18

Background papers

- None identified.

Herefordshire Safeguarding Children Board

Annual Report - 1 April 2015 – 31 March 2016

Contents

Section		Page
1.	Foreword from the Independent Chair	3
2.	About this report	4
3.	Executive Summary	5
4.	The local context	12
5.	Progress on priorities 2015-16	12
a.	Priority 1: HSCB is a truly effective agent for change that has a real impact for children and young people	13
b.	Priority 2: To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people	13
c.	Priority 3: To support increased resilience in individuals, families and communities	16
d.	Priority 4: To safeguard and promote the welfare of children and young people who are abused and/or neglected	19
6.	How the HSCB has carried out its statutory functions	22
a.	Policies, procedures, practice guidance	22
b.	Training, single and multi-agency, including practitioner forums	23
c.	Children in Care	24
d.	Allegations concerning persons who work with children	27
e.	Private Fostering	28
f.	Case Reviews	28
g.	Child Death Overview Panel	29
7.	Effectiveness of agency safeguarding arrangements in Herefordshire	30
8.	Development of HSCB and its effectiveness 2015-16	31
9.	Conclusion and future priorities	33

Appendix 1	Attendance of agencies at HSCB Board meetings	35
Appendix 2	Partnership boards budget	36
Appendix 3	Children exposed to domestic abuse	37
Appendix 4	Number of children and young people involved with children's domestic abuse advisers	38
Appendix 5	PEEPS training (definition)	39
Appendix 6	Single agency assurance reporting	40
a.	West Mercia Police	40
b.	National Probation Service	41
c.	Community Rehabilitation Company	42
d.	West Mercia Youth Offending Service	43
e.	Herefordshire Clinical Commissioning Group	44
f.	2gether NHS Foundation Trust	44
g.	Wye Valley NHS Foundation Trust	45
h.	Education and schools	46
i.	Herefordshire Council: Children's Wellbeing Services	47

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

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.

Authors: Sally Halls – HSCB Independent Chair & Bill Joyce, Interim Business Unit Manager
Date of Publication: September 2016
This report can be downloaded from the HSCB website at: www.herefordshiresafeguardingchildrenboard.org.uk
Herefordshire Safeguarding Children Board
Council Offices
Plough Lane
Hereford
HR4 0LE
Alternatively you can e-mail us on admin.hscb@herefordshire.gov.uk or call us on 01432 260100.

3. Executive Summary

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.

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 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	Impact
Improving identification of and response to CSE.	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.
Improved consistency and quality of "front door" services.	MASH Governance Group established. Clarification of agencies responsibilities in the MASH. Continued identification of areas for improvement (deep dive analysis commissioned).
Improving the "step down" process so it works better for children.	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.
Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.	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.
Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.	HSCB has included this in all Board meetings, sources of voice of the child are illustrated in this report.
Audit of CSE cases to assist in improving identification & response to CSE.	Development of the work of the Operational Group to identify themes and factors relating to CSE to support disruption activity.
Increasing the pace of the development of the early help offer in Herefordshire.	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

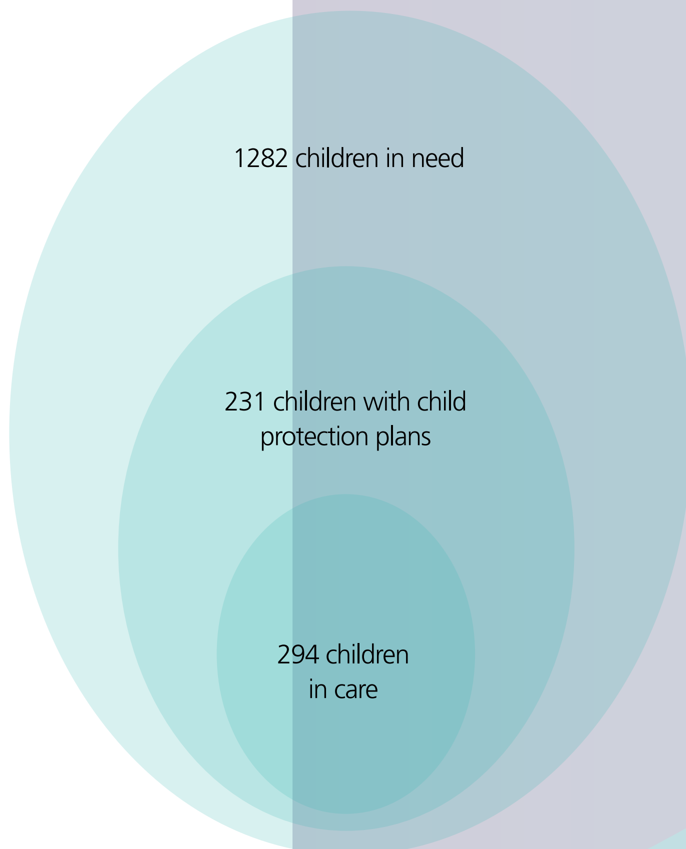
The latest (mid-2014) estimate of **Herefordshire's resident population is 187,200**; 0.6 per cent higher than the year before.

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"

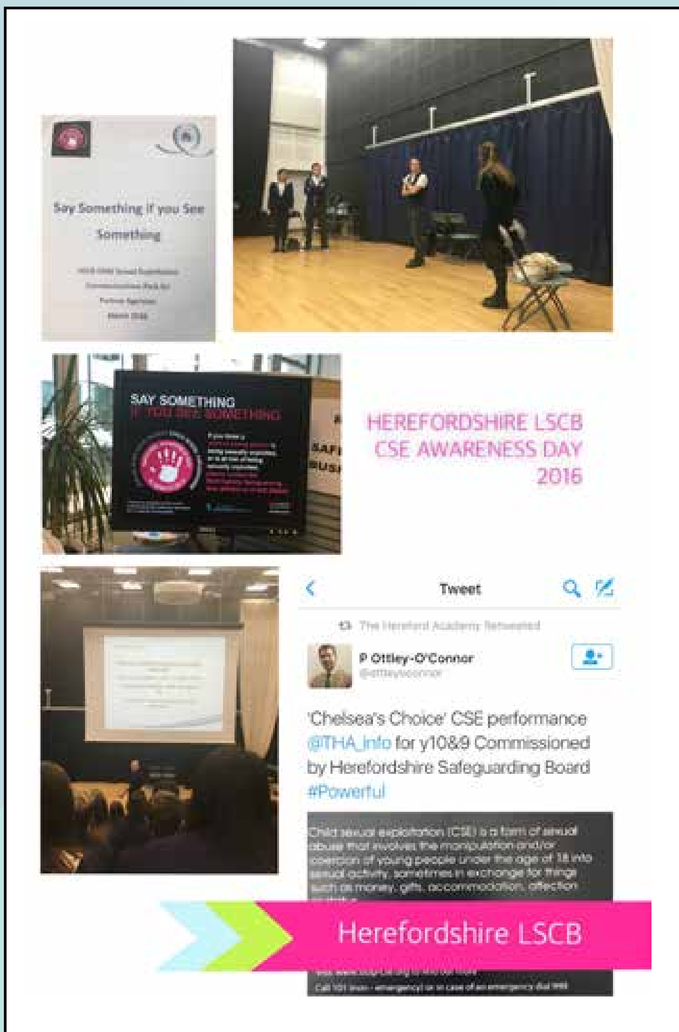
"This covered a lot of detail about different aspects of exploitation and grooming. As its true, it kind of makes you think this can actually happen"

"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.

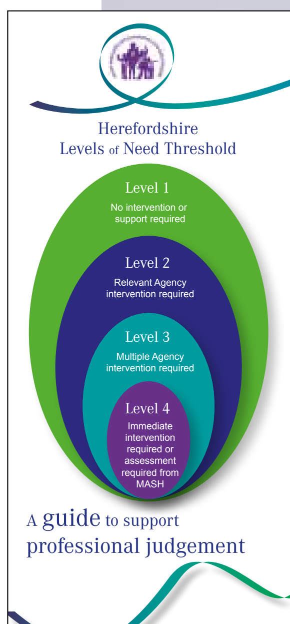
Priority 3: To support increased resilience in individuals, families and communities.

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.

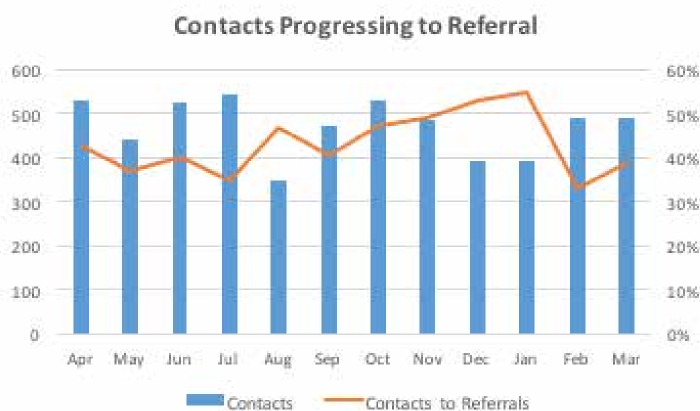
HSCB will continue to receive reports on the prevalence of domestic abuse in cases involving children, review the quality and availability of services designed to reduce the risk of harm to children and address the impact of domestic abuse. The Board will also want to see increased availability and use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

What we have learned and what difference we have made

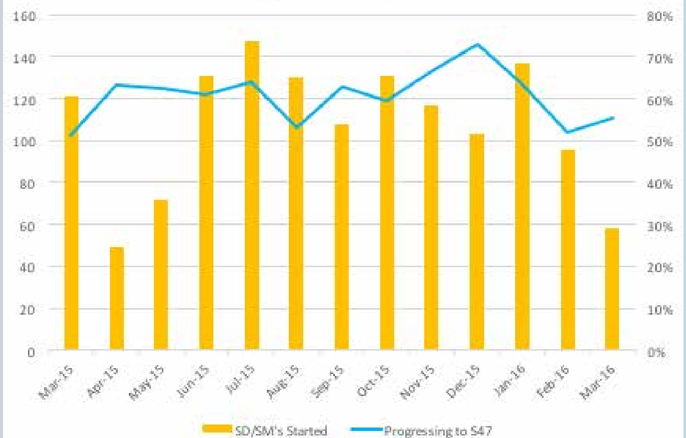
Our plan for the year 2015-16 set out some key areas where we wanted to see improvements:

- 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.



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 issue 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
Emotional Abuse	96 (49%)	122 (50%)	152 (55%)	136 (59%)
Multiple Abuse	0 (0%)	0 (0%)	1 (0%)	0 (0%)
Neglect	71 (37%)	85 (35%)	83 (30%)	71 (31%)
Physical Abuse	11 (6%)	13 (5%)	18 (7%)	12 (5%)
Sexual Abuse	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/ section47 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 this what I want

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 given really informative and useful and will continue to use the book. [name] was brilliant and someone that I felt 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 Triple P parenting 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	✓				
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	✓				

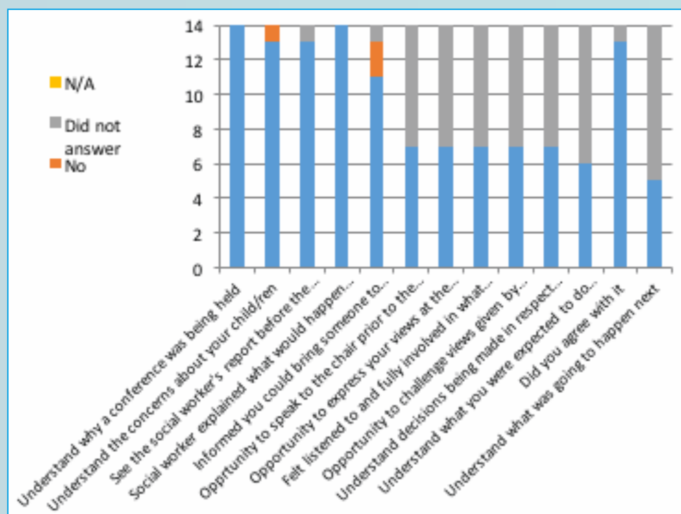
4. Which areas did you and the support worker focus on?

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

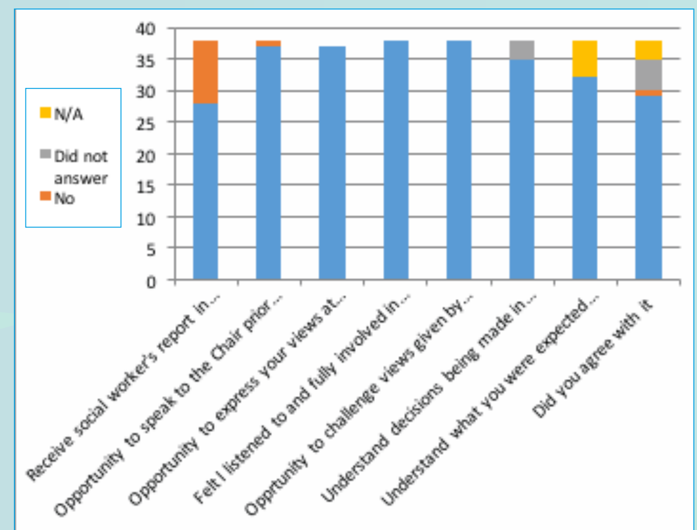
5. Which of these areas did you feel that the support worker was most helpful with and why?
parenting - helped me learn and develop more as a dad

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 practioners, and to receive feedback so that the voice of the practitioner is taken into account in the work of the HSCB

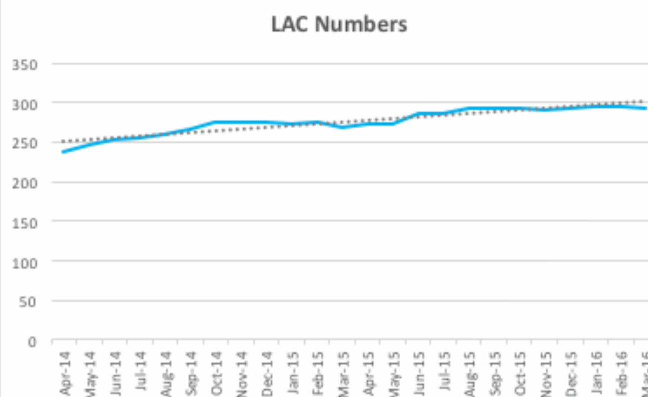
A number of these forums have been run jointly with the Adult Safeguarding Board. Topics have included:

- 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.



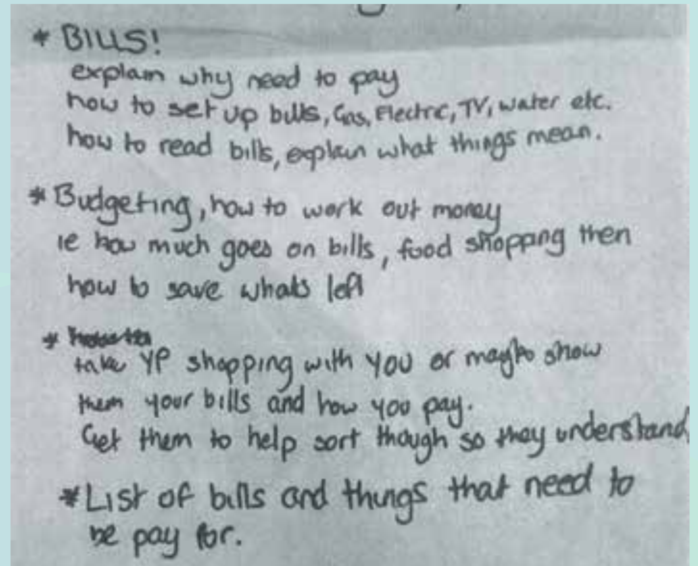
In terms of placement stability there is a positive picture, with only 2.4% of children in care having experienced three or more placements.

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 are 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.

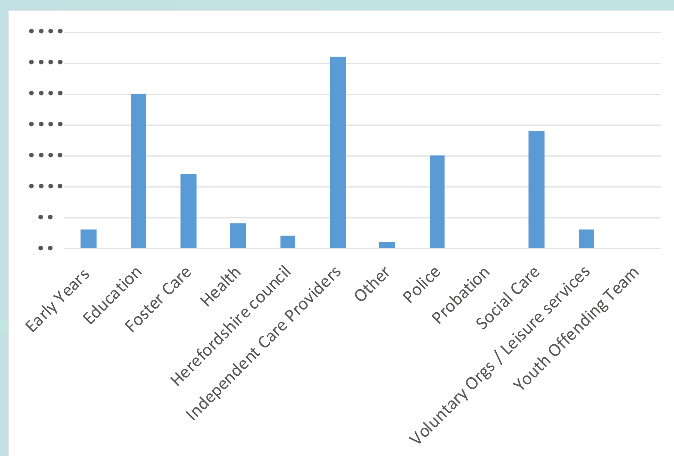
The duties of the LADO in relation to managing allegations are to:

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

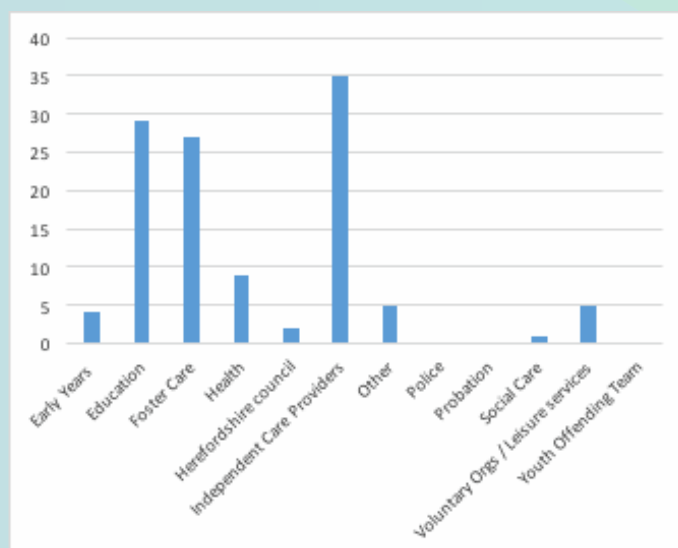
Between 1st April 2015 and 31st March 2016 a total of 117 allegations against professionals were managed by the LADO, compared to 175 in 2014/15. Although this suggests a downward trend, figures for the preceding six years show a discernible fluctuation and the total for 2015/2016 is not significantly 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

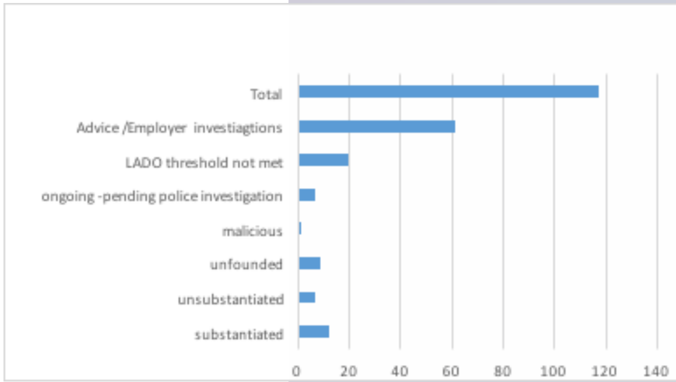


The graph below shows referring agencies to the LADO for 2015/16



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.

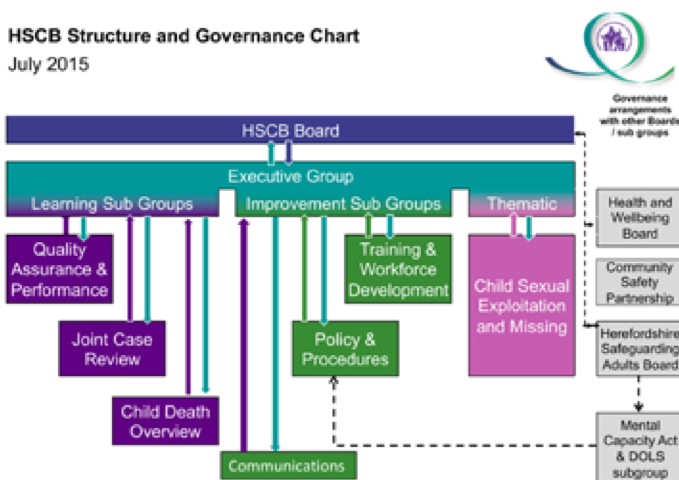
A further full section 11 audit will take place in 2017-18

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.



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
Improving identification of and response to CSE.	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.
Improved consistency and quality of "front door" services.	MASH Governance Group established. Clarification of agencies responsibilities in the MASH. Continued identification of areas for improvement (deep dive analysis commissioned).
Improving the "step down" process so it works better for children.	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.
Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.	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.
Improving the effectiveness and efficiency, planning and outcomes for children in the child protection process.	HSCB has included this in all Board meetings, sources of voice of the child are illustrated in this report.
Audit of CSE cases to assist in improving identification & response to CSE.	Development of the work of the Operational Group to identify themes and factors relating to CSE to support disruption activity.
Challenge regarding the pace of the development of the early help offer in Herefordshire	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.

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
TOTAL GROSS BUDGET	**383,964**

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	
TOTAL	**383,964**	

*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								
Number of unique children - quarterly totals	West Mercia Women's Aid	Q1 15-16 284	Q2 15-16 376	Q3 15-16 243	Q4 15-16 273	-35%		
Number of children exposed to DA crimes and incidents	West Mercia Police	Q1 15-16 300	Q3 15-16 298	Q3 15-16 298	Q4 15-16 315	9%		Smaller is better
Children exposed to DA three or more times	West Mercia Police	Q1 15-16 36	Q3 15-16 26	Q3 15-16 26	Q4 15-16 26	8%		Smaller is better
Number of children exposed to DA as recorded by: Children's Social Care	Herefordshire Council Children's Social Service	Q1 15-16 93	Q3 15-16 79	Q3 15-16 79	Q4 15-16 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 OMs, 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.

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 OMs, 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.

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. Variously, 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.

Herefordshire Safeguarding Children Board
Council Offices
Plough Lane
Hereford
HR4 0LE

Email: admin.hscb@herefordshire.gov.uk
Tel: 01432 260100

Herefordshire
Safeguarding
Adults board

Annual Report

2015-2016

Contents

Welcome 3

How well are we doing? 4

Partnership working to ensure best practice is maintained across all agencies 6

Mental Capacity Act and Deprivation of Liberty Safeguards are embedded into practice 6

Making Safeguarding Personal (MSP) is embedded into practice 8

MSP Audits – results 8

The voice of the adult informs decisions 8

Partner agencies and providers are aware of legislation and raise appropriate referrals 10

Communities and individuals are aware of what safeguarding means and who to contact and when 10

Service providers deliver quality care 10

Staff are well trained and learning from audits and Safeguarding Adults Reviews are embedded into practice 11

This year we have undertaken four reviews of practice 12

Other achievements for 2015/16 13

What does safeguarding look like in Herefordshire? 14

How the Board works to deliver results 16

What the sub groups have delivered this year 17

What the sub groups will deliver next year 20

Appendix 1 22

Welcome

Welcome to Herefordshire's Safeguarding Adults Board Annual Report 2015-16, which provides the Board and partner agencies with the opportunity to reflect on their achievements and to consider our plans for the year ahead.

The commitment of Board members and those who work on the supporting sub groups is very positive. There is a culture of genuine inter agency working together with constructive challenge across and between the agencies, the result of which is a strong collaborative inter agency approach to safeguarding adults.

Our three year strategic plan is supported by an annual business plan, against which each sub group is tasked with delivering progress and reporting to the Board accordingly.

The Board has held two development days this year, which have given us the opportunity to reflect on the content of our strategic plan and next year's business plan to ensure they are fit for purpose

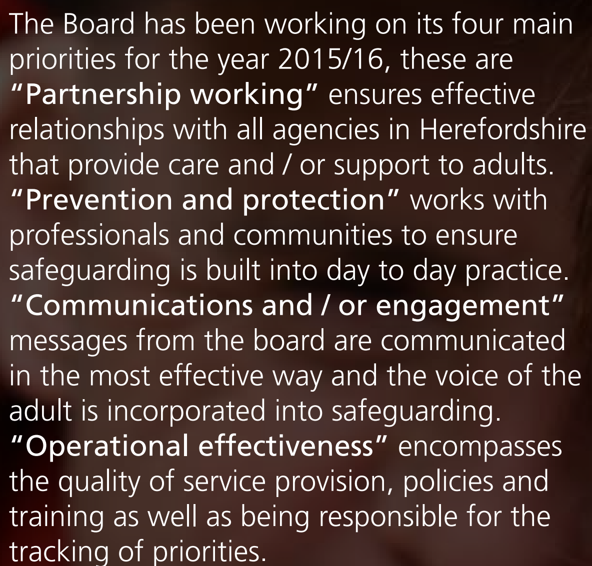
The past year for staff has been a time of change, a need to work on revised policies and procedures, and in particular to focus on making safeguarding personal, that is the process by which we put the adult at the centre of our work. Some adults do choose to live in risky situations. Some of the work the Board does is to ensure staff and the public understand that although much can be done to support adults who are at risk, we also have to respect their right to live as they wish. We cannot insist they follow what might seem sound advice, and we continue to recognise that this will remain a challenge.

We remain committed to working more closely with individuals, their families, friends and carers who have been through the safeguarding system to learn from their experience. We have made some progress in this key area, but more remains to be done during the forthcoming year.

Over the past year, we have done more to prevent neglect and abuse. Welcome, thoughtful and professional contributions have come from all Board members, notably our Faith Groups, Social Housing Providers and the Care Sector, but again there is further work to be done under the preventative agenda.

The work to raise awareness and understanding of the law regarding mental capacity and deprivation of liberty has led to a very significant increase in requests for the assessment of people who may lack capacity to make decisions and where there is a need for a decision to be made on their behalf, or indeed in some way they are being deprived of their liberty. This is not unique to Herefordshire and is reflected nationally, again this remains of significant interest moving forward for the Board.

I hope you find the content of this report interesting and informative, and I ask that you use it to raise awareness within your own organisation. My thanks to all of you who continue to work to support and protect some of our most vulnerable people in Herefordshire.



The Board has been working on its four main priorities for the year 2015/16, these are **"Partnership working"** ensures effective relationships with all agencies in Herefordshire that provide care and / or support to adults. **"Prevention and protection"** works with professionals and communities to ensure safeguarding is built into day to day practice. **"Communications and / or engagement"** messages from the board are communicated in the most effective way and the voice of the adult is incorporated into safeguarding. **"Operational effectiveness"** encompasses the quality of service provision, policies and training as well as being responsible for the tracking of priorities.

The following section details some of the individual projects that have been delivered to meet these priorities and some case studies that show the impact of this work on individuals.

How well are we doing?

Performance against last year's key outcome measures

Partnership working to ensure positive outcomes for adults at risk of abuse or neglect.

We continue to develop the membership of the Board and have recently recruited new members from further education and faith groups to represent the views of the adult in safeguarding processes.

We invite representatives from key agencies to present the work that they do with the adult at risk to practitioners and key frontline staff. We recently had the annual report from the West Mercia Rape and Sexual Assault Centre presented to inform staff of the work that they undertake for the residents of Herefordshire.

How partnership working has helped a resident in Herefordshire

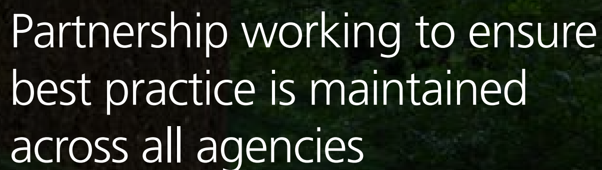
Mrs D came to the attention of trading standards through a neighbour and the local policing team who were concerned that she was being targeted by scammers. A home visit was made and it became clear that Mrs D was being bombarded with mail and phone calls from individuals and business trying to extort money from her. The problem was so bad that she was receiving dozens of letters each day and sometimes up to 20 scam phone calls through the day and night. Her home was filled with catalogues of medicinal products, which had been marketed at her knowing she had existing health problems as a way of preying on her vulnerability. Mrs D was spending up to £400 a month on products, thinking that the scammers were actually trying to help her, when in fact their only interest was in exploiting her.

As an incentive the fraudsters offered her free entry into a non-existent prize draw every time she ordered a product from their catalogue. Guess what happened next? They then wrote telling her she'd won a big cash prize and needed to send a £20 administration fee to process and deliver her winning cheque securely, which she thought was genuine - clearly something needed to be done.

Following long discussions with Mrs D, the biggest issue for her personally was the constant phone calls that she simply couldn't ignore or escape: even with serious mobility problems, she felt she had to answer every call in case it was somebody she knew who was in trouble. Her health was deteriorating rapidly as a result and she couldn't think straight. Trading standards were able to install a sophisticated call blocking device in her home to ensure that the scammers couldn't get through to her, and more importantly the phone wouldn't ring and wake her during the night. She started to relax in her own home again and had time to contemplate her spending. Mrs D soon realised that the amount of money she was spending on the array of worthless products was completely unnecessary and she recognised that she was being financially exploited. A 'scam mail bin' was provided as a way of empowering Mrs D to simply throw away the mail she was receiving, whilst providing trading standards with tangible examples of current scam mailings, which would help protect other consumers.

To date, Mrs D's quality of life has dramatically improved and she has stopped sending thousands of pounds a year to the fraudsters. She no longer feels a prisoner in her own home and has become quite an expert at identifying scam mail.

If you think you know a scam victim then please contact Herefordshire trading standards service on 01432 261761.



Partnership working to ensure best practice is maintained across all agencies

We have been working with other Boards across the region to develop safeguarding policies and procedures to support staff. These policies have been adopted by the Board and shared with providers and all partner agencies. Having one set of policies and procedures across the whole system helps to ensure that all staff understand their safeguarding responsibilities.

Mental Capacity Act and Deprivation of Liberty Safeguards are embedded into practice

A new policy to aid professionals to understand their responsibilities in both of these areas has been agreed and is available on our website.

New guidance has been developed for other interested parties and is available on both the HSAB website and the WISH website (the newly launched Wellbeing Information Service for Herefordshire) www.WISHerefordshire.org

How partnership working has helped a resident in Herefordshire

Miss Jones was 79 years old and lived alone in her own property. Diagnosed with Schizophrenia she was under the care of Mental Health Services. Although she was able to manage her daily needs, she also had the support of carers who visited her at home, but she was often reluctant to engage with the carers, apart from one that she got on well with. Miss Jones had no family who can support or advocate on her behalf but she did have a deputy appointed by the court of protection to manage her finances.

Although Miss Jones' day to day personal care needs were met, she had been assessed as lacking the capacity to look after and maintain her home. Carers had noted the house was in such a bad state of repair it was becoming dangerous to her and her neighbours. Pipes were leaking, part of the ceiling had collapsed, the electricity supply was unsafe and a fire risk. Miss Jones used electric convection heaters for warmth.

Miss Jones refused to allow professionals into her home to address these issues. Due to the concerns about the house the council had approached the Court of Protection which, after consideration, had made a court order giving the council the power to maintain the property on her behalf and in her best interest.

In spite of the court order, Miss Jones continued to be resistive to anyone entering the property to assess what needs to be undertaken. Mental Health Services arranged a best interest meeting with involved professionals to discuss how to progress the situation.

The meeting considered the following options: to remove Miss Jones from the property and place her in care, assess her under the Mental Health Act and detain her to a psychiatric hospital whilst her home is repaired or allow her to remain in her home and try to obtain her agreement to let contractors in.

It was felt that to place Miss Jones into care would cause her great distress and was not necessary as she was, with support, able to look after herself quite well in the community. An admission to hospital would not be appropriate as Miss Jones was mentally stable she did not meet the criteria to be detained under the Mental Health Act. It was agreed that it would be in Miss Jones best interest for the carer she got on well with to talk to her about allowing people to assess the work that needs to be done. Although this may affect the future relationship with the carer it was felt to be the only viable option.

Following the talk with the carer contractors were able to access the property and completed an initial assessment of the work, however Miss Jones was unhappy and threatened to call the Police. A further electrical assessment was needed and this was then conducted by an electrician with the support of the police and a fire officer as Miss Jones respected the authority of the Police.

Making Safeguarding Personal (MSP) is embedded into practice

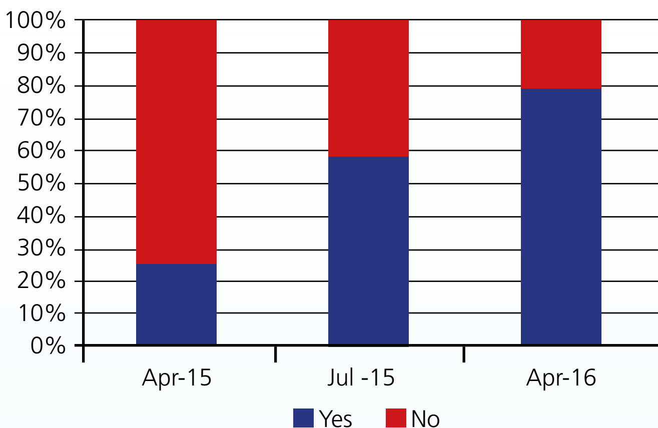
The local authority commenced the implementation of MSP in January 2015. The strategic decision to launch MSP across adult social care within the local authority rather than across the broader partnership was endorsed by the Board.

Front facing adult social care staff were provided with intensive training, and alongside this processes and paperwork were redesigned to ensure confidence with the Care Act.

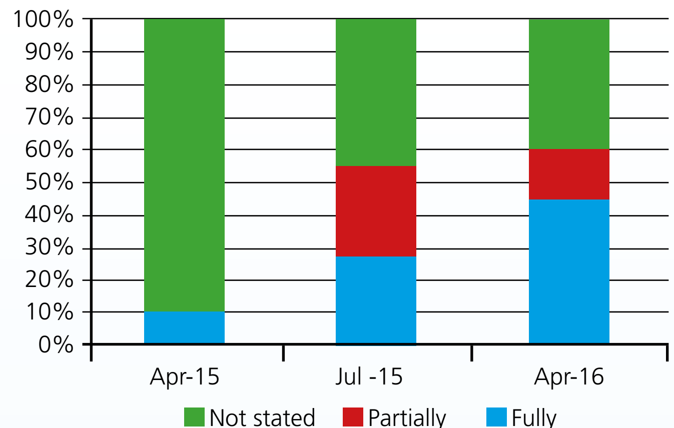
In order to measure the impact of this on those that have been subject to safeguarding investigations, we have undertaken three audits, one in April 2015 before we started the journey to get a picture of current practice, one in July 2015, and the last in April 2016 to allow us to gauge progress.

MSP Audits – results

Did the investigating officer ask the service user or their representative what outcomes they wanted to achieve from the safeguarding process?



Did the investigating officer consider/ask whether or not these outcomes had been met and whether the service user or their representative considered that the safeguarding process had been worthwhile?



The project team that were responsible for the implementation of MSP undertook a review in April 2016. When the results of this have been shared with the HSAB, an action plan will be developed, identifying areas for improvement and this will be monitored throughout the year. The results of this will be reported in next year's annual report

The voice of the adult informs decisions

We have committed to listen to people who have been subject to abuse and / or neglect, and to ensure that they are empowered to make decisions and can achieve their best outcomes and if necessary are supported to do this.

How an individual's choices are supported by professionals

Miss A is a 33 year old lady who has a supported living tenancy in a shared house. She has a learning disability and a significant mental health condition. She has capacity to make her own decisions but is extremely vulnerable.

Mr B was appointed to the staff team providing support at Miss A's home. He was observed by other staff to be behaving inappropriately towards her. Mr B was interviewed by his line management and the importance of an appropriate and professional relationship reinforced. Staff again reported concerns and Mr B's line manager arranged an investigation, but Mr B immediately resigned, before the meeting took place.

It became clear that there was a relationship between Miss A and Mr B. Support staff ascertained that Miss A's finances were being controlled; a mail order account was taken out in her name and expensive items purchased. She was observed outside a bank while Mr B withdrew money from her account. Miss A told her support team that she agreed to this because she wanted to maintain the relationship. Professionals may consider that this relationship is unwise but it is Miss A's choice and it is the role of agencies to respect her decision and to work with Miss A to minimise the risks she faces. She considers herself a more capable and confident person and feels loved and needed when in the relationship.

The support provider raised a safeguarding alert for suspected financial abuse, and the police were informed. The police added a 'flag' to Mr B's name so any application to the Disclosure and Barring Service (DBS) would indicate concerns if he applied for another caring role working with vulnerable people (Notifiable Occupation). The safeguarding alert was closed.

There have been intermittent breaks in the relationship, when Miss A can become extremely distressed and needs extensive additional support. Immediate intervention has been necessary to avoid Miss A self-neglecting and to avoid further risk to her mental health. She also needs support to maintain her tenancy. Collaborative working between all stakeholders including GP, mental health nurse, social worker and care provider ensures she has a consistent support network and manages the impact of the breaks in the relationship.

Partner agencies and providers are aware of legislation and raise appropriate referrals

As part of the implementation of MSP, a review of the structure of the council's "Advice and Referral Team", which is responsible for the receipt of all safeguarding concerns raised was carried out. Following this review, the way that staff handled concerns changed. Where a concern is found not to meet the threshold for safeguarding, a discussion is had with the person who raised the concern to help them understand when safeguarding is appropriate and when some other recourse may be used. This has led to fewer unnecessary investigations being carried out.

Communities and individuals are aware of what safeguarding means and who to contact and when

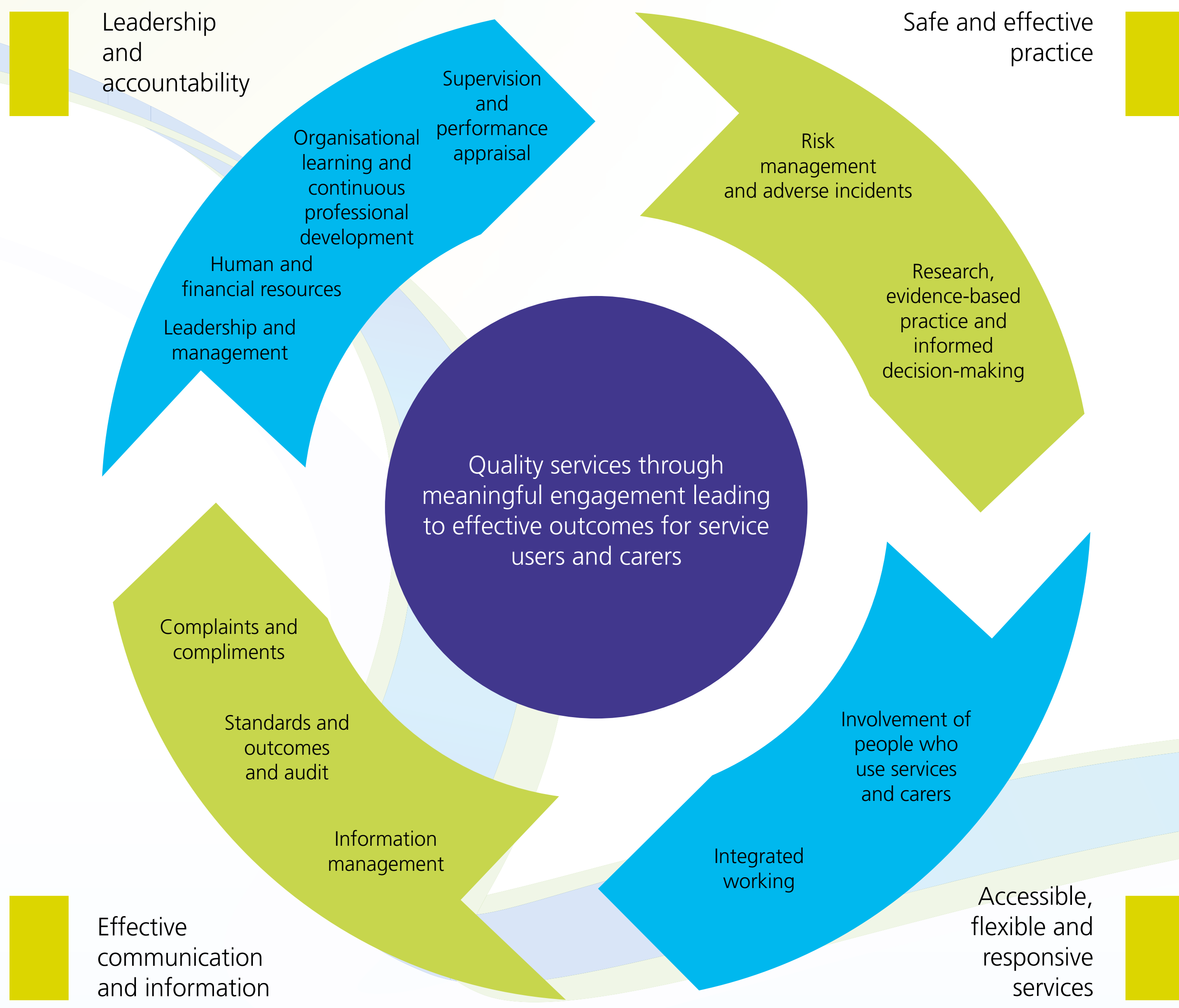
To raise awareness of safeguarding and provide information that is easy for individuals to access, we redesigned our leaflets. Copies were then issued to GP surgeries, dental surgeries and community areas.

A new website has been commissioned and is in the process of being populated as we go to press. This will have more information for individuals and communities on the work that we do throughout the year.
Take a look here:
www.herefordshiresafeguardingboards.org.uk

Service providers deliver quality care

Herefordshire Council, in conjunction with the CCG, Police, Healthwatch and CQC, has introduced a new approach to the quality assurance of care and support services offered in the county. The new Quality Assurance Framework has been designed to ensure that local care and support services provide the appropriate care and support that individual adults need. It is a set of processes which are put in place with one goal; to deliver high quality care and support services in Herefordshire.
Building positive relationships between the range of agencies, care providers and adults in Herefordshire is fundamental to achieving this. It is through supportive partnership based working that continued improvement in quality can be delivered with better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

As part of the framework, new quality standards, reflecting what good practice looks like, which includes reference to the newly developed West Midlands Adult Safeguarding Procedures, that has been communicated to all stakeholders. These will be required to work collaboratively to make sure that good quality care and support is delivered.



Staff are well trained and learning from audits and Safeguarding Adults Reviews are embedded into practice

We have introduced a competency framework relevant to all areas of service delivery, including providers, practitioners and other professionals. This framework outlines the levels of training required for each role and provides monitoring information which can be fed into the Quality Assurance Framework.

Practitioner forums continue to be run on a regular basis and are available to all agencies, recent subjects have included domestic abuse and information sharing.

These learning events are targeted across adults' and childrens' services where possible to encourage cross agency knowledge and working and to make the best use of resources.

This year we have undertaken four reviews of practice

The Joint Case Review sub group received four adult's referrals in 2015/16. These are referrals that are made by professionals when they feel that multi-agency practice has not been as effective as it should have been. Two of these cases were deemed to meet the threshold for a full Safeguarding Adults Review (SAR). Of the remaining two, one was passed to our public health team as they have a statutory requirement to investigate drug related deaths and one was managed through a practice learning review.

A Herefordshire Evaluation Learning Process (HELP) was commissioned for the first case, which involved an elderly gentleman in a care home who had a history of repeated falls. This review was the first that the Board had commissioned using this process and, subsequently, the JCR sub group felt that the report needed further detail. Although this meant that more time was required before the report could be finalised, the group felt this was absolutely necessary in order to consolidate the learnings and the recommendations from the review. The process in itself was a learning for the JCR subgroup. As a result, the commissioning process is now being more robustly considered at the beginning of the process. This will improve how adult reviews are undertaken in the future.

The second SAR involved an elderly gentleman in his own home. As the learnings from this review mainly focussed on Health and Adult Social Care, a root cause analysis and a chronology from Adult Social Care were commissioned and reported to the sub group.

The learnings from both of these reviews will be built into our work with practitioners once finalised.

A Practice Learning Review (PLR) was identified as being the most appropriate review process for one referral, with a multi-agency review meeting taking place with 6 agencies present. A report has been written by a member of the JCR sub group, independent of the case. The report has been considered at JCR Sub Group meeting, where recommendations and an action plan were agreed.
The following actions and learnings were identified as a consequence of the four reviews undertaken:-

1) The Community Safety Partnership reviewed the domestic abuse care pathway to capture adult facing services and ensures the pathway is underpinned by a training strategy.
2) The HSAB set multi-agency standards for safeguarding supervision in statutory agencies.
3) Wye Valley NHS Trust reviewed their processes regarding Mental Capacity Act and Depravation of Liberty Safeguards (MCA/DoLS) and the support offered to front line staff.
4) The Clinical Commissioning Group and Adults Wellbeing Directorate reviewed the pathway for people suffering from an acquired brain injury to ensure that the pathway is fit for purpose.
5) The HSAB ensured that Best Interest Decision making is included in the MCA/DoLS suite of procedures.

JCR will continue to regularly monitor the recommendations and actions arising from reviews for implementation and improvement to practice.

Other achievements for 2015/16

Making safeguarding personal

MSP was successfully launched across the council/adults social care in January 2015. This followed the training of social work teams to the level assessed as being needed for their role. A review was recently carried out by the council to evaluate how successful the implementation has been, and to make recommendations to aid in embedding this way of working. It will also make recommendations to inform the embedding of MSP across partner agencies. The next steps are for the board to receive the report and for board members to develop an action plan to embed MSP across the partnership.

The Care Act 2014

This legislation, which was implemented in April 2015, heralded a change in the Board's way of working, as it places the Board on a statutory footing for the first time.

During this year, we have reviewed our meeting structures, streamlining membership in consideration of members' other commitments, and also reduced our meeting frequency to allow for more meaningful work to take place between meetings.

We continue to develop the work of the Board in line with the requirements of the Care Act and have recently introduced an engagement group to improve the methods of gaining the views of the general public in matters of safeguarding.

Peer Challenge

A peer challenge is designed to help the local authority assess its current position and to advise on areas for improvement. It is carried out by professionals external to the authority.

The challenge, which took place in September 2015, was commissioned by the council and included a review of the Safeguarding Adults Board.

Whilst they found many encouraging things to report on, such as positive partnerships across agencies, good political leadership and the implementation of the cross cutting business unit, they also identified some areas for improvement. Some of these, such as the Independent Chair becoming a member of the Executive Group were implemented immediately. Others will take longer to achieve and there is an action plan which is regularly monitored and updated to show progress.

If you would like to see the full report and corresponding action plan you can visit https://herefordshiresafeguardingboards.org.uk/herefordshire-safeguarding-adults-board/for-professionals/learning-and-improvement/ and review the documents in the external reviews of our effectiveness and self-evaluation section.

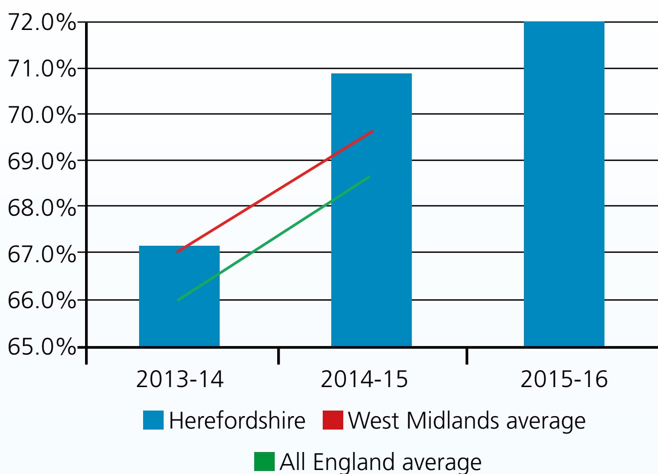
What does safeguarding look like in Herefordshire?

Every year the local authority takes part in a survey, commissioned by the government, collecting multi-agency performance data and asking individuals that they have worked with about how the safeguarding experience has been for them.

Some key highlights are:

Proportion of people who use services who feel safe

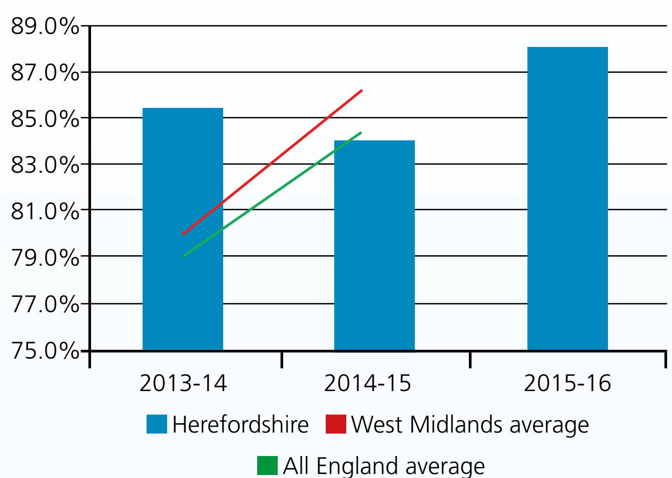
	2013-14	2014-15	2015-16*
Herefordshire	67.10%	70.90%	72.00%
West Midlands average	67.10%	69.50%	Not yet available
All England average	66.00%	68.50%	Not yet available



*Figures for 2015/16 are not yet finialised and may be subject to change

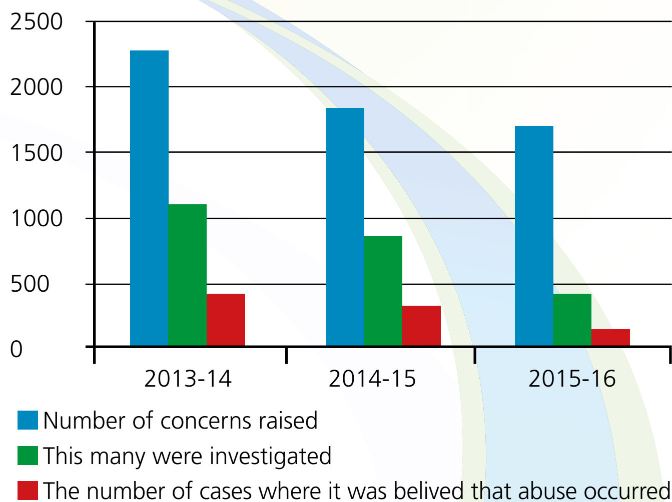
Proportion of people who use services who say that those services have made them feel safe and secure

	2013-14	2014-15	2015-16*
Herefordshire	85.50%	83.90%	88.00%
West Midlands average	79.90%	86.10%	Not yet available
All England average	79.20%	84.50%	Not yet available



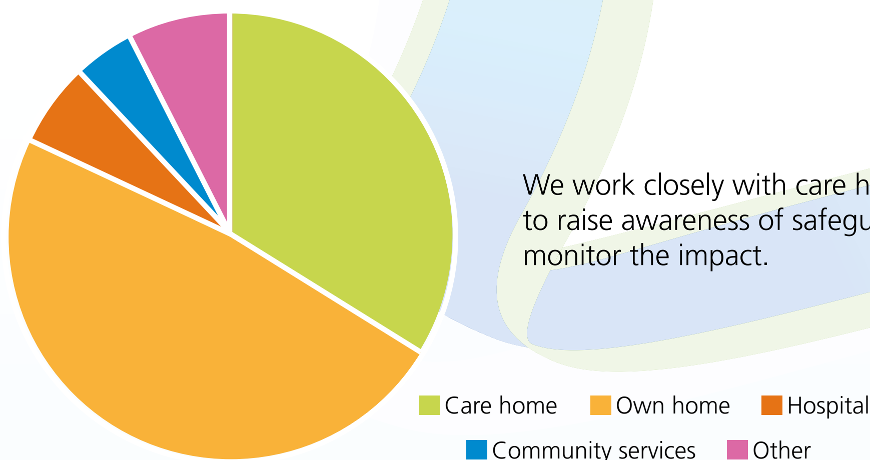
*Figures for 2015/16 are not yet finialised and may be subject to change

About the concerns regarding abuse that have been raised



Although the number of concerns raised has not differed much over the last two periods the reduction in the number of investigations is as a result of the introduction of MSP as, generally, concerns are no longer investigated unless there is agreement from the individual involved.

Where abuse has occurred



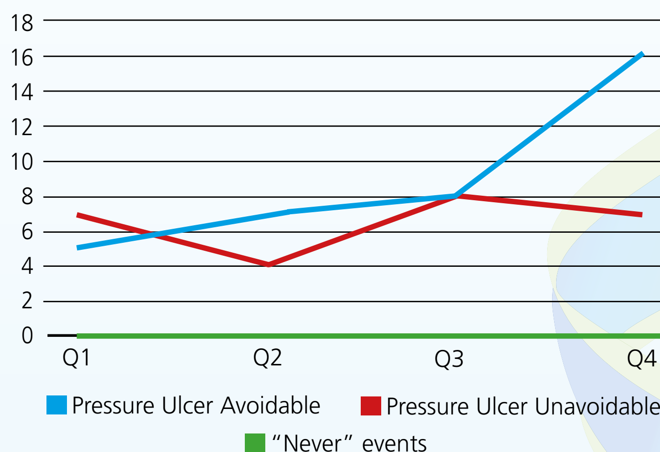
We work closely with care homes and providers in the community to raise awareness of safeguarding and we will continue to monitor the impact.

Wye Valley NHS Trust

During the course of the year Wye Valley NHS Trust, a Board partner, which provides health services in Herefordshire, report key figures with regard to patient safety.

We are pleased to report that they have had no "never" events during the year. These are, as the name suggests, events that should never happen, such as instruments being left in situ after an operation.

Pressure areas, both categories 3 and 4, are also reported. For each reported incident a root cause analysis is carried out and learnings from this are shared with hospital staff, with a view of increasing awareness and knowledge across the Trust.



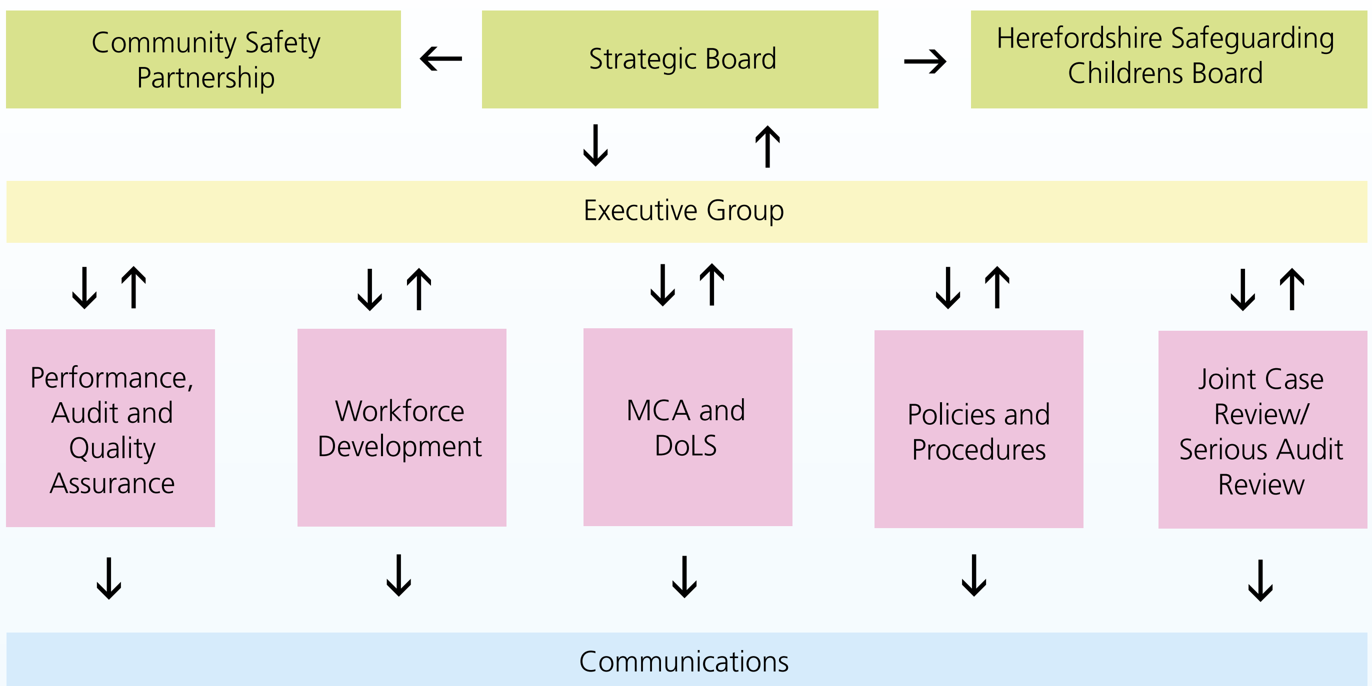
How the Board works to deliver results

The Board brings together representatives from
- local authority (social care)
- the clinical commissioning group (responsible for the purchase of health care)
- Wye Valley Trust and 2Gether NHS Trust (health care providers)
- Healthwatch
- West Mercia Police
- National Probation Service and Community Rehabilitation Company
- Herefordshire Housing
- West Midlands Ambulance Service
- Herefordshire and Worcestershire Fire and Rescue
- Members from provider and voluntary services.

This multi-agency approach ensures that all partner organisations work cohesively, using the same information and communicate consistent messages to provide the strategic direction for the work undertaken on their behalf.

It is the task of the Strategic Board to agree the priorities for the year and to inform the Executive group of these.

Sub groups then develop work plans aligned to each priority. These contain the activity required to deliver the priorities. Each sub group chair has the responsibility of reporting back to the executive the successes, developments and any barriers to progress.



What the sub groups have delivered this year:

Performance and Quality Assurance

This group is responsible for data quality, audit and effective information systems to meet current and future expected national and local data reporting requirements and enable performance to be managed and reasonable assurance secured on the quality of local safeguarding.

CHAIR'S UPDATE (Lynne Renton, Deputy Chief Nurse, CCG).

The group has developed a performance scorecard; this allows us to consider multi-agency information that has an impact on safeguarding.

We have carried out multi-agency case audits which have highlighted learning needs across agencies which are being delivered via the workforce training sub group.

Together with the MCA sub group the PAQA group has conducted a multi-agency MCA awareness/ governance audit to ascertain each agency's compliance with MCA legislation. As a result of the findings the Board has designed MCA leaflets, enhanced the content of the MCA information on the web site and started a system wide review of the MCA/Do Not Attempt Cardiac Pulmonary Resuscitation processes.

We have carried out a review of the multi-agency self-assessment audit to ensure that agencies actions which were agreed in 2014/15 have been progressed.

Policies and Procedures

This group aims to ensure there is a comprehensive catalogue of policies which underpin the multi-agency safeguarding procedures. Its goal is that staff across the partnership have access to the necessary range of multi-agency safeguarding and adult protection policies and procedures and that these are embedded into practice. It also includes the review and maintenance of existing policies.

CHAIR'S UPDATE (Mandy Appleby, Principal Social Worker, Herefordshire Council)

HSAB Policies and Procedures sub group are contributing to the development of the multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands which has now reached editorial stage.

During this year we have worked with colleagues to promote making safeguarding personal (MSP) in Herefordshire, to develop the self-neglect policy for Herefordshire and to develop and disseminate the revised information sharing protocol.

We have also contributed to the development of the prevent strategy for Herefordshire, and the implementation of the channel process, input into the domestic abuse referral pathway and made representation on both the multi-agency child sexual exploitation strategic group and the Herefordshire female genital mutilation strategic group to develop safe pathways for those adults at risk.

The sub group has met on four occasions since April 2015. With attendance at meetings becoming challenging as we moved into 2016 most of the work has been developed virtually.

The sub group develops and adopts policy, but works closely with the Joint Workforce Development and Training sub group and the Joint Communications sub group to ensure dissemination and training concerning the policies and procedures is delivered in a co-ordinated manner.

Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

This group provides clear leadership on the promotion of the application of the Human Rights Act, Mental Capacity Act and the Deprivation of Liberty Safeguards in everyday clinical practice and ensures that a framework is in place to support staff in relation to their responsibilities and monitor compliance with this legislation.

CHAIR'S UPDATE (Jane Higgins, DoLS Lead, Herefordshire Council).

Following on from a supreme court judgement in 2014 which stated that "Incapacitated people subject by state decision to continuous supervision and control without option to leave setting are deprived of their liberty" care providers have had to review where they might be restricting someone's freedom in order to keep them safe. As a direct consequence the number of people being referred to the Herefordshire DoLS service for assessment has continued at a high level.

In response to this demand, Herefordshire has created a dedicated DoLS service. We now have a full time permanent senior best interest assessor, a number of permanent full time best interest assessors and in addition to this have increased our pool of independent assessors who can help meet demand.
(If you want to read the full report it can be found here: https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf)

Over the last 12 months we have sought to raise awareness of the MCA and DoLS and increase effective practice in a number of ways: we have created multi-agency policies for the MCA and DoLS, have put information regarding MCA and DoLS on the HSAB Web site and on the Local Authorities Wellbeing Information and Signposting (WISH) web pages,

We have also developed information leaflets regarding MCA and DoLS and have started to undertake engagement work within the wider community.

Training in relation to MCA and DoLS continues to be provided to partner agencies and providers of care.

Joint Training and Workforce Development

This group is responsible for developing and maintaining Herefordshire's competency framework and provides evidenced assurance that partner agencies are meeting the requirements of the framework.

The group has particular responsibility to ensure that multi-agency development opportunities exist for all practitioners. By undertaking such activities the group will ensure people working with or engaging with adults at risk in Herefordshire understand their responsibilities.

CHAIR'S UPDATE (Ali Chambers, Senior Manager Workplace Learning Support Services, Hoople)

At the beginning of the year a focused working group developed the new multi-agency workforce strategy which determined the workforce development plans for those who work with and support adults at risk to ensure that they are skilled and competent.

The HSAB multi-agency workforce development strategy also contains the new HSAB competency framework. The competency framework aims to;

- Raise standards and ensure consistent and proportionate response to safeguarding issues for adults at risk of abuse and neglect
- Improve partnership working and consistency to secure better outcomes for adults at risk of abuse and neglect
- Support work based evidence of learning and competence in practice
- Provide managers with a framework to evaluate performance, and identify workforce development needs
- Clarify expectations of the role of all relevant members of the workforce in safeguarding
- Provide a quality assurance tool for commissioners of services and for contract monitoring.

A set of recording forms have also been developed to compliment the Framework for agencies to use.

Work is continuing by the sub group through the training needs analysis (TNA) to establish training needs for the workforce in the coming year. There has been low numbers of completed TNA forms coming back to the sub group. This will make it more difficult to determine what learning resources will be required for the coming year to meet the needs of the workforce.

A new evaluation process has also been established and all training delivered on behalf of the HSAB will be subject to this new process. This will enable the sub group to measure if training has made an impact on the knowledge and skills of the workforce and in turn improved the experience of those who access services.

Safeguarding Practitioner Forums are now well established. During the year 166 practitioners representing 20 agencies have attended the 5 sessions held.

This forum includes dissemination of learning from SARs, informing practitioners about the work of the Board and sharing knowledge and best practice across agencies.

As the Care Act is not prescriptive over the methodology used, the joint case review sub group will use their discretion to decide on the most appropriate methodology on a case-by-case basis in order to optimise the learnings.

HSAB have also been actively involved in the consultation process to establish a regional learning repository for the outcomes from SARs.

Joint Case Review

The Board has a legal duty to undertake reviews of cases where an adult at risk has died or suffered serious harm as set out in the Care Act 2014. The reviews involve all agencies which were, or should have been, working with the adult and are used to identify learning outcomes for practitioners.

CHAIR'S UPDATE (Adam Scott, Assistant Director Safeguarding and Early Help, Childrens Wellbeing, Herefordshire Council).

Since the Care Act 2014 made Safeguarding Adults Reviews (SAR) statutory, a Case Review Toolkit has been developed which overarches both adults and children's reviews.

The Toolkit details the processes to be followed from receipt of a SAR referral, through to publication. It sets out the thresholds and procedures for safeguarding adult reviews and also for reviews which do not meet the threshold.

Communications

This is a joint group across the Safeguarding Adult and Children Boards and the Community Safety Partnership. It was fully established in February 2016, and works to ensure a more coordinated and effective approach across the three partnerships.

CHAIR'S UPDATE (Bill Joyce, Business Manager, Safeguarding Boards Business Unit)

Immediate benefits were realised by the group in terms of sharing communication activity.

There was a very effective campaign in March 2016 promoting awareness of child sexual exploitation around CSE awareness day 17 March 2016. Messages from children's services, health and police were well coordinated for maximum impact.

We will continue to work together to co-ordinate the communication of safeguarding messages to maximise impact.

What the sub groups will deliver next year:

The review of progress against the priorities for 2015-16 took place in November 2015. Additionally future improvement opportunities were identified:

- Partnership working (including annual review of Board membership and effectiveness and build inter-relationships between Boards / partnerships)
- Prevention and protection (including care homes, carers and young carers, self-neglect)
- Communications and engagement
- Operational effectiveness (including workforce development, statutory functions and performance)

The document at appendix 1 shows the proposed 2016-17 strategic priorities and the sub groups work plans to deliver against them. The Board will now be consulting with Healthwatch and the local community to seek feedback on these priorities.

Budget 2016/17
Contributions from statutory partner agencies for 2016/17 remained the same as in 2015/16.

Total £383,964

Note: This total contribution is for the support of the Herefordshire Safeguarding Adults Board, the Safeguarding Children Board and the Community Safety Partnership.

Projected costs 2016/17:

Staffing costs:
The staffing complement as identified in the establishment of the Business Support Unit is as follows:
Business Unit Manager: F/T
Learning Development Officer: F/T X 3
Training Officer: P/T 0.41
Business Support F/T X 3

Basic pay and on costs	£292,738
Independent Chairs HSCB & HSAB:	£38,520
Council recharge costs:	£32,000
Total expenditure	£363,258
Balance:	£20,706
Potential income from training based on 2015/16 figures:	£14,000
Final balance (assuming same income from training):	£34,706

Proposed use of partnership budget 2016/17:

Workforce Development (WFD) training offer:
Administration of training programmes (face to face, bookings; evaluation; reporting; training needs analysis etc.) £15,900

Cost of Face to face training: HSCB; joint HSAB/HSCB practitioner forums:
To be covered by the £10,034 designated to Training Officer Post (staffing costs above).

Note: The Business Unit are developing a multi-agency training pool, for partners to deliver training together (contributions in kind), wherever possible to use free venues where refreshments can be easily purchased by course participants (e.g. Local Authority Plough Lane Offices).
The Business unit are also collating and making available any free to access E-Learning courses, which will be made available on the HSAB/HSCB joint website.

Total cost of training offer:	£25,934
Residual balance:	£18,806

The remaining balance is what remains to cover any Serious Case Reviews, Serious Adult Reviews, Domestic Homicide Reviews, annual conference/ promotions and any sundry costs.

Appendix 1

2015-18 Business Plan

Strategic Priorities	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Focus for 2016/17	All partners have a shared and universal understanding of safeguarding Increased involvement from voluntary sector Active participation from all partners Multi-agency focus Sharing the right data Connectedness with other boards	Service user involvement Good mental health Greater focus on prevention	Awareness raising Understanding the work of the Board Reach to smaller / community organisations MCA and DoLS	Challenge single agency issues Shared learning Links into commissioning and public health Embed MSP Embed competency framework Multi-agency training Better tracking of priorities

Sub group work plans

Delivery group	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Executive Board	Monitor actions arising from peer review Learning from other areas including DHR's, SAR's and SCR's Risk register Ensure the needs of adults at risk are addressed in the Joint Strategic Need Analysis and Health and Wellbeing strategies	Monitor relevant sub group work plans Risk register	Monitor relevant sub group work plans Risk register	Monitor relevant sub group work plans Risk register Publish annual report on the effectiveness of local safeguarding arrangements Better tracking of priorities
Policy and Procedures	Maintain up to date HSAB procedures that align with sub regional arrangements and address cross border issues. Embed MSP protocols into practice Embed MCA protocols into practice	Embed self-neglect policy into practice Develop arrangements to gather service users feedback of the safeguarding experience (MSP)	Launch of new policies	Embed new policies Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Communications	Consider the experiences of adults at risk at each Board meeting via case study Introduce "Chairs Message"	Increase awareness of DoLS and MCA Promote community resilience for town and parish councils.	Raise awareness of adults at risk	Pilot a safeguarding initiative with existing community champions Contribution to annual report
MCA and DoLS	Develop shared learning tool Multi-agency audit	Gather from Best Interest Assessors evidence of the voice of those without capacity	Raise awareness of MCA and DoLS • Website • Roadshow • Newsletter	Contribution to annual report
Performance and Quality Audit	Monitor multi-agency and single agency scorecards 6 monthly reports from Making It Real evaluating their work with vulnerable groups	Monitor results of the support provided via the Domestic Violence, Substance Misuse and Reducing Reoffending work plans held by the Community Safety Partnership (annual)	Monitor support provided to carers and young carers Adapt LA audit format to include the voice of the carer	Monitor the effectiveness of services provided to adults at risk via 6 monthly report from Quality and Review team Contribution to the annual report
Workforce Development	Practitioner forum Engage with front line staff and use their experiences to inform HSAB activity.			Develop guidance to support partner agencies to evaluate training Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Key Outcome Measures	• Partner agencies are committed and attendance at meeting is at least nn% • More voluntary organisations are aware of the work of the Board and engage effectively when required • Other Boards are aware of the work of the Board and engage effectively when required	• Production and publication of a prevention strategy • Partner agencies and providers are aware of legislation and raise appropriate referrals • MCA and DoLS are embedded into practice • MSP is embedded into practice	• Messages from the Board are effectively disseminated • Communities are aware of what safeguarding is • Individuals are aware of what safeguarding is • Communities are aware of Mental Capacity Act • Individuals are aware of Mental Capacity Act • Communities are aware of Deprivation of Liberty Safeguards • Individuals Communities are aware of Deprivation of Liberty Safeguards • Communities are aware of Lasting Power of Attorney • Individuals are aware of Lasting Power of Attorney	• Service providers deliver quality care • Staff are well trained • Learnings from SARs are embedded into practice • Priorities are tracked effectively

Herefordshire
Safeguarding
Adults board

HSCB Business Plan 2016/18

This business plan builds on the work and progress of the 2015/16 business plan. A number of priority areas remain relevant and continued development and improvement should be planned. It is intended that from these strategic priorities the sub groups of the HSCB will develop action plans that interlink, to ensure that practices and processes are in place to improve outcomes for children and young people in Hereford and, protection from significant harm

Strategic Priorities	***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.*
Areas for sub group action plans: Under these strategic priorities the HSCB want the sub groups to develop effective action plans that take in to account the following areas	• The pathway for addressing concerns about cases of suspected CSE are clear. • There is clear data relating to CSE risks and children missing from home • There is good	• The process an 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	• Concerns about possible childhood neglect are identified early and interventions put in place to ensure children's needs are met and they are not at risk of, or experiencing, neglect. • Where chronic cases of neglect are	• 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

	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	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.	identified plans are put in place to protect children from further neglect • Innovative tools and approaches are put in place to support practitioners in assessing and understanding neglect and improving and better targeting work and interventions with families.	families and planning interventions (there is clear multi agency engagement in this process) • Lead professionals are identified in each case deemed level 2 or 3

	post abuse support			
Measures: How will we know if we are achieving good outcomes for children in these priority areas?	• As awareness and understanding of CSE develops the HSCB will need to agree about expectations of a rise in cases of known CSE; convictions and disruptions, and at some point expecting reduction in cases • Reduction in the numbers of children going missing and numbers of times missing • Return home interviews take place in all cases,	• From a base line of numbers of strategy discussions; sec 47 enquiries; child protection conferences; children made subject to a CP plan, targets to be set to reach over the next 12 months. • CP conferences; core groups occur within timescale and have appropriate multi agency involvement • The data on length of time children on a child protection plan/ repeat child protection plans, should indicate that plans are reducing/eradicating risk of significant harm	• Reduction in the numbers of children and young people subject to CP plans under the category of neglect. • If agreed, use of neglect tools across the partnerships to assess for and identify incidence of childhood neglect, and factors that impact upon this.	• Reduction in (inappropriate) referrals to MASH. • Findings from the Herefordshire Family Outcomes Framework indicate identified needs being met, outcomes for children and factors that impact on their care improving. • Is there a value in measuring numbers of CAF's; by agency; numbers receiving interventions from CAF's?

	consistent with the guidance and procedures.			

In addition to the priorities identified above, throughout 2016/17 the HSCB will seek reporting on assurances/ risks in the following areas:

Safeguarding area	**Expectations**
Looked after children	Looked after children reviews, including health; education; care leavers, take place within timescales set out by guidance and procedures; the views of children are evident in care planning and views taken account of; numbers of children in care in Herefordshire are not at odds with national average/ statistical neighbours;
Female Genital mutilation (FGM)	There is a clear strategy in place to support identification of and response to cases of FGM
Radicalisation	Awareness of radicalisation is through mediums such as PREVENT training takes place across the authority, particularly in education Channel meetings take place in response to any referrals of concern of radicalisation, and plans and actions reduce the risks of radicalisation
Health Services assurance reporting	CCG/WVT/2gether all report to the HSCB on any inspections/ reviews/ audits relating to safeguarding children, and progress on any action plans drawn up from the findings
Public Protection Assurance reporting	Police/ Probation (NPS/CRC), YOS report to the Board on any inspections/ reviews/ audits relating to safeguarding children, and progress on any action plans drawn up from the findings. To include MAPPA/MARAC
Education assurance reporting	The Board to receive reports regarding children missing education, and children home educated, being assured regarding plans to respond to any trends or concerns.
Child death Reviews	The Board will receive an annual report regarding child deaths in Herefordshire, and any recommendations/ lessons learnt.
Serious Case Reviews and other case reviews that the Board have identified should take place	These case reviews are completed within timescale and reported to the Board with clear recommendations and actions for improvements. Actions are tracked and included in future auditing.
Private Fostering	Awareness raising/ identification of circumstances that may be private fostering; reporting on the number of private fostering arrangements and assessments/ reviews carried out within timescale.
Adult Factors that impact upon the safety and wellbeing of children	To receive reports and information on the extent of Domestic Abuse/ substance misuse/ mental ill health among those caring for children, how this is impacting upon children, and partner agency responses

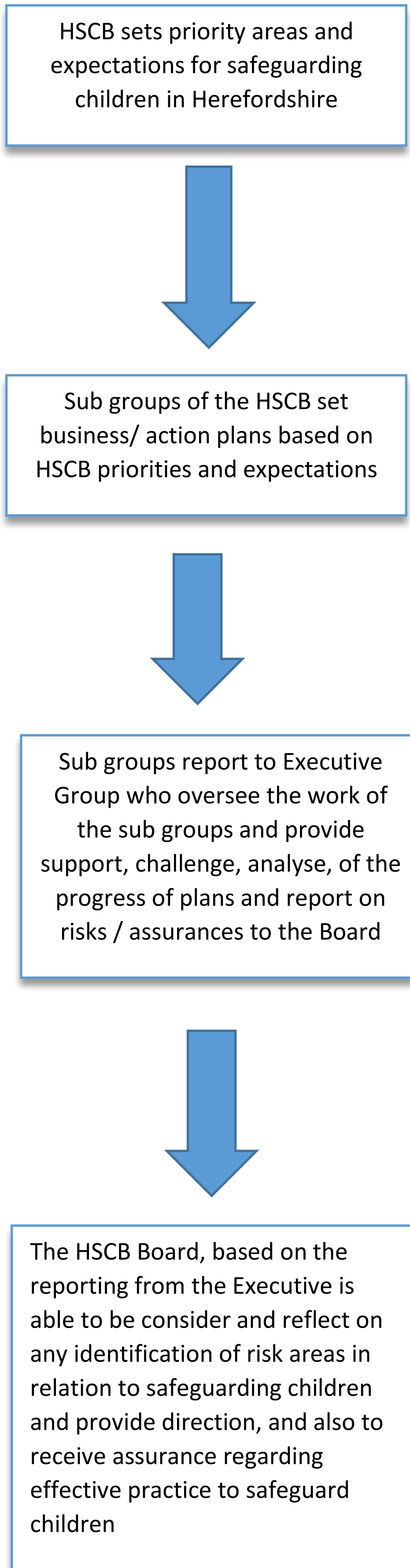
The reporting cycle that accompanies this business plan sets out the expectations for when the performance information, data and other reports should be made available to the Board. Alongside the performance score cards there will also be data and qualitative information from:

- 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 responsibilities under Sec 11 Children act 2004, Sec 175; 157 Education Act 2002
- Schedule of multi-agency case audits based on the HSCB priority areas.

All the sub groups of the HSCB will identify plans to progress the priority areas of the Board to improve outcomes for children and keep them safe. The Performance and Quality Assurance sub group of the HSCB will take the lead on identifying issues and progress based on the HSCB scorecard/ data provided from partner agencies; agency assurance reporting; case auditing; findings from Sec 11 audits and progress in actions as a response. This, and other sub groups of the HSCB, will identify any risks / assurances in reports to the HSCB executive group. This will enable the Board to receive clear reporting from the Executive Group to enable the Board to consider risk areas and progress, and the direction/ expectations of the multi-agency partnership working to develop and improve to meet the needs of children in Herefordshire and keep them safe (see diagram below).

Linked documents:

- HSCB reporting cycle
- HSCB reporting process
- Sub group action plans (to be developed)


HSCB sets priority areas and expectations for safeguarding children in Herefordshire
Sub groups of the HSCB set business/ action plans based on HSCB priorities and expectations
Sub groups report to Executive Group who oversee the work of the sub groups and provide support, challenge, analyse, of the progress of plans and report on risks / assurances to the Board
The HSCB Board, based on the reporting from the Executive is able to be consider and reflect on any identification of risk areas in relation to safeguarding children and provide direction, and also to receive assurance regarding effective practice to safeguard children

Herefordshire Safeguarding Adults board

2015-18 BUSINESS PLAN

Introduction
A review of the priorities agreed for 2016-17 took place in November 2016 and future improvement opportunities were identified for populating the work plans for 2017/18, these align to the existing priorities:

- Partnership working
- Prevention and protection
- Communications and engagement
- Operational effectiveness

Strategic Priorities	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Aim	To develop relationships across agencies that deliver positive changes to safeguarding	To ensure that Herefordshire residents can recognise safeguarding concerns and know what to do	To deliver the messages from the board and recognise the voice of those we safeguard	To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies
Focus for 2017/18	All partners have a shared and universal understanding of safeguarding Define and understand involvement from voluntary sector Active participation from all partners Multi-agency focus Sharing the right data Shared understanding of other boards priorities	Service user involvement Greater focus on prevention	Awareness raising Understanding the work of the board Reach to smaller / community organisations MCA and DoLS	Challenge single agency issues Shared learning Embed MSP Embed competency framework Better tracking of outcomes against priorities

Strategic Priorities	**Partnership working**	**Prevention and protection**	**Communications and engagement**	**Operational effectiveness**
Strategic board work plan	Single agency contributions to annual report Address recommendations from MSP review Promote MSP across all partner agencies	Review prevention strategy Monitor prevention work plan	Ensure the messages from the board are communicated in a timely and consistent manner Ensure the voice of those who have been safeguarded are considered in the work of the board HSAB partners to ensure MSP messages and awareness are cascaded to staff	Publish annual report on the effectiveness of local safeguarding arrangements Ensure the needs of adults at risk are addressed in the JSNA and HWB strategies

Sub group work plans

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Executive group	Monitor relevant sub group work plans Monitor actions arising from peer review Learning from other areas including DHR's, SAR's and SCR's Risk register	Monitor relevant sub group work plans Risk register	Monitor relevant sub group work plans Risk register	Monitor relevant sub group work plans Risk register

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Policy and Procedures	Maintain up to date HSAB procedures that align with sub regional arrangements and address cross border issues. Embed MSP protocols into practice Embed MCA protocols into practice	Embed self neglect policy into practice	Launch of new policies	Report to Executive group Embed new policies Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Communications	Promote RIPFA as a resource	Promote community resilience for town and parish councils. Raise understanding and awareness of the advocacy offer	Raise awareness of adults at risk Sharing of best practice and case studies	Report to executive group Contribution to annual report Raise awareness of partner agencies

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
MCA and DoLS	Develop suitable tools for all professionals to aid understanding Multi agency audit	Gather evidence of the voice of those without capacity	Raise awareness of MCA and DoLS • Website • Roadshow • Newsletter Increase awareness of the Court of Protection Increase the understanding of consent	Report to executive group Contribution to annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Performance and Quality Audit	Monitor multi-agency and single agency scorecards Programme of multi-agency audits Introduce multi-agency MSP audit	Monitor results of the support provided via the Domestic Violence, Substance Misuse and Reducing Reoffending work plans held by the Community Safety Partnership (annual) Audits to include the voice of those without capacity Adapt LA audit format to include the voice of the carer Monitor support provided to carers and young carers	Introduce 7 minute learnings for findings from audit and SARs 6 monthly reports from MIR evaluating their work with vulnerable groups	Report to executive group Monitor the effectiveness of services provided to adults at risk via 6 monthly report from Q and R team Continue to review performance measures and reporting Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Workforce Development	Practitioner forum Engage with front line staff and use their experiences to inform HSAB activity Ensure learning from MSP review is aligned to competency framework	Empower staff to deliver person centred care Empower staff to professionally challenge	Ensure competency framework is embedded across all partners	Report to executive group Develop safeguarding supervision standards Develop guidance to support partner agencies to evaluate training Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Safe Voice			Obtain views of safeguarding and services Develop independent arrangements to verify SU feedback of the safeguarding experience (MSP)	Review of user facing material

	Partnership working	Prevention and protection	Communications and / or engagement	Operational effectiveness
Key Outcome Measures – How will we know how successful we have been	• Partner agencies are committed and attendance at meeting is at least nn% (yet to be agreed) • The board is aware of voluntary organisations and the work that is undertaken to support the safeguarding agenda • Other boards are aware of the work of the board and engage effectively when required	• Production and publication of a prevention strategy • Partner agencies and providers are aware of legislation and raise appropriate referrals • MCA and DoLS are embedded into practice • MSP is embedded into practice	• Messages from the board are effectively disseminated • Communities are aware of what safeguarding is • Individuals are aware of what safeguarding is • Communities are aware of Mental Capacity Act • Individuals are aware of Mental Capacity Act • Communities are aware of Deprivation of Liberty Safeguards • Individuals Communities are aware of Deprivation of Liberty Safeguards • Communities are aware of Lasting Power of Attorney • Individuals are aware of Lasting Power of Attorney	• Service providers deliver quality care • Staff are well trained / supervised • Learnings from SARs are embedded into practice • Priorities are tracked effectively