Herefordshire Council

Agenda

Children and young people scrutiny committee

Date: **Monday 1 October 2018**

Time: **2.00 pm**

Place: **The 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:

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If you would like help to understand this document, or would like it in another format, please call Matthew Evans, Democratic Services Officer on 01432 383690 or e-mail matthew.evans@herefordshire.gov.uk in advance of the meeting.

Agenda for the meeting of the Children and young people scrutiny committee

Membership

Chairman	**Councillor CA Gandy**
Vice-Chairman	**Councillor FM Norman**
	Councillor CR Butler
	Councillor ACR Chappell
	Councillor JF Johnson
	Councillor MT McEvilly
	Councillor A Seldon

Co-optees

Mr P Burbidge	**Archdiocese of Cardiff**
Mr A James	**Parent Governor Representative**
Mr A Teale	**Diocese of Hereford**

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES

To receive details of members nominated to attend the meeting in place of a member of the committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest from members in respect of items on the agenda.

4. MINUTES 5 - 10

To approve and sign the minutes of the meeting on 17 September 2018.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive any written questions from members of the public.
Deadline for receipt of questions is 5:00pm on Tuesday 25 September. Accepted questions and answers will be published as a supplement prior to the meeting. Please submit questions to: councillorservices@herefordshire.gov.uk.

6. QUESTIONS FROM MEMBERS OF THE COUNCIL

To receive any written questions from members of the council.
Deadline for receipt of questions is 5:00pm on Tuesday 25 September. Accepted questions and answers will be published as a supplement prior to the meeting. Please submit questions to: councillorservices@herefordshire.gov.uk.

7. OUTCOME OF OFSTED INSPECTION OF LOCAL AUTHORITY CHILDREN'S SERVICES (ILACS) AND ACTION PLAN 11 - 46

To receive the outcome of the Ofsted inspection of children's services and the council's proposed response to areas for improvement identified.

8. HEREFORDSHIRE SAFEGUARDING CHILDREN BOARD (HSCB) ANNUAL REPORT 2017/18 47 - 110

To receive the annual report of the HSCB setting out the Board's annual assessment of safeguarding arrangements for children and young people in Herefordshire.

9. REFERRALS TO THE MULTI AGENCY SAFEGUARDING HUB 111 - 132

To receive a report concerning referrals to the MASH from partners and agencies.

10. WORK PROGRAMME REVIEW 133 - 150

To review the attached work programme for 2018/19 and note updates against recommendations made in the recommendations tracker contained in the appendix.

11. DATE OF NEXT MEETING
Date of next meeting – 12 November 2018, 10.15 a.m.

Herefordshire Council

Minutes of the meeting of Children and young people scrutiny committee held at Committee Room 1 - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 17 September 2018 at 10.15 am

Present: **Councillor CA Gandy (Chairman)**
Councillor FM Norman (Vice-Chairman)

Mr P Burbidge, CR Butler, ACR Chappell, Mr A James, JF Johnson, MT McEvilly and A Seldon

In attendance: **Councillor EJ Swinglehurst, Cabinet Member Young People and Children's Wellbeing**

Officers: **Chris Baird, Director, Children and Families (DCF), Keith Barham, The Head of Service (HOS), West Mercia Youth Justice Service (WMYJS), John Coleman, Statutory Scrutiny Officer, Gill Cox, Head of Looked After Children (HLAC), Liz Elgar, Assistant Director Safeguarding and Family Support and Matthew Evans, Democratic Services Officer.**

11. DECLARATIONS OF INTEREST

Councillor FM Norman declared a non-pecuniary interest in agenda item number 8, Corporate Parenting Strategy Action Plan, as a member of the Corporate Parenting Panel.

12. MINUTES

RESOLVED: that the committee approves the minutes of the meeting on 16 July 2018.

13. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

14. QUESTIONS FROM MEMBERS OF THE COUNCIL

There were no questions from members of the Council.

15. YOUTH JUSTICE PLAN 2018-2019

The committee considered a report which set out the draft Youth Justice Plan 2018 – 2019, for pre-scrutiny ahead of its presentation to Cabinet and full Council. The Head of Service (HOS), West Mercia Youth Justice Service (WMYJS), introduced the report and provided the presentation circulated in the supplement to the item. During the presentation the statistics relating to first time entrants (FTEs), use of custody and reoffending were provided

Councillor Bowen, Chair of the General Scrutiny Committee, commented on the response provided in the presentation to the recommendations of the committee from

2017. It was hoped that the timing of the preparation of the plan could be reconsidered to enable earlier comments and recommendations from scrutiny. It was pleasing that the evaluation of informal disposals had been undertaken and was included in the Plan and the year on year comparisons were welcomed. The ongoing impact of low numbers in Herefordshire was mentioned and the distortion of statistical comparisons. *The HOS confirmed that the low numbers in Herefordshire did distort the figures but the WMYJS was moving to a method of presenting the numbers alongside the rate.*

The committee raised the issues below in the discussion that followed:

- The purpose of the Plan was questioned and whether it was a statistics gathering exercise. The benefit to the community of the Plan was queried. *The HOS explained that the Plan was a requirement of the Crime and Disorder Act 1998 and its contents were prescribed. It was explained that the primary aims of the Plan and the WMYJS was to reduce the level of FTEs and reoffending rates which contributed to the efforts to reduce risks to the wider public and young people.*
- There were concerns that the statistics used in the Plan presented an impression that crime and disorder in Herefordshire was at a very low level however it was felt that the reality on the ground was very different. Police intervention in petty crime was an area of frustration as very little appeared to be done about low level crime which contributed to its incidence in the county. This was felt to be particularly pronounced in anti-social behaviour.
- There were concerns expressed that the experience of local communities did not accord with the presentation of the figures in the report. *The HOS confirmed that the WMYJS management board had held discussion to attempt to understand the figures contained in the report in the context of increases in the level of recorded crime.*
- There was concern regarding the relatively high reoffending rate and whilst it was acknowledged that the statistical numbers might be small it was still problematic in Herefordshire. The first time entrant rate was also perpetually higher than acceptable.
- The research undertaken on the adverse childhood experiences was raised and when any outcomes from this research would be available. It was queried whether any information could be shared with the committee. *The HOS explained that the first report would be available in October and this could be shared with the committee.*
- It was queried whether there were any parallels between some of the experiences in childhood of young people that contributed to reasons for reoffending and experiences of some looked after children (LAC) early in their lives that then contributed to issues that they faced in later life. *The Head of Looked After Children (HLAC) confirmed that that there were a very low number of LAC in the criminal justice system in Hereford.*
- The increase in the rate of drug offences was a significant concern and it was queried what work was ongoing with organisations such as Addaction. It was further queried whether the work of Addaction was limited to the city and market towns which allowed drug problems in rural areas to persist. *The HOS explained that the majority of drug offences concerned the possession of small amounts of cannabis, ecstasy and cocaine*. *The WMYJS had employed a drug worker who provided a link and liaison to groups such as Addaction.*
- The previous recommendation of the General Scrutiny Committee to circulate the Plan at an earlier stage of its preparation was supported by the committee.
- The committee discussed inviting witnesses to future meetings from partners, including the Community Safety Partnership (CSP), the Police and groups such as Addaction to provide a context around the figures presented in the Plan.

- A role for the General Scrutiny Committee was discussed to review work by the Herefordshire CSP relating to reducing youth offending and scrutinising the associated delivery plan. It was commented that the committee could look at the broader issue of youth crime and anti-social behaviour. Mentoring of children and young people by the police was also raised. *The HOS explained that an overall prevention strategy would be looked at by the CSP.*
- The involvement of the WMYJS with Children and Adolescent Mental Health Services (CAMHS) and the Children and Young People Mental Health Partnership was queried. *The HOS explained that a CAMHS worker had been seconded into the local team and was delivering assessments and interventions to the Youth Justice Service. Funding accessed through the transformation fund is supporting training so that staff are able to respond to mental health issues which fall below the CAMHS threshold.*
- It was requested that the Plan includes clarity regarding why it was produced, to whom it was aimed and which communities it serves.

RESOLVED: that the Committee:

- **endorses the Plan for presentation to full Council;**
- **notes the improvement in the rate of first time entrants across West Mercia but recognises further progress is required to reduce the rate in Herefordshire;**
- **supports an increase in the use of informal responses, such as community resolution, to divert young people from the formal justice system and recommends that this is progressed as a priority;**
- **expresses concern regarding the persistently high level of reoffending in Herefordshire and recommends that the General Scrutiny Committee review the reducing youth offending delivery plan, being produced by the Herefordshire Community Safety Partnership, and also scrutinises the CSPs approach to youth crime and anti-social behaviour;**
- **agrees witnesses from the police, the CSP and other relevant partners, such as Addaction, will be invited to participate in the committees future consideration of the Youth Justice Plan; and**
- **requests that the Plan incorporates clarity regarding why it is produced, to whom it is aimed and the communities it serves.**

There was a brief adjournment at 11.55 a.m. The meeting reconvened at 12.03 p.m.

16. CORPORATE PARENTING ANNUAL UPDATE

The committee received a report which provided an update on the corporate parenting strategy and action plan ahead of its presentation to Cabinet. The Head of Looked After Children (HLAC) introduced the report and provided an update on actions undertaken on the scrutiny committee's recommendations on the Corporate Parenting Strategy. It was explained that challenges remained to ensure members completed the skills directory, finding more apprenticeships at the Council for LAC and the current level of LAC in the county.

The committee raised the issues below in the discussion that followed:

- Detail was requested of the LAC who had attended university and whether they had now found employment. *The HLAC confirmed that this information would be provided;*

- It was recognised that progress had been made in certain areas of the action plan.
- The committee highlighted the importance of all members completing the skills directory and also identifying where potential work opportunities existed in their wards. Details of the number of LAC looking for opportunities was requested and it was suggested that detail regarding the type of placements sought was compiled and the economic development team encouraged to work with micro business to identify potential placements. *The Cabinet Member Young People and Children's Wellbeing confirmed that members would be contacted individually to encourage greater engagement with corporate parenting responsibilities and to request details to include in the directory. Work was ongoing to include a social value element to contracts the council procured to include opportunities for LAC. The HLAC confirmed that approximately 20 LAC were looking for opportunities.*
- The committee encouraged corporate parenting to be presented at the forthcoming parish summit.
- The committee emphasised the importance of the early help and the edge of care service which had been recognised by Ofsted and the peer review. *The Director of Children's Wellbeing explained that as part of the budget setting process for 2019/2020 resources concerning an edge of care service would be evaluated.*
- It was recognised that LAC had concessions to leisure facilities and it was felt that such concessions to cultural providers locally should also be explored. It was suggested that the chair of the committee writes to local cultural providers to request concessions for LAC.
- The committee requested detail of how unsuitable accommodation was defined. *The HLAC explained that unsuitable accommodation was accommodation which was not felt to be meeting the needs of LAC, including sleeping on sofas, being in inappropriate relationships. Better recording of accommodation had been achieved through Mosaic and a reduction in the number of LAC in bed and breakfast settings had been achieved.*
- Detail of progress with the savings proposal to reduce the numbers of looked after children was requested. *The DCF confirmed that there had been progress in meeting the needs of some looked after children in different family based arrangements and that the directorate was delivering on its medium term financial savings target for this area. However the expenditure on LAC in the current year would exceed planned spending. This was down to a number of reasons including the number of LAC had increased in the current year, the number of residential placements had increased significantly this year compared to what was planned for and there was a lack of placement choice that contributed to higher prices. The increase in spending on children's services was a national trend that saw a reported £800m spend over budget across all local authorities in England for 2017.*

RESOLVED: that the Committee:

- **notes the update and recognises the progress made;**
- **asks the executive to encourage all members to use local contacts to identify employment and work experience opportunities for LAC; and**
- **agrees to write to local cultural providers to request concessions for LAC.**

17. EDUCATION, DEVELOPMENT AND SKILLS STRATEGY 2018-2021

The committee considered a report which contained the draft education, development and skills strategy for preview scrutiny ahead of its approval by the executive. The DCF introduced the report and outlined the role of the Council and its core legal responsibilities. It was explained that the educational landscape was complex with

maintained schools, academies and free schools and the regional schools commissioner. The strategy was based on the principles of keeping children safe and giving them a great start in life. There was a particular focus in the strategy on 16-19 education and reducing the gap in attainment for additional needs and free school meals pupils.

The committee raised the issues below in the discussion that followed:

- A query was raised regarding performance measures and action plans associated with the strategy. *The DCF explained that performance would be assessed through performance challenge sessions and cabinet performance reports.*
- When would further details of the review of the strategy to improve SEN and disabilities provision be available and would there be a role for the committee in this work? *The strategic approach had already secured £500k to be used in Herefordshire to promote improvement from the DfE and also a successful bid to develop a 16-19 SEN Free School*. *The DCF explained that further work would be undertaken in the autumn and the SEN task and finish group could be involved in work around the review of the strategy.*

RESOLVED: that the Committee:

- **supports the Strategy as a high level statement of intent and requests that further detail on the individual projects is circulated when available; and**
- **requests that the committee is involved in the review of the SEND strategy.**

18. WORK PROGRAMME REVIEW

The committee received and noted its work programme 2018/19 and the updates contained in the recommendation tracker.

19. DATE OF NEXT MEETING

The committee noted the next meeting would be held on Monday 1 October at 2.00 p.m.

The meeting ended at 1.00 pm **Chairman**

Herefordshire Council

Meeting:	**Children and young people scrutiny committee**
Meeting date:	**1 October 2018**
Title of report:	**Outcome of children's Ofsted Inspection of Local Authority Children's Services (ILACS) inspection and action plan**
Report by:	**Cabinet member young people and children's wellbeing**

Classification

Open

Decision

This is not an executive decision

Wards affected

All Wards

Purpose and summary

To receive the outcome of the Ofsted inspection of services under the new Inspection of Local Authority Children Services (ILACS) framework, which was conducted between 4 June 2018 and 22 June 2018.

To consider the council's response to areas for improvement identified and to make any recommendations to cabinet regarding the council's proposed submission to Ofsted and proposed actions to address the areas of improvement that have been identified.

The council is required to submit an action plan to Ofsted within 70 days if the publication of their report (which is 25 October 2018), outlining how the council intends to address each of the areas for improvement, the timescales for action to be undertaken, and the monitoring arrangements.

Further information on the subject of this report is available from
Chris Baird, director for children and families Tel: 01432 260264, email: cbaird@herefordshire.gov.uk, Liz Elgar, assistant director safeguarding and family support Tel: 01432 260004,
email: liz.elgar@herefordshire.gov.uk

Recommendation(s)

That:

(a) the committee determine any recommendations it wishes to make to the executive to strengthen the draft action plan attached as appendix 2; and

(b) the committee determine any issues for inclusion in its future work programme.

Alternative options

1. There are no alternative options to the above recommendations; it is a function of the scrutiny committee to make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive.

Key considerations

2. The previous Ofsted inspection of children's safeguarding took place in April and May 2014, at which time services were found to be requiring improvement overall. The 2014 inspection was used as a baseline to assess what was taking place in Herefordshire in 2018.

The inspection

3. The Ofsted inspection team contacted Herefordshire on 4 June 2018 and were in Herefordshire from 11 to 22 June 2018. The inspection was carried out under the new Inspection of Local Authority Children's Services (ILACS) framework, implemented in November 2017. The new inspection framework focuses much more on the experience and outcomes for children as the basis for its judgements. The inspection does this by looking at case records and speaking to social workers and other front line workers directly. The old inspection framework was wider in scope and spent more time considering processes, other agencies and the views from a wider range of staff, partners and elected members.

4. The inspection focused on the effectiveness of local authority services and arrangements in place to help and protect children; the experiences and progress of children in care wherever they live including those children who return home; the arrangements for permanence for children who are looked after (including adoption); and the experiences and progress of care leavers. In addition Ofsted evaluated the effectiveness of leaders and managers and the impact they have on the lives of children and young people and the quality of professional practice.

5. Herefordshire Council has to submit an action plan by 25 October 2018, 70 days after receiving the final inspection report. This is a standard requirement of the Ofsted inspection framework.

6. The outcome of the inspection was that Herefordshire has been judged as requires improvement overall. The judgements contributing to this outcome are set out below:

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Requires Improvement
The experiences and progress of children in care and care leavers	Requires Improvement
Overall effectiveness	Requires Improvement

7. Ofsted reported that there were no children seen during the inspection who were found to be at risk of immediate harm and that the Multi-agency Safeguarding Hub (MASH) is responsive in its approach and ensures that children who need immediate help or protection have their needs met. Children who are looked after who were seen by Ofsted are in appropriate placements and the majority are developing well and their outcomes are improving. There were positive comments about a number of different areas, including early help, care leavers, children with disabilities, children at risk of sexual exploitation or wider exploitation, the council's approach to elective home education, and for children who go missing.

8. However, Herefordshire was judged as inadequate in the impact of leaders on social work practice with children and families. This is a significant judgement and one that reflects that a number of areas for improvement from the last inspection in 2014 still require attention. Ofsted noted throughout the inspection that the council's own self-assessment had identified the areas for improvement and also recognised that the 2017/18 year had been an extremely challenging one for leaders and managers. This in itself does not provide a full explanation for why there are still areas for improvement.

9. Some areas, including caseloads for social workers had improved over the four years but had also then deteriorated in some teams. Reductions in staffing numbers, including management posts has stretched capacity. Herefordshire continues to have difficulties in recruitment of social workers, especially experienced social workers and has done over a number of years. This is also a challenge regionally and nationally.

10. There has not been sufficient improvement in the consistency and quality of practice in some areas, in the use of performance management over a number of years, with a significant development to the casework system over the period presenting additional challenges to improvement. As the high court judgement on section 20 cases in 2018 noted, there has been drift and delay in social work practice in a number of areas for a significant period of time in Herefordshire. The range of preventative services and the resources available to support this area has reduced over this period. Herefordshire as a whole struggles to have a consistent approach to applying thresholds of need for children. The inspection therefore provides an opportunity for Herefordshire to focus on improvement and to commit to doing so consistently for a number of years to achieve embedded and sustained good quality services and an environment for good social work to flourish.

11. Inspectors did see evidence of leaders and managers capacity to implement improvements in the children with disabilities service and in the care leavers and 16+ team. They also noted that the management team's response to section 20 Children Act 1989 cases had also been effective. Actions, including linking with other local authority areas of good practice and those set out following the local government association peer review that took place in February had not had time to take effect.

12. The areas for improvement are detailed in appendix 1 as well as those areas that Ofsted recognised as strengths. The inspection summarised what needs to improve as follows::

- Senior leadership urgency in implementing a robust and timely action plan to deliver improvements and to address deficits in social work practice;
- The sufficiency of social workers and managers with capacity to cope with the need for services and the volume of social worker caseloads;
- Senior managers' interaction with social workers to enable staff to feel listened to;
- The pace of progressing child protection and child in need plans and the quality of practice with children in need;
- The regularity and quality of social work supervision;
- The quality and purposefulness of management oversight and decision making and the existing quality assurance and performance management system;
- The quality of life-story work for all children.

13. As part of the inspection, Ofsted identified some strengths including the following:

- Children identified at risk or immediate harm receive an appropriate prompt and responsive intervention, which ensures that they are safeguarded;
- Early help family support services that is received by families is responsive and there are good intense packages of support that are being provided; with good quality plans that clearly identify ongoing actions to sustain change;
- Multi-agency risk assessment conferences (MARAC) clearly identify risks to adults and children; the quality of actions plans are good;
- There is an effective out of hours service in place that provides timely and appropriate responses to children and families;
- The strengthening of assessment for children with disabilities through strong effective work results in effective support to children and their families;
- There is effective management of child sexual exploitation and other child exploitation; appropriate support and information is provided to parents and carers that enables them to understand their key role;
- The local authority are making appropriate decisions when children need to come into care; and where the risk increases and children are no longer able to remain at home we are making increasingly good use of our legal powers to safeguard and protect children;
- The majority of children in care live in good placements that facilitate the improvement in their individual outcomes;
- Where children and young people are unable to return to their birth families we are supporting them to live with connected persons;
- The local authority ensure where possible that siblings are placed together if this is appropriate and good assessments inform the contact plans.

- Where adoption is identified as the permanence decision this is achieved in a timely manner with families being carefully matched to children; introductions are managed well;

- Skilled work with unaccompanied asylum seeking children is taking place; the needs of these young people are well understood; where necessary we are placing them out of county to ensure that we meet their cultural and religious inclusion needs;

- The young people in care and care leavers are positive about their engagement with senior managers and the corporate parenting board;

- Care leavers are aware of their entitlement to services and they are provided with the support that they need to access information, legal rights and the benefits and financial help that they can receive;

- The council has made significant financial investment to support the development and improvement of children's social care services.

The council's action plan and performance monitoring

14. The draft action plan, attached at appendix 2 will continue to be refreshed and updated. The initial focus has been on short term actions to address key areas for improvement and these will be refreshed and renewed on at least a 3 monthly basis. Cabinet will be kept informed of progress against the action plan as part of the performance reporting process. The draft plan includes clear responsibilities and a process for monitoring.

15. Herefordshire is working closely with the Department for Education's (DfE) regional improvement and support lead for the West Midlands and making links with local authorities to aid our improvement. The DfE under-secretary of state for children and families will expect an update on progress in six months time.

16. Ofsted colleagues meet regularly with the director of children's wellbeing and the assistant director safeguarding and family support where progress will be reviewed. Ofsted will also probably undertake a focused visit sometime within the next 12 months and will critically evaluate what progress has been made on key areas of the ILACS inspection.

17. Since the Ofsted inspection in June 2018, work has already commenced as follows:

    - We have established a new approach within the Multi-Agency Safeguarding Hub (MASH) to address how contacts and referrals are being processed which will be in place from 1 October 2018;

    - We now have an Early Help Coordinator in MASH to ensure that children are managed in the correct part of the system and stepped up and down appropriately according to their identified needs;

    - We have reviewed 181 Child in Need (CIN) cases; 89 have been closed and a further 132 are being reviewed. 42 are being stepped down to Early Help;

    - We have systematically reviewed all Section 20 cases and taken the relevant action required on all of them, and have put in a system to stop this reoccurring which was acknowledged as good by Ofsted;

    - We identified that some cases were in the wrong teams, we are in the process of transferring these cases to the correct teams and will keep this under review;

- We have not been consistently completing supervision for workers and have implemented a supervision tracker from week commencing 30th July 2018. This is monitored weekly by heads of service and fortnightly by the assistant director;

- We are improving our performance data for managers to use. A data book is being circulated from the 1 October 2018 to enable mangers to more effectively manage their service areas and be able to plan work.

- We have increased management capacity and have an additional Head of Service to concentrate on MASH/Assessment. We have increased team manager capacity and have an additional team manager in both the assessment and children protection court teams.

- We have recruited additional family support workers to provide capacity and take some tasks from social workers.

- We are actively recruiting social workers and are part of a regional approach which at the time of writing has secured 4 social workers;

- We have increased business support capacity to increase the availability of business support for convening and minuting of meeting releasing social work time from these tasks;

- We are recruiting additional contact workers to clear the back log of life story work and maintain completion of life story work, particularly for children who are going to be adopted;

- We have run a 3 month assessment improvement project in the assessment team to improve the quality of children and family assessments. This will be rolled out across all social work teams;

- We have revised panel arrangements and a new panel will commence on the 25th September 2018 which will provide a much more robust challenge to requests for children to enter the looked after system;

- We are revising our quality assurance approach to enable greater learning and improvement in practice by revising our audit tool and establishing a framework which closes the loop of learning;

18. Every social work service area has a clear action plan to drive forward improvement and will be monitored on a monthly basis by the directorate leadership team. The council has been clear that its ambition and expectation is for safeguarding services to be good. The Ofsted report and these action plans are important staging posts in monitoring progress to achieve this expectation and ensure that where child protection services are needed, they are of high quality.

19. The council has established its longer term strategy to secure good child protection services within an environment of reducing resources. The priorities for change are to build independence and self-support within families and communities; to target support services proactively in areas of need; and to change the models of delivery.

20. Council oversight and governance will be through the performance framework, specifically the children's performance monitoring and the cross council quarterly performance reviews. Final challenge and assurance will occur through Cabinet and the Children and Young People's Scrutiny committee as appropriate.

Community impact

21. In accordance with the adopted code of corporate governance Herefordshire Council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review. To support effective accountability the council is committed to reporting on actions completed and outcomes achieved, and ensuring stakeholders are able to understand and respond as the council plans and carries out its activities in an open and transparent manner.

22. The successful implementation of the action plan will bring about further improvement towards achieving the council's priorities of keeping children and young people safe and giving them a great start in life and enabling resident's to live safe, healthy and independent lives; improving access to learning opportunities at all levels and improved outcomes for all children and young people.

23. Vulnerable children and young people, their families and carers, will experience different and improved approaches to service delivery as a consequence of the implementation of the actions set out in the plan and in the context of the plan's status within the wider children's development plan. This includes looked after children and care leavers up to the age of 25.

Equality duty

24. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

25. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services. We will make sure that as action plan is implemented will pay due regard to equality legislation.

26. The action plan will support the council in its overall duty to promote equality. In particular, the plan makes proposals to improve the outcomes of children and young people, by ensuring their diversity factors are assessed and assisting children and young people and their families to access services that meet their needs.

Resource implications

27. There are no resource implications associated with the recommendations of this report. The resource implications of any recommendations made by the committee will inform Cabinet's consideration of those recommendations.

28. The action plan appended to this report in appendix 2 will require additional resources and these are being considered as part of the council's budget setting process, including what can be done in terms of prevention and edge of care.

29. Within the 2018/19 financial year the cabinet has agreed £1.6m of resource to support the increase in capacity of social workers, social work managers, and family support and business support to undertake work that will reduce the demands on social workers themselves. There is also some investment being used to support further development of performance management reports and systems and to address life story work.

Legal implications

30. The Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007 sets out the requirements on the Council following an inspection report. The council is required to prepare a written statement of the action and the period which they propose to take that action. The appended action plan complies with this.

31. The action plan must be published within 70 working days of receiving an inspection report and a copy must be made available by either inspection at Council offices or by providing a copy upon payment of a reasonable fee.

Risk management

32. The risks associated with the failure to implement the action plan are:

- The council does not deliver sustained improvement. Too many children and young people receive a poor service, there is drift and delay and children and young people receive high threshold services that are reactive. There is not sufficient capacity for good social work to flourish and there are not the range of effective preventative and edge of care services to support children and young people safely in families. The council then runs the risk of being judged as inadequate under subsequent Ofsted ILACSs.

- Reputational. The council does not make progress quickly enough and this diversely affects the recruitment and retention of social work staff. This can have the knock on effect of increasing caseloads, which in turn has the potential to negatively impact on performance and quality of services for children and families.

Consultees

33. A meeting of partners is to take place on the 25th September 2018 and their views and responses will be noted here.

Appendices

34. Appendix 1 - Ofsted Inspection of Local Authority Children's Services (ILACS) report.
Appendix 2 - Ofsted ILACS inspection June 2018 action plan

Background papers

35. None identified

Herefordshire

Inspection of children's social care services

Inspection dates: 11 June 2018 to 22 June 2018

Lead inspector: Pauline Higham
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Requires improvement
The experiences and progress of children in care and care leavers	Requires improvement
Overall effectiveness	Requires improvement

Leaders and managers have not secured an environment in which good-quality social work practice can flourish, and the majority of core practice requires improvement. Senior leaders acknowledge that insufficient progress has been made in key aspects of their service, and many weaknesses found during this inspection mirror many of those identified in 2014. The pace of planning and action to remedy some long-standing deficits has been too slow. This had led to drift and delay for children before, during and after care proceedings, and means that outcomes have not improved for children in a timely way.

Since the last inspection in 2014, senior leaders have made some progress and have improved practice in some areas, for example in strengthening assessments for disabled children and in ensuring that information about children who go missing is shared effectively and is robustly analysed by partner agencies. The vast majority of children in care live in good placements, where their outcomes improve.

Children identified as at risk of immediate harm receive prompt and responsive intervention, ensuring that they are safeguarded. When risks increase, and children are no longer able to live safely at home, the local authority is making increasingly good use of its legal powers to safeguard and protect children. Decisions about whether some children who experience neglect need to become looked after are not taken swiftly enough. The quality of management oversight and decision-making across the wider service is too variable.

What needs to improve

- Senior leadership urgency in implementing a robust and timely action plan to deliver improvements and to address deficits in social work practice.
- The sufficiency of social workers and managers with capacity to cope with the need for services and the volume of social worker caseloads.
- Senior managers' interaction with social workers to enable staff to feel listened to.
- The pace of progressing child protection and child in need plans and the quality of practice with children in need.
- The regularity and quality of social worker supervision.
- The quality and purposefulness of management oversight and decision-making and the existing quality assurance and performance management system.
- The quality of life-story work for all children

The experiences and progress of children who need help and protection requires improvement

1. No children seen during the inspection were found to be at risk of immediate harm. The Multi-agency Safeguarding Hub (MASH) is responsive and ensures that good-quality information sharing results in strong decision-making. Children who need immediate help or protection receive appropriate interventions.

2. A significant number of contacts are signposted away from children's social care, which means that too many children are being referred who do not need this level of support. A number of children who would benefit from early help services experience delay because thresholds are not appropriately applied or understood. This is an area that needs to be strengthened so that children and families who might benefit from early help are quickly identified and do not experience any delays in receiving the help they need.

3. Despite this, early help family support services received by families are responsive and an intense package of support is provided. Early help plans are of good quality and detail clearly ongoing actions that are required in order to make and sustain change. These plans are reviewed

regularly and changes in needs are quickly responded to, resulting in demonstrable positive change for children and their families. When concerns escalate, thresholds for stepping cases up to statutory social care are well understood.

4. The majority of contacts into the MASH are progressed within 24 hours. Children identified as at risk of immediate harm receive a timely and responsive intervention, ensuring that they are safeguarded. Strategy discussions in the MASH involving the appropriate range of partner agencies take place promptly. Subsequent strategy meetings are well attended by professionals who know the children well, and planning for children is appropriate and well informed.

5. Similarly, section 47 child protection investigations are carried out in a timely way and appropriate decisions are reached. Poor recording in some cases means that there is not always evidence in children's records that they have been seen or the extent of direct work that has been undertaken with children.

6. The current arrangements within the MASH are not fully collaborative. Domestic abuse notifications are not triaged prior to them arriving in the MASH, which places additional burden upon the MASH manager. Police notifications classed as medium or standard risk (other than domestic abuse) are reviewed by police development officers appropriately and on a daily basis. However, there is no social care oversight of these cases, and, currently, there are no agreed timescales for ensuring that all notifications are reviewed. The consequence of this is that any risks to children might not be identified in a timely way, or they might be missed entirely. When alerted to this deficit, the local authority responded immediately to ensure thorough and timely management oversight of such cases.

7. Multi-agency risk assessment conferences (MARAC) are effective in identifying risks to adults and children. Information is relevant and specific. The quality of action plans is good, addressing risks by identifying actions for relevant agencies.

8. An effective out-of-hours emergency duty service (EDS) provides timely and appropriate responses to children and families. Information sharing, contact with daytime services and access to the electronic database enables EDS staff to make informed decisions and take any immediate actions to protect or help children.

9. Some children and family assessments are thorough, child centred and robust, and result in the provision of services and evident progress for children. However, this is not consistent. In poorer assessments, and particularly where neglect is a long-standing issue, social workers do not routinely consider historic concerns and their analysis can be over-

optimistic. Children are not routinely spoken to alone by social workers as part of their own assessments, and so subsequent plans are not informed by a child's view of their lived experience. In some cases, assessments are overly focused on the needs of adults.

10. Social workers across this service have high caseloads. In addition, and because of delays in transferring to other teams, they are also holding a mixed caseload. This means that social workers are struggling with competing demands and are prioritising their work with child protection and court cases taking precedence. In best case examples seen, social workers are tenacious and responsive. Evidence showed that there is effective child-centred practice that improves children's circumstances, but this is not consistent for all children.

11. The quality of services and practice for children in need is poor in many cases. Responses to their needs are too slow and lack the focus required to make meaningful changes to their situations. Current arrangements do not provide effective oversight, and while senior managers have developed an action plan to improve this situation, they do not ensure that all children in need are receiving the services they need in a timely way or that they their needs are prevented from escalating.

12. The local authority has invested in graded care profile training to support social workers in dealing with cases of neglect. Despite staff speaking positively about this, no evidence of this training was seen being used with individual children.

13. Initial child protection conferences are held in a timely way. There is good multi-agency attendance, which ensures a holistic contribution to the child's plan. The quality of child protection plans is too variable and is poor in some cases. The plans for some children result in good multi-agency support that improves their circumstances and achieves sustainable change. Weaker plans lack sufficient details for families to see clearly what services are going to be offered, who will provide them, their responsibilities and the timescale for them to take particular actions. This makes it difficult for families to understand what needs to change and by when.

14. Children in need and children subject to child protection plans do not always receive timely visits. Over half of children who are the subject of a child protection plan are not visited the locally defined minimum amount or visited enough times to meet their needs in line with their plans. Children are not always seen alone when social workers visit. This means that children are not always able to develop meaningful and trusting relationships with their social workers. Further social workers do not always have a sufficiently full understanding of children's current

circumstances to mitigate risk and to effectively progress the child's plan.

15. Fewer children are the subject of repeated referrals to children's social care and fewer children are subject to repeat child protection plans. This means that, for some children, intervention is effective and their improved outcomes are sustained.

16. Some children benefit from good direct work by social workers they know and trust, but this is not a consistent feature of social work practice. Children in this service experience too many changes of managers and social workers.

17. Management oversight of frontline practice is not consistently effective. It is not evident in all cases and does not provide the robust challenge and direction needed to urgently progress plans and avoid drift and delay. Social workers do not receive regular supervision, and when it does take place, it does not provide the necessary support and direction to ensure that all children's cases progress without delay.

18. The quality of help and protection offered to children by the disabled children's team is a strength. Strong and effective work with partner agencies results in effective support to children and their families. Workers know the children they are working with very well and they ensure that children's views are evident in their reviews and assessments. Assessments are updated regularly and provide a good analysis of the needs of children.

19. When children live in households where multiple risks are present, these risks are identified well. However, this identification of risk is not then routinely followed up by well-coordinated and focused intervention, with the result that there are delays in progress for children. Often, there is too much focus on single issues, rather than understanding how risks relate to each other and then formulating an overarching plan to address this. The impact on children who are living in such circumstances is not well understood by senior managers, and assertive and timely action is not always well coordinated to improve their circumstances.

20. Work with families is not always consistently child-centred. Following an initial public law outline (PLO) meeting, in some cases the significance of what happens to a child is lost as the focus shifts on to the adults. Some letters before proceedings are too long and do not assist parents to understand what they need to prioritise and how they are going to be supported to change. Some children experience drift and delay at this stage, and review PLO meetings are not taking place in a timely way.

21. For children at risk of exploitation, effective multi-agency working results in risks being identified and appropriately assessed. Robust risk assessments result in children being supported at the right thresholds to mitigate risk. Where concerns increase and where it is appropriate, children come into care without delay to ensure that they are safeguarded.

22. Child sexual exploitation and other child exploitation is effectively managed. Timely information sharing between professionals enables effective mapping to take place, identifying potential adults of concern and other children at risk of exploitation. Appropriate support and information is provided to parents and carers to enable them to develop a better understanding of child exploitation and the key role that they play in safety planning.

23. The local authority's designated officer ensures that prompt and effective action is taken when allegations are made against professionals or persons in positions of trust. Position of trust meetings are timely and well attended, ensuring that appropriate actions are taken to effectively safeguard children.

24. For children who go missing from home or care, return home interviews are completed in a timely manner. The recordings of discussions with children lack analysis, with the result that it is not always clear how the information gathered informs safety planning for children. The local authority is aware of this deficit and has taken action to improve the way that staff can record their findings that supports more effective analysis and data collection.

25. There has been concerted work to get children who have been reported missing from education back into school. Schools report any concerns promptly and officers follow up cases effectively, working in partnership with other agencies and local authority teams. Officers keep detailed records of their work and cross-check any emerging concerns with social care colleagues.

26. Local authority officers know which pupils are being electively home educated. The elective home education officer works effectively with families to make checks on the quality of education that pupils receive. Any safeguarding concerns are promptly acted on.

27. The arrangements for children in private foster care are not well managed. Children do not receive a timely and responsive assessment of their needs or of their carers' abilities to meet their needs. Not all required checks are carried out and not all children have been seen in a timely way. The local authority responded immediately to concerns

raised by inspectors for the very few children living in these arrangements and has taken appropriate steps.

The experiences and progress of children in care and care leavers requires improvement

28. Appropriate decisions are made when children need to come into care. When risks increase, and children are no longer able to live safely at home, the local authority is making increasingly good use of its legal powers to safeguard and protect children.

29. Decisions for children to become looked after are not always based on up-to-date assessments. Assessments are not routinely updated to reflect changes in a child's circumstances and needs. Historical concerns are not always fully considered, and this means that some children whose circumstances had not changed should have come into care sooner. Better assessments take good account of historical concerns effectively, using research and analysis to inform planning.

30. When children and young people become accommodated under s20 Children Act 1989, the initial decision-making is appropriate. The planning that follows is not always sufficiently robust or purposeful, and, as a result, several children have remained subject to these arrangements for too long. This has resulted in prolonged drift in progressing their care.

31. As a consequence of a recent court judgement, it was recommended that the local authority should review all cases where children were subject of s20 Children Act 1989 arrangements. As a result, a targeted and effective action plan has led to more recent assertive decision-making and the progression of plans for some children.

32. Children's care plans are of variable quality. Some are specific and clear, while others are overly long. In these plans, outcomes are not measurable and actions and timescales are recorded as 'ongoing'. In some cases, this has contributed to drift and delay for children.

33. Where appropriate, children and young people who are unable to return to their birth families are being supported to live with connected persons. Family group conferences are used well to facilitate the exploration of family-based solutions.

34. The local authority is succeeding in ensuring that brothers and sisters are placed together where possible and where it is appropriate. Good assessments inform contact plans, and any changes to contact

arrangements meet the needs of the children and support family relationships.

35. Children are actively encouraged to attend their reviews, and advocacy is used appropriately. Children are routinely seen alone. In most cases, recording of visits is thorough. Social workers know children well and are able to clearly articulate their needs, identify risks and vulnerabilities and describe their personalities. However, this knowledge is not always fully reflected in case records. Views of parents and other family members are well recorded and are reflected in children's care planning.

36. Despite this good work, the quality and progress of care planning is compromised for some children because of too many changes in social worker. This also means that it is difficult for children to build trusting relationships with their social workers.

37. Children's views are well recorded within review minutes. Child-centred letters are written to children by independent reviewing officers (IROs), informing them of outcomes and decisions of their reviews, and this helps children understand what is happening. IRO visits to children are not always recorded on their case files, and so the IRO footprint is not consistently evident. IRO scrutiny and challenge to progressing plans and addressing drift is not always sufficiently robust.

38. Children seen are in appropriate placements, and are having their needs met, with the majority developing well and their outcomes improving. The process for supporting stability of placements is effective and help is available early to prevent concerns from escalating further. Access to Herefordshire intensive placement support service therapeutic support is a strength. Case records do not demonstrate that matching takes place at the point of children coming into care, and for some children permanence is not achieved within their timescales.

39. The authority's arrangements for delegating authority to carers is not sufficiently clear and has not been for some time, despite the issue being raised by young people previously. This is an important issue for young people and means that some foster carers are still unable to make appropriate day-to-day decisions on their behalf. Senior managers have acknowledged this and have agreed to take immediate action to remedy the situation.

40. Foster carers go through an appropriate approval process and receive the right range of training to meet the needs of children placed with them. The local authority is struggling to provide a sufficient number of foster families, and in particular those that meet the needs of sibling groups and teenagers.

41. Too many children do not have life-story work completed and this means that carers do not have a comprehensive and accessible account of a child's life history to enable them to fully support children.

42. Educational outcomes for children in care are variable across the local authority. The attainment of key stage 4 children in care has been in line with, or above, national levels for the last two years. The attainment of children in care in key stages 1 and 2 has been variable for the last two years. The local authority is aware of this variability and is committed to raising standards further. The electronic system that has been introduced to record children's outcomes does not provide the virtual school with sufficiently detailed information about the children's attainment and progress. As a result, it is not yet possible to fully track outcomes and respond accordingly to any identified issues or trends.

43. The virtual school headteacher has a clear view of the strengths and priorities of the local authority provision. The virtual school does not have sufficiently detailed information about the attainment of children in care, and schools report that children in care achieve mixed levels of progress. Targets within personal education plans are not specific or measurable enough to allow professionals to make an accurate judgement about the progress of children in care. This is particularly the case for looked after children and care leavers in secondary and 16–19 provision. Personal education plans do include the views and feelings of children in care.

44. For the majority of children for whom the permanence decision is adoption, adoption is achieved in a timely manner. Family finding and matching are strong areas of practice. Families are carefully matched to children, and information sharing is good. Introductions are well managed, with input from the adoption social worker as well as the child's social worker.

45. Arrangements for adoptive families to access post-adoption support are good, enabling help and support to be available without delay. The service keeps in touch with adopters, sending out emails and flyers to invite them to tailored training and social events. All adopters have access to a play therapist based in the service if children require this type of support. This is good practice.

46. Care leavers have timely effective pathway plans that address their needs. Plans are individual, aspirational and reflect young people's hopes for the future. Young people clearly contribute to their plans and they focus on what is important to them. Care leavers have trusted relationships with their personal assistants.

47. While young people at 18 years old have a meeting with the child looked after nurse, not all young people have access to their health

information. Inspectors identified this as an important issue for young people and the local authority has agreed to take this forward as an area for immediate improvement.

48. Skilled work with unaccompanied asylum-seeking children takes place. The diverse needs of these young people are well understood, and it is recognised that their needs cannot always be met within the Herefordshire area. Out-of-county placements are sourced and meet children's cultural religious and inclusion needs. Staff proactively seek to further develop their skills in this area to appropriately support young people.

49. Young people in care and care leavers are positive about their engagement with senior managers and the corporate parenting board. They spoke positively about the recent council 'take over day' in November, which also included other agencies.

50. Care leavers live in good-quality placements and accommodation, including supported living and staying put arrangements. Care leavers are aware of the advocacy service, although they feel that their voices are not always heard or taken account of. Access to mental health services for care leavers is difficult, and to date there is no strategy to improve this situation. Care leavers know about their entitlement to services and they receive good support to access information, legal rights, and the benefits and financial help that they can receive.

The impact of leaders on social work practice with children and families is inadequate

51. The last year has been extremely challenging for leaders and managers. A very specific set of circumstances occurred from September last year that included restrictions on the range of functions some senior managers have been able to undertake and challenging personal circumstances that have resulted in a leadership team with constrained capacity, lack of stability and, in some areas, poor performance.

52. A number of areas for improvement from the last inspection in 2014 still require attention and this is a concern. These include caseloads that are too large, ineffective quality assurance and performance management and continuing difficulties in recruiting good-quality social work staff and managers.

53. Senior leaders have sought and are receiving support from colleagues within the social care sector who lead children's social care effectively in the sector, but it is too early to evaluate this.

54. Leaders and managers have not been effective in overseeing and ensuring that social work practice flourishes. Their lack of grip and direction has resulted in a service where some decision-making is very poor, some staff do not receive supervision and workforce capacity is not at the level required to provide a good-quality service for children and families.

55. Social workers from various teams are prevented from providing the quality of service they know is required because of excessive caseloads and ineffective deployment of staff. This is further hampered by a lack of robust, clear and timely management oversight and case direction. Senior leaders acknowledge this and now have the early stages of an improvement strategy in place. However, it is too early to see any impact.

56. Too many children in need of help and protection and children in care are receiving a poor service. Practice is not consistently child focused. Planning for children is not always sufficiently robust or purposeful and this is compounded by management oversight that is not effective in addressing this. As a result, some children experience unnecessary drift and delay and their circumstances do not improve in a timely way.

57. Staff in some teams feel a strong disconnect from their senior managers, which is inhibiting improvement. If improvements are to be made securely, this needs immediate attention.

58. Sufficiency planning lacks effective strategic direction and future needs are not articulated clearly. This is compounded by the current commissioning strategy not being underpinned by a comprehensive assessment of future needs.

59. Senior managers acknowledge that their current performance and management information data is underdeveloped and does not provide sufficient accurate detail to support their understanding of what is happening in their service. This requires immediate and robust attention.

60. Quality assurance processes are undertaken routinely, but they are rendered ineffective because of a lack of follow-through on issues of concern. This is a missed opportunity to improve the quality of social-work practice and a failure of managers.

61. Leaders and managers are aware of deficits in practice and service provision, but currently there is a lack of timely action planning to remedy this. Inspectors have seen evidence of their capacity to

implement improvements in the children with disabilities service and in the care leavers and 16-plus team. The management team's response to s20 Children Act 1989 cases has also been effective.

62. Furthermore, the council has made a recent significant financial investment to support the development and improvement of children's social care services. This is supported by a recent appointment to the senior management team of an assistant director who brings a renewed focus to long-standing issues. The director of children's services is aware of the need to take robust and immediate measures to strengthen his management team and there is very recent evidence of assertive action.

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Herefordshire Council

Children and Families Directorate
Ofsted Improvement Plan

The improvement plan sets out the seven key areas for improvement as identified by Ofsted, further areas for improvement are then grouped according to the areas of the Safeguarding and Early Help Development Plan. This plan will be developed further with local authorities identified by the DfE to aid Herefordshire's improvement.
Actions contributing to the delivery of the plan will be reviewed weekly, fortnightly and monthly within the service. Updates will be provided to management board and to Cabinet as part of performance and budget reporting. Children and Young People's Scrutiny Committee will regularly review progress against the plan.

RAGB Status	Indicator / Definition	Actions
Red	"Action" is behind schedule. Performance measure not yet achieved	Director / Assistant Director will review the "Action" to identify the root causes of the red status. Action Plan owners will produce plans to prevent further deterioration and ensure action is back on track – plans will be approved by Assistant Director.
Amber	"Action" has experienced some issues. Delays forecasted. Performance measure unlikely to be achieved on time	Director / Assistant Director will maintain a watching brief over amber "Action/s". Action Plan owners will produce plans to ensure action is back on track – plans will be approved by Assistant Director.
Green	"Action" is on track. Completion date and performance measure is expected to be achieved.	Director / Assistant Director need assurance the "Action" is truly green.
Blue	"Action" completion date and performance measure achieved. "Action" complete/closed.	

Ofsted Inspection of children's social care services 04/06/18 - 22/06/18 - What needs to improve

Ofsted No. 1 — **Senior leadership urgency in implementing a robust and timely action plan to deliver improvements and to address deficits in social work practice**

RP 51 — A leadership team with constrained capacity, lack of stability and, in some areas, poor performance.

RP 61 — Leaders and managers are aware of deficits in practice and service provision, but currently there is a lack of timely action planning to remedy this.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
1.1	Establish specific Service Area Action Plans to address immediate areas for improvement, these to be refreshed at least every 3 months to ensure they drive improvement. These feed into the overall Ofsted Improvement Plan.	31/08/2018	Assistant director safeguarding and family support	Action plans agreed and actions taking place	Improvements in core quality of practice is evident through performance and audit reporting	Action plans in place and actions are being delivered. Monitoring process established.	B
1.2	Develop draft Ofsted Improvement Plan to address Ofsted areas for improvement, building on existing development plan, self assessment and peer review.	21/09/2018	Director for children and families	Draft action plan complete.	N/A	Plan drafted and sent to Ofsted for initial view.	B
1.3	Cabinet sign off Ofsted Improvement Plan following scrutiny by Children and Families Scrutiny Committee.	18/10/2018	Director for children and families	Ofsted Improvement Plan signed off	Scrutiny have reviewed and made their recommendations to Cabinet. Cabinet have agreed the action plan.		G
1.4	Formally share Improvement Plan with Ofsted.	25/10/2018	Director for children and families	N/A	N/A	N/A	G

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
1.5	Enhance management grip through weekly performance information, including timeliness of visits and assessments, to be used by team managers and heads of service.	from 10/09/2018	Assistant director safeguarding and family support	Visits completed within targets, assessments completed within 45 day timescale	Team managers are actively using the performance information, evidenced by improvements in performance within their teams.	Information produced and being shared. Performance booklet on track to be produced from 1/10/2018	G
1.6	Deliver and monitor Ofsted Improvement Plan and Service Area Action Plans using project management approach, fortnightly/monthly review meetings and reports. Quarterly updates to cabinet and children and families scrutiny.	from 10/09/2018	Assistant director safeguarding and family support	N/A	Change is evidenced	Monitoring process and procedure agreed and implemented.	G
1.7	Progress update sent to Department for Education (DfE) for 6 monthly review	01/04/2019	Director for children and families	N/A	N/A	N/A	G

Ofsted No. 2	The sufficiency of social workers and managers with capacity to cope with the need for services and the volume of social worker caseloads
RP10	Social workers across this service have high caseloads. In addition, and because of delays in transferring to other teams, they are also holding a mixed caseload. This means that social workers are struggling with competing demands and are prioritising their work with child protection and court cases taking precedence. ... Evidence showed that there is effective child-centred practice that improves children's circumstances, but this is not consistent for all children.
RP 16	Some children benefit from good direct work by social workers they know and trust, but this is not a consistent feature of social work practice. Children in this service experience too many changes of managers and social workers.
RP 36	Despite this good work, the quality and progress of care planning is compromised for some children because of too many changes in social worker. This also means that it is difficult for children to build trusting relationships
RP 52	Caseloads are too large, ineffective quality assurance and performance management and continuing difficulties in recruiting good quality social work staff and managers.
RP 54	Despite this good work, the quality and progress of care planning is compromised for some children because of too many changes in social worker. This also means that it is difficult for children to build trusting relationships with their social workers.
RP 55	Social workers from various teams are prevented from providing the quality of service they know is required because of excessive caseloads and ineffective deployment of staff. This is further hampered by a lack of robust, clear and timely management oversight and case direction. Senior leaders acknowledge this and now have the early stages of an improvement strategy in place. However, it is too early to see any impact.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
2.1	Cabinet to agree additional investment to support recruitment (£1.6m)	01/05/2018	Director for children and families	Cabinet agreed additional investment of £1.6m.		Achieved	B
2.2	Implement package of measures to support retention of experienced staff	01/08/18 - phase 1 (Market forces supplement, relocation, recommend a friend). 28/12/18 - phase 2 (learning accounts, retention payments). 29/03/19 - phase 3 (corporate employee benefits)	Organisational development business partner	Vacancies levels in Child Protection/Court Team	Child Protection/Court Team is fully staffed and internal movement other than for promotion is reduced to zero	Market forces supplement implemented across social worker roles. Increased relocation payment in place. Drop in sessions held to get staff views on next steps. Proposals drafted for consideration by mini-board	G
2.3	Develop and implement revised career pathways to support professional and personal development	31/10/2018	Organisational development business partner	Number of appointments to social worker from student placements, Step Up and apprenticeships.	We have developed and implemented clear career pathways that staff tell us they understand - via health check and employee opinion survey.	Consultation on career pathway undertaken and first draft produced.	G

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
2.4	Identify additional routes to recruit and retain permanent employees, including collaboration with the West Midlands region	31/10/2018	Organisational development business partner	A number of new permanent employees in place via agreed routes	We have agreed new routes to recruit experienced people, have a plan of action and have implemented it.	Agreed to develop proposals around overseas.	G
2.5	Recruit a team of 10 agency social workers into the Child Protection/Court Team to provide six months cover.	22/10/2018	Organisational development business partner	Social workers recruited and team in place no later than 22/10/18	Timely and high quality services are delivered to children and families (frequent change of social worker and drift/delay is avoided). Social work caseloads are reduced and case transfers across the service are enabled.	4 appointed, start dates confirmed. Further 7 interviews arranged	A
2.6	Recruit up to 8 newly qualified social workers to the Assessed and Supported Year of Employment programme and retain them within the organisation	from 01/09/2018	Principal social worker	8 Assessed Supported Year of Employment newly qualified social workers recruited		As of 20/09/2018 2 Assessed Supported Year of Employment newly qualified social workers have been recruited; with a further 2 candidates being interviewed on 08/10/2018	A

Ofsted No. 3	Senior manager's interaction with social workers to enable staff to feel listened to
RP 57	Staff in some teams feel a strong disconnect from their senior managers, which is inhibiting improvement. If improvements are to be made securely, this needs immediate attention.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
3.1	Regular staff briefings on outcomes of Ofsted inspection and immediate steps.	31/07/2018	Director for children and families	Briefings complete and briefing materials distributed to all staff.	Staff surveys illustrate that staff feel engaged/informed/clear regarding areas for improvement and next steps. Staff feel more positive, their views are making a difference and a greater connect to Senior Management.	Briefings provided to staff at range of locations	B
3.2	Rolling programme of regular staff briefings regarding Children and Families Development Plan and underpinning philosophy regarding how to deliver services to children/families.	24/09/2018	Director for children and families/Assistant director safeguarding and family support	Briefings complete and briefing materials distributed to all staff.		Programme in place	G
3.3	Establish a variety of methods of communication, including monthly blog.	30/10/2018	Director for children and families/Assistant director safeguarding and family support	Staff access communication mediums			G
3.4	Assistant director Open Door session to all staff once a month.	28/08/2018	Assistant director safeguarding and family support	Staff attend sessions.		In place	B
3.5	Staff views requested and received on how to improve methods of communication/ engagement.	03/09/2018	Director for children and families/Heads of service	Views collated/established/ embedded.		Carried out during July/August. Review effectiveness Jan 2019. Suggestions implemented at staff conference, drop in sessions, and variety of communications	B

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
3.6	Implement Cascade Model of information sharing from Assistant director/ Head of service meetings to Head of service /Team manager meetings through to team meetings to embed information flow through the organisation.	10/09/2018	Assistant director safeguarding and family support	Model implemented/embedded.		In place	B
3.7	Senior manager's to increase level of interaction with staff/teams.	24/08/2018	Director for children and families/Assistant director safeguarding and family support and all Senior managers.	Positive feedback from staff at briefings.		Heads of service spending time working alongside staff in different buildings. Assistant director/director have programme of visits with teams. Director establishing programme of shadowing individual workers through the year.	B
3.8	Request staff views regarding changes required to improve social worker experience and implement outcomes.	06/08/2018	Director for children and families/Assistant director safeguarding and family support and all Senior managers.	Positive feedback from staff at briefings.		Business support have taken on additional work and social workers have reported this is helpful and making a difference.	B
3.9	Distribute Social Work Survey and encourage staff to complete.	30/11/2018	Director for children and families/Assistant director safeguarding and family support, Head of service, Principal social worker and Organisational development business partner.	50% of staff return survey results.		Staff survey launched	G

Ofsted No. 4	The pace of progressing child protection and child in need plans and the quality of practice with children in need
RP11	The quality of services and practice for children in need is poor in many cases. Responses to their needs are too slow and lack the focus required to make meaningful changes to their situations. Current arrangements do not provide effective oversight, and while senior managers have developed an action plan to improve this situation, they do not ensure that all children in need are receiving the services they need in a timely way or that they their needs are prevented from escalating.
RP 13	The quality of child protection plans is too variable and is poor in some cases. ... Weaker plans lack sufficient details for families to see clearly what services are going to be offered, who will provide them, their responsibilities and the timescale for them to take particular actions. This makes it difficult for families to understand what needs to change and by when.
RP 14	Children in need and children subject to child protection plans do not always receive timely visits. Over half of children who are the subject of a child protection plan are not visited the locally defined minimum amount or visited enough times to meet their needs in line with their plans. Children are not always seen alone when social workers visit. This means that children are not always able to develop meaningful and trusting relationships with their social workers. Further social workers do not always have a sufficiently full understanding of children's current circumstances to mitigate risk and to effectively progress the child's plan.
RP 19	Identification of risk is not routinely followed up by well-coordinated and focused intervention, with the result that there are delays in progress for children. Often, there is too much focus on single issues, rather than understanding how risks relate to each other and then formulating an overarching plan to address this. The impact on children who are living in such circumstances is not well understood by senior managers, and assertive and timely action is not always well coordinated to improve their circumstances.
RP 56	Too many children in need of help and protection and children in care are receiving a poor service. Practice is not consistently child focused. Planning for children is not always sufficiently robust or purposeful and this is compounded by management oversight that is not effective in addressing this. As a result, some children experience unnecessary drift and delay and their circumstances do not improve in a timely way.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
4.1	Establish accurate data of all open child in need cases	30/09/2018	Assistant director safeguarding and family support	Clear data set of Herefordshire child in need population established	Focused attention on reviewing child in need cases can take place	Data cleansing commenced in July 2018, to date over 200 cases categorised as child in need have been reviewed.	G
4.2	Review all open child in need cases	30/10/2018	Assistant director safeguarding and family support	All child in need cases have been reviewed by a Team manager or Head of service	Appropriate actions identified for children who's child in need plans have been subject to drift and delay	Once we have a clear data set of children in need with a child in need plan in place this will commence	G
4.3	Review, revise and implement Herefordshire Child in Need guidance	30/12/2018	Assistant director safeguarding and family support	Child in need guidance has been understood and accepted by all social work and family support workforce across the children and families directorate	Children who require a child in need plan receive a consistent, timely and child focused service	Negotiations have commenced to recruit additional capacity to undertake this work.	G
4.4	A comprehensive action plan will be implemented to raise the standard and quality of child protection plans	30/11/2018	Head of service safeguarding and review	All Independent Reviewing Officer's (IRO's) and Team managers understand and accept principles and practice of Specific, Measurable, Achievable, Realistic, Timebound (SMART) child protection plans	All children who require a child protection plan will have a robust child centred child protection plan	Action plan in place, to date achievements made against timescales including Head of service reviewing quality of child protection plans in every 1:1 on monthly basis.	G
4.5	Targets will be set to measure improvement in timeliness of visits to children in need and children with child protection plans. The performance information will be reviewed on a weekly basis by Team managers, Heads of service and Assistant director safeguarding and family support.	10/09/2018	Assistant director safeguarding and family support / Head of service	Timescales set end of Sept 65%; end Oct 80%; end Nov 90%	Children will receive the service they require and deserve and statutory timescale visits are completed	Targets set. September performance data will inform us if we have achieved these targets which is due to come to Assistant director / Head of service meeting on 08/10/2018	A

Ofsted No. 5	The regularity and quality of social worker supervision
RP 17	Social workers do not receive regular supervision, and when it does take place, it does not provide the necessary support and direction to ensure that all children's cases progress without delay.
RP 54	Leaders and managers have not been effective in overseeing and ensuring that social work practice flourishes. Their lack of grip and direction has resulted in a service where some decision-making is very poor, some staff do not receive supervision and workforce capacity is not at the level required to provide a good-quality service for children and families.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
5.1	Recruit additional managers to enable increase in frequency of Supervision.	31/07/2018	Organisational development business partner	Additional managers in post.	We see the supervision figures increase to target set at 80%	2 Team managers recruited to Child Protection /Court Team and 1 Team manager recruited to Assessment Service. 1 Managing Practitioner recruited to Multi-agency safeguarding hub (MASH) and 1 Managing Practitioner recruited to Looked After Children.	B

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
5.2	Establish fortnightly reporting on Supervision figures/numbers.	01/09/2018	Performance service manager	Figures available		Performance information on frequency of supervision is now being received and September figures will indicate if target of 80% is being achieved	B
5.3	Undertake an audit of the quality of Supervision provided to Social workers by Team managers	30/12/2018	Heads of service	Audit completed	When the quality of supervision is consistently good.		A

Ofsted No. 6	The quality and purposefulness of management oversight and decision making and the existing quality assurance and performance management system
RP 6	The current arrangements within the MASH are not fully collaborative. Domestic abuse notifications are not triaged prior to them arriving in the MASH, which places additional burden upon the MASH manager. Police notifications classed as medium or standard risk are reviewed by police development officers appropriately and on a daily basis. However, there is no social care oversight of these cases, and, currently, there are no agreed timescales for ensuring that all notifications are reviewed. The consequences of this is that any risks to children might not be identified in a timely way, or they might be missed entirely.
RP 17	Management oversight of frontline practice is not consistently effective. It is not evident in all cases and does not provide the robust challenge and direction needed to urgently progress plans and avoid drift and delay. Social workers do not receive regular supervision, and when it does take place, it does not provide the necessary support and direction to ensure that all children's cases progress without delay.
RP 42	Educational outcomes for children in care are variable across the local authority. The attainment of key stage 4 children in care has been in line with, or above, national levels for the last two years. The attainment of children in care in key stages 1 and 2 has been variable for the last two years. The local authority is aware of this variability and is committed to raising standards further. The electronic system that has been introduced to record children's outcomes does not provide the virtual school with sufficiently detailed information about the children's attainment and progress. As a result, it is not yet possible to fully track outcomes and respond accordingly to any identified issues or trends.
RP 43	The virtual school does not have sufficiently detailed information about the attainment of children in care, and schools report that children in care achieve mixed levels of progress. Targets within personal education plans are not specific or measurable enough to allow professionals to make an accurate judgement about the progress of children in care. This is particularly the case for looked after children and care leavers in secondary and 16–19 provision. Personal education plans do include the views and feelings of children in care.
RP 54	Leaders and managers have not been effective in overseeing and ensuring that social work practice flourishes. Their lack of grip and direction has resulted in a service where some decision-making is very poor, some staff do not receive supervision and workforce capacity is not at the level required to provide a good-quality service for children and families.
RP 55	Social workers from various teams are prevented from providing the quality of service they know is required because of excessive caseloads and ineffective deployment of staff. This is further hampered by a lack of robust, clear and timely management oversight and case direction. Senior leaders acknowledge this and now have the early stages of an improvement strategy in place. However, it is too early to see any impact.
RP 59	Senior managers acknowledge that their current performance and management information data is underdeveloped and does not provide sufficient accurate detail to support their understanding of what is happening in their service. This requires immediate and robust attention.
RP 60	Quality assurance processes are undertaken routinely, but they are rendered ineffective because of a lack of follow-through on issues of concern. This is a missed opportunity to improve the quality of social-work practice and a failure of managers.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
6.1	Improve the quality and detail of performance information to enable managers to have a grip on how their teams are performing and take appropriate action where required	31/12/2018	Performance team lead	Accurate performance information is available and practice standards are improved	Managers are using performance information as business as usual and performance measures are improved	Data book goes live 01/10/2018; reports on weekly visits and supervision in place. Local authority has worked with Staffordshire to determine offer of support via DfE	G
6.2	Recruit additional capacity into the performance team to improve the performance information and analysis	30/09/2018	Performance service manager	Additional posts are in place	Accurate timely performance data is available to all managers across the service and being used to drive up the quality of social work practice	Children's Service Performance team leader appointed. Further recruitment taking place to provide additional capacity	A
6.3	Review the development programme of Mosaic and establish further enhancements, plan and resources to deliver	31/12/2018	Assistant director safeguarding and family support	Mosaic supports the social work systems efficiently	Performance culture is embedded across the children and families directorate and enables us to take swift and appropriate action for areas that require improvement	Use the expertise from other local authorities via the DfE to support the development of the programme	G

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
6.4	Produce Performance Overview Report and review at Heads of service/Assistant Director meeting. Risks and highlights identified and reported to Senior management team (SMT) on monthly basis.	31/07/2018	Performance service manager and all Heads of service/Assistant Director safeguarding and family support	Report produced and discussed at monthly meetings.	Leaders at all levels have full understanding and grip of performance across the whole service. Appropriate/ timely actions/intervention is taken by leaders at all levels when performance levels decline.	Implemented on 13/08/18	B
6.5	Ensure schools are set appropriate and rigorous attainment targets for looked after children.	28/09/2018	Head of learning and achievement	Appropriate targets set.	Educational outcomes for children in care will be in line with national or above for looked after children at Early Years Foundation Stage (EYFS), phonics, Key Stage 1 (KS1), KS2, KS4 and KS5 for all external performance measures in 2019 and beyond;	Training for schools on 26/09/2018 will include Herefordshire Council expectations regarding: targets, interventions, ePEPs and effective use of pupil premium funding for looked after children.	G
6.6	Monitor progress towards targets schools set for looked after children.	30/08/2019	Head of learning and achievement	Targets achieved.		National data for external measures in 2018 not yet available.	G
6.7	Develop the Virtual School Team to enable robust conversations with schools regarding the progress pupils are making.	31/10/2018	Head of learning and achievement	Training completed	Gaps will reduce between Herefordshire looked after children and Herefordshire non looked after children	Training was delivered by Marlbrook Teaching School and Head of learning and achievement in the summer term on external progress and attainment measures. Further training booked for 18/10/18.	G
6.8	Ensure effective use of pupil premium for looked after children that enhances attainment and progress.	30/11/2018	Head of learning and achievement	Evidence of pupil premium being used appropriately.		The Virtual School Team is now risk (RAG) rating ePEPs for the quality of academic targets set. In July 238 ePEPs were RAG rated of which 10 were red (of which 7 were school issues) and 58 were amber. The seven schools who had a red risk rating ePEP did not receive pupil premium funding for that term	A
6.9	Scrutinise data to identify key issues/trends in schools for LAC.	28/09/2018	Head of learning and achievement	Trend analysis completed.			A
6.10	Provide training to school staff regarding effective ePEP writing / how to conduct an ePEP meeting.	28/09/2018	Head of learning and achievement	Training completed.	Meeting structure revised to ensure progress towards all targets is monitored and scrutiny of interventions are in place.	A reviewed ePEP that contains sufficiently detailed information about children's attainment and progress is in place by 01.10.2018. Evidence that the virtual school team routinely analyse the ePEPs in order that issues or trends are identified and recorded actions are taken to address any issues. All ePEPs have aspirational English and maths targets that are based on a child's prior attainment, as a minimum.	G
6.11	Identify pupils at risk of not meeting targets early and ensure support in place from school's designated teacher for looked after children.	30/11/2018	Head of learning and achievement	Targets identified.	Adequate support is in place for pupils.		G
6.12	Ensure care leavers receive good support/careers guidance from 16+ Team.	30/10/2018	Head of learning and achievement	Analysis undertaken.	Pathway plans are more focused/reviewed more frequently.		G
6.13	Report on ePEP targets	30/11/2018	Head of learning and achievement	Report produced and discussed.	Targets reached and attainment improved.	All ePEP meeting minutes and ePEPs demonstrate that staff from the virtual school review and challenge progress towards these targets.	A
6.14	Quality assure ePEPs and provide feedback.	31/08/2018	Head of learning and achievement	ePEPs audited and feedback provided.	Improved standard of ePEP.		B

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
6.15	Ensure each ePEP has minimum of English and maths attainment target.	30/11/2018	Head of learning and achievement	Targets in ePEP.	English and maths targets in ePEPs.	Resulting in educational outcomes for children in care that are in line with national or better. The virtual head will be able to respond to any issues or trends identified in the ePEP system.	G
6.16	Heads of service required to audit 2 cases a month and provide feedback and learning to close the learning loop with individual social workers.	From September 2018	Heads of service	2 cases audited per month. 100% compliance required for all adults completed.	Evidence of cases being audited per month and feedback being provided to individual social workers		G
6.17	Revise audit tool to measure evidence of management grip and oversight in each case that is audited	From September 2018	Head of service safeguarding and review	Audit tool revised and updated and communicated	Evidence proves that management oversight is taking place on each case that is audited	Audit tool in place	B
6.18	Quality assurance responsibilities of team managers made explicit with a quality assurance forward plan, requiring them to audit 2 cases per month.	From October 2018	Head of service safeguarding and review / Assistant director safeguarding and family support	Quality assurance forward plan in place. 100% completion rate required.	Evidence of cases being audited per month		G
6.19	Monthly learning briefing circulated from Assistant director safeguarding and family support and Heads of service meeting to all social workers to embed learning	From October 2018	Head of service safeguarding and review	Learning briefing being circulated	Social workers are in receipt of the learning briefing and are able to embed the lessons learnt from the audits undertaken		G
6.20	Quarterly workshops held to improve quality and consistency to audit approach across all Team managers and Heads of service.	From 11/10/2018	Assistant director/ safeguarding and family support	Workshops being held on a regular basis	Workshops have taken place and the quality and consistency of practice improves across the children and families directorate	First workshop scheduled for 11/10/18	G
6.21	Assistant director to lead quarterly learning event with relevant service area to close the learning loop from the Quality Assurance Team Manager audit activity in service area.	10/10/2018	Assistant director/ safeguarding and family support	Learning events are in place	We are able to evidence that the learning loop is being closed and that the learning is embedded		G
6.22	Establish a clear action plan to improve frequency and quality of quality assurance activity and establish a mechanism to evidence closure of the learning loop	From July 2018	Head of service safeguarding and review	Action plan in place with appropriate mechanism to close the loop	The frequency and quality of the audits improve and there is an appropriate mechanism in place to ensure closure of the learning loop	Quality assurance manager completed 3 month period of performance improvement activity in the assessment service, including auditing cases, providing feedback, following up on actions, provided workshops and best practice checklist	B

Ofsted No. 7	The quality of life story work for all children						
RP 41	Too many children do not have life-story work completed and this means that carers do not have a comprehensive and accessible account of a child's life history to enable them to fully support children.						
No.	**Actions**	**By when**	**Delivery lead**	**Performance Measure**	**We will know it's working when**	**Progress**	**RAGB Status**
7.1	Recruit additional staff to carry out life story work	30/11/2018	Head of looked after children	Staff in post and backlog of life story work completed	Backlog of life story work is cleared	Business case approved for additional resource and recruitment underway	G
7.2	Life story work established as business as usual with resource in place to carry this out.	23/12/2018	Head of looked after children	Business plan signed off and recruitment of staff underway.	Life story work is carried out to a high standard and supports carers to share life story work with children	Business case approved for additional resource and recruitment underway	G

DP No.3	Delivering our Permanency Plan for looked after children
RP 20	Work with families is not always consistently child-centred. Following an initial public law outline (PLO) meeting, in some cases the significance of what happens to a child is lost as the focus shifts on to the adults. Some letters before proceedings are too long and do not assist parents to understand what they need to prioritise and how they are going to be supported to change. Some children experience drift and delay at this stage, and review PLO meetings are not taking place in a timely way.
RP 27	The arrangements for children in private foster care are not well managed. Children do not receive a timely and responsive assessment of their needs or of their carers' abilities to meet their needs. Not all required checks are carried out and not all children have been seen in a timely way.
RP 30	The planning that follows is not always sufficiently robust or purposeful, and, as a result, several children have remained subject to these arrangements for too long. This has resulted in prolonged drift in progressing their care
RP 32	Children's care plans are of variable quality. Some are specific and clear, while others are overly long. In these plans, outcomes are not measurable and actions and timescales are recorded as 'ongoing'. In some cases, this
RP 37	IRO visits to children are not always recorded on their case files, and so the IRO footprint is not consistently evident. IRO scrutiny and challenge to progressing plans and addressing drift is not always sufficiently robust.
RP 38	Case records do not demonstrate that matching takes place at the point of children coming into care, and for some children permanence is not achieved within their timescales.
RP 39	The authority's arrangements for delegating authority to carers is not sufficiently clear and has not been for some time, despite the issue being raised by young people previously. This is an important issue for young people and means that some foster carers are still unable to make appropriate day-to-day decisions on their behalf.
RP 40	The local authority is struggling to provide a sufficient number of foster families, and in particular those that meet the needs of sibling groups and teenagers.
RP 47	Not all young people have access to their health information. Inspectors identified this as an important issue for young people and the local community has agreed to take this forward as an area for immediate improvement.
RP 50	Care leavers are aware of the advocacy service, although they feel that their voices are not always heard or taken account of. Access to mental health services for care leavers is difficult, and to date there is no strategy to improve this situation.
RP 58	Sufficiency planning lacks effective strategic direction and future needs are not articulated clearly. This is compounded by the current commissioning strategy not being underpinned by a comprehensive assessment of future needs.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
DP 3.1	Head of Safeguarding and Review and case progression officer to review current PLO cases to identify any drift and delay and take appropriate actions to resolve.	09/10/2018	Head of Service Safeguarding and Review	No PLO cases subject to drift and delay.	Decisions on children's futures are taken in a more timely manner		G
DP 3.2	PLO letters to be revised regarding attendance/representation of parents and embedded in Mosaic	01/10/2018	Head of Looked After Children	Letters signed off.	Revised letters built into Mosaic and being used appropriately..	Letters revised by 10/09/18.	G
DP 3.3	Implement PLO Training	From July 18.	Principal Social Worker/Head of Fieldwork	Training implemented.	Drift/delay reduced. Timeliness in making decisions regarding children's futures improved.	Training commenced, delivered by legal services	B
DP 3.4	Head of service action plan established to improve IRO involvement in planning for children	01/09/2018	Head of Service Safeguarding and Review	Operational action plan is in progress and meeting its targets	Quality of children's care plan improves, every child has a SMART care plan and children are not subject to drift and delay.	Action plan in place and head of service progressing to timescales, including regular reviews of care plans in 1:1s	B
DP 3.5	Establish new panel arrangements which will review all s20 cases on a monthly basis	25/09/2018	Assistant director safeguarding and family support / Head of Looked After Children	Panel in place and operational	All children accommodated under s20 receive a review of their cases to ensure that there is no drift and delay in making appropriate plans for them.	New arrangements agreed and due to start 25/09/2018 chaired by Assistant Director Safeguarding and Family Support	B
DP 3.6	Undertake monthly audits to ensure delegation of authority to foster carers is completed at point of admission to care	13/08/2018	Head of Looked After Children	Monthly audits take place and after a period of 4 months compliance can be assured	Fosters carers feel empowered to make appropriate decisions for children/young people in their care.	First audit undertaken on the 13/08/18 and did not evidence full compliance. Head of Service following up with social workers on compliance to standards.	R
DP 3.7	Implement named lead links between NHS mental health services and the 16+ care leaver service	01/10/2018	CCG – Mental Health lead	There are named leads for care leavers within mental health services and improved communication between services.	The 16+ care leaver service is confident that it is able to escalate and resolve any difficulties regarding access to mental health services		G
DP 3.8	Ensure that the mental health needs of care leavers are addressed by: developing care pathways for assessment and treatment; developing access to self-referral help and support; and supporting young people to take-up help with their mental health.	01/05/2019	CCG – Mental Health lead	Information available for care leavers on where to go and how to access treatment. Agreed multi-agency care pathway in place. Service measures to be defined as part of the development of service delivery	Frontline services and teams are able to access appropriate support with care leavers. Care leavers report they know how to access support if required and that its delivered at the right time to make a positive difference.		G
DP 3.9	Establish and implement the LAC Permanency action plan to avoid delay in achieving Permanency for children.	31/08/2018	Head of Looked After Children	Improvement in timeliness of achieving permanency for looked after children.	Children's life chances are enhanced by achieving Permanency in their future placements in a timely manner.	action plan in place.	B

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
DP 3.10	Draft placement Sufficiency strategy informed by LAC population estimates	31/12/2018	Childrens Joint Commissioning Manager	Draft strategy approved through council governance	There are clear expectations on the number and type of bed nights required to meet expected demand, and action plans in place to secure sufficient provision		G
DP 3.11	In-house fostering recruitment targets and action plan in place as part of Sufficiency Strategy.	31/10/2018	Childrens Joint Commissioning Manager	Recruitment targets and action plan approved by DLT	Carer recruitment and retention rates increase to meet demand. Recruitment targets and performance is reported through CWB scorecard.		G
DP 3.12	Develop an appropriate format for the sharing of information with LAC health to ensure young people have access to their health records when they leave care.	21/12/2018	Head of Looked After Children	Format developed, signed off and implemented.	Health records are accessible to young people when they leave care.		G
DP 3.13	Social work academy to lead on embedding compliance with Private Fostering Guidance	31/10/2018	Head of Looked After Children	Guide embedded and practice is compliant with statutory responsibilities	Social workers and managers are able to identify private fostering arrangements and demonstrate understanding of statutory responsibilities. The needs of children living in private fostering arrangements are met.		G

DP 4 (i)	Application and understanding of Herefordshire Safeguarding Children Board (HSCB) thresholds
RP 2	A significant number of contacts are signposted away from children's social care, which means that too many children are being referred who do not need this level of support. A number of children who would benefit from early help services experience delay because thresholds are not appropriately applied or understood. This is an area that needs to be strengthened so that children and families who might benefit from early help are quickly identified and do not experience any delays in receiving the help they need.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
DP 4(i).1	Raise awareness at Safeguarding Board that too many children are referred to MASH who do not require this level of support - review thresholds.	21/09/2018	Assistant director safeguarding and family support	Issue raised/discussed at meeting on the 11/09/18.	There is an improved understanding of thresholds across the partnership and an improvement in the performance data that can be shared with partners. Contacts into MASH are decreased.	Assistant Director Safeguarding and Family Support has raised at Herefordshire Safeguarding Children's Boarfd (HSCB) executive. Director for Children and Families and Assistant Director Safeguarding and Family Support met partner leads 21/09/2018 and established a partner improvement group.	B
DP 4(i).2	HSCB Policy and Procedures group revise Herefordshire Level of Need document to enhance understanding of thresholds across the partnership	30/11/2018	Principal Social Worker	Greater understanding of thresholds evidenced by decrease of contacts into MASH			G
DP 4(i).3	Reconfigure contact and referral process.	28/09/2018	Assistant director safeguarding and family support	Establish what percentage of contacts into MASH convert to referrals.		Process reconfigured, commencing on 01/10/2018	B

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
DP 4(i).4	Quality and appropriateness of referrals into MASH - improve process to feedback to refers on quality of requests for service.	30/11/2018	Assistant director safeguarding and family support	Process established.			G
DP 4(i).5	Re-establish MASH Partnership Forum - meet monthly and ensure referral rates are a standing agenda item.	04/10/2018	Assistant director safeguarding and family support	Forum re-established.			G
DP 4(i).6	Early Help to be represented in MASH daily to ensure early identification of cases requiring this service.	13/08/2018	Assistant director safeguarding and family support	Early Help in MASH team.	There is no delay in providing early help and family support services to children.	Completed	B
DP 4(i).7	Develop Early Help Strategy 2018 - 2023 and delivery with partners and have in place from April 2019	01/04/2019	Early Help Manager	Strategy in place and owned across Herefordshire services	The Early Help offer is embedded and understood by all partners.	Initial proposals set out. Contact made with other local authority via the DfE to bring in learning from outside Herefordshire	A
DP 4(i).8	Deliver Early Help Assessment training to stakeholders on a monthly basis.	31/12/2018	Early Help Manager	400 Professionals trained.		364 Professionals trained by the 08/08/18.	G

DP4 (ii)	Improving quality and consistency of practice
RP 5	Poor recording in some cases means there is not always evidence in children's records that they have been seen or the extent of the direct work that has been undertaken with children.
RP 9	In poorer assessments, and particularly where neglect is a long standing issue, social workers do not routinely consider historic concerns and their analysis can be over optimistic. Children are not routinely spoken to alone
RP 12	The local authority has invested in graded care profile training to support social workers in dealing with cases of neglect. Despite staff speaking positively about this, no evidence of this training was seen being used with individual children.
RP 24	The recordings of discussions with children lack analysis, with the result that it is not always clear how the information gathered informs safety planning for children.
RP 29	Decisions for children to become looked after are not always based on up-to-date assessments. Assessments are not routinely updated to reflect changes in a child's circumstances and needs. Historical concerns are not always fully considered, and this means that some children whose circumstances had not changed should have come into care sooner.

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
DP 4(ii).1	All operational Heads of Service will establish, implement and progress improvement action plans to drive the quality and consistency of practice in their service areas.	21/09/2018	Heads of service	Actions are signed off by Assistant Director Safeguarding and Family Support	Monthly review of action plans evidences progress against targets	Action plans have been developed and being quality assured by the Assistant Director Safeguarding and Family Support	B
DP 4(ii).2	Decision to be made on the most appropriate social work model to be implemented across Herefordshire Children and Families Directorate and appropriate implementation plan established	31/08/2018	Principal Social Worker/Assistant Director Safeguarding and Family Support	Social Work Practice Model implemented and training undertaken.	We can evidence consistency and quality of practice.	Social work model identified. Director establishing support from local authority that has experience of implementing Signs of Safety via DfE improvement lead	A
DP 4(ii).4	Establish clear workforce development and learning plan for the 2018/19.	08/10/2018	Head of Service Safeguarding and Review and Head of Looked after Children	Workforce development plan signed off at Assistant Director / Head of Service group and ready for implementation.	Social work skills will be enhanced across the directorate to improve the quality and consistency of practice		G

No.	Actions	By when	Delivery lead	Performance Measure	We will know it's working when	Progress	RAGB Status
DP 4(ii).5	Design/develop and implement 2 year Quality assurance and learning framework (QALF).	31/01/2019	Head of Service Safeguarding and Review	QALF Strategy implemented by 31/10/19.	The authority will have a strong learning culture underpinned by focused, collaborative, quality assurance work. This will provide meaningful learning to enable the organisation to continuously improve.		G
DP 4(ii).6	Establish a comprehensive assessment improvement approach to be delivered in all areas across social work practice	From 16/07/2018	Head of Service Safeguarding and Review	All teams have undertaken assessment improvement training	All children who need an assessment will receive a timely child centred, high quality assessment service.	Quality Assurance Manager completed 3 month period of performance improvement activity in the assessment service, including auditing cases, providing feedback, following up on actions, provided workshops and best practice checklist.	G

Herefordshire Council

Meeting:	**Children and young people scrutiny committee**
Meeting date:	**Monday 1 October 2018**
Title of report:	**Herefordshire Safeguarding Children Board (HSCB) Annual Report 2017/18**
Report by:	**Director of Children and Families**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To consider the annual report of the Herefordshire Safeguarding Children's Board (HSCB), which address the work of the multi-agency partners in Herefordshire in safeguarding and promoting the welfare of children and young people at risk within the county, including achievements and areas for improvement, and priorities identified for 2018/19 and assess if the report provides assurance.

Recommendation(s)

That:

a) **the annual report and effectiveness of the safeguarding arrangements for children and young people in Herefordshire as assessed by the board be reviewed;**

b) **the committee determine any recommendations it wishes to make to relevant bodies to secure further improvement in safeguarding children and young people in Herefordshire.**

Alternative options

1. There are no alternative recommendations. It is a function of the committee to make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive and to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised.

Key considerations

2. The work of the Herefordshire Safeguarding Children Board (HSCB) is a critical element of the ongoing multi-agency approach to keep children and young people safe from harm.

HSCB annual report 2017/18

3. The HSCB annual report details a number of developments in 2017/18 within the priorities set for that period. Key developments, impact and continuing areas for development are detailed below.

4. Priority 1 – Childhood neglect is recognised and responded to in a timely way

   The work this year has included:

   a) Developed and launched a multi-agency neglect strategy and development / action plan.
   b) Agreed the use of an evidence informed assessment tool to assist practitioners with the identification and assessment of neglect - the Graded Care Profile 2 (GCP 2).
   c) Commissioned and implemented a comprehensive multi-agency training programme for the use of GCP 2, to support practitioners across the partnership in identifying and assessing concerns in relation to childhood neglect and developing interventions to reduce risk and support families. As at year end 240 professionals have attended multi-agency training and an additional tranche have attended their own single agency training sessions.
   d) Delivered a multi-agency conference as part of raising awareness of the issue of childhood neglect and promoting the use of GCP 2.
   e) Revised the HSCB Threshold document / guidance to include reference to childhood neglect and the use of GCP2.
   f) Completed a multi-agency case audit of cases involving childhood neglect in November 2017, to act as a benchmark to support evidence of progress in identifying and responding to cases of child neglect.

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

   The work this year has included:

   a) Revised the CSE strategy and delivery plan to focus on effective governance; prevention and early identification; safeguarding children who are being exploited; pursuing and disrupting offending.
   b) Developed guidance to ensure the capture of information about children from Herefordshire placed out of authority who go missing.

c) Promoted the involvement of young people in risk management meetings, with their views sought and taken account of.
d) Provided raising awareness training for taxi drivers and hotel and B&B staff.
e) Promoted the SELFIE programme in primary and secondary schools.
f) Police delivered presentations in schools about texting and internet safety.
g) Included resources on the HSCB website for use in schools and other settings.
h) Developed a HSCB CSE training offer.
i) Promoted community awareness through participation in national CSE awareness day and associated resources, including NWG's "Thunderclap" initiative.

6. Priority 3 – Safeguarding vulnerable children

The work this year has included:

a) Maintaining up to date LSCB procedures that align with regional arrangements and statutory guidance to inform the journey of the child through the child protection process
b) Developing the focus on 'hidden harm' and the increased risk to children with disabilities within multi-agency training
c) Using multi-agency performance data to ensure the effectiveness of local safeguarding practice, specifically the application of LSCB thresholds, and the quality of child protection plans
d) Ensuring learning from case reviews was being appropriately used to improve the journey of the child through the child protection process
e) Securing feedback from children and young people who are subject to a child protection plan or who are looked after, to understand the effectiveness of the local safeguarding system.
f) Undertook a multi-agency audit that sought assurance of the effectiveness of practice in identifying, assessing and planning for the emotional and mental health of looked after children between the ages of 10 and 15.

7. Priority 4 - Early Help

a) Ensured LSCB procedures support the early help strategy and address the impact 'hidden harm' has on children and young people, for example children living with substance misuse and domestic abuse within the family.
b) Evaluated the availability and effectiveness of early help support, particularly in relation to children living with neglect and domestic abuse, and children with disabilities.
c) Worked with the Children and Young Person's Partnership to ensure LSCB training products promote understanding of the early help offer with practitioners, to include overhaul of Working Together training sessions, and use of evaluation process to monitor effectiveness.
d) Sought feedback from children, young people and their parents/carers about their experience of accessing and receiving early help (including Families First).
e) Audited to assess the impact of threshold decisions

8. Priority 5 – Strong Leadership, Strong Partnership

Whilst there has been evidence of engagement and some very good involvement between partner agencies, such as through the CSE and Neglect strategies, agencies are experiencing resource issues and constraints on capacity. There have been periods of poor attendance at subgroups, and changes have been made to try and improve this such as extending the period between meetings. There have also been examples of agencies not being available to be involved in practice learning reviews or case audits

Priorities for 2018/19

9. Reflecting on the achievements of the board through 2017-2018, and using a range of sources of information, which has included inspections, self-assessments, learning from reviews and consultation with our partners in Herefordshire, highlighting areas where development is required, the board has set four priorities for 2018/19. The safeguarding board pays 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 within the HSCB in 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.

10. The priorities for 2018/19 are:

    a. Priority 1: Neglect.
    b. Priority 2: Child exploitation (including children who go missing).
    c. Priority 3: Safeguarding vulnerable children.
    d. Priority 4: Early help.

    Further information on the priorities and how these are to be achieved is provided within the HSCB Business Plan 2017/19; attached at appendix 2.

Community impact

11. In accordance with the adopted code of corporate governance, Herefordshire Council must ensure that it has an effective performance management system that facilitates effective and efficient delivery of planned services. The council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review. The council must ensure that those making decisions and delivering services are accountable for them. Reporting on actions completed and outcomes achieved, supports effective accountability.

12. The partners represented on the board have statutory responsibilities for services in Herefordshire that safeguard and promote the wellbeing of children, young people and vulnerable adults. The board has a statutory duty to scrutinise, challenge and support this work. The HSCB is key mechanism for challenge, supporting and promoting improvement of these services within the council. The annual report and priorities going forward 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 People's Partnership's focus on early help, neglect and safeguarding, and the Community Safety Partnership's focus on domestic abuse.

Equality duty

13. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

    The safeguarding board pays 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 within the HSCB in 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.

Resource implications

14. None associated with the recommendations. Any resource implications associated with recommendations made by the committee will inform a response from the relevant body to the recommendations.

15. The HSCB receives contributions from partner agencies to fund its organisation and work. A budget is set out and reviewed throughout the year and any risks identified.

Legal implications

16. There should be a clear framework to allow the HSCB to monitor the effectiveness of local services.

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

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

    - To co-ordinate 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.

19. Regulation 5 of the LSCB Regs 2006 sets out the functions of the safeguarding board in relation to the above objectives.

20. Under statutory guidance, the safeguarding board has a duty to produce an annual report on the effectiveness of safeguarding children 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

21. None associated with the recommendations.

22. There are a number of identifiable risks associated with a reduction in the effectiveness of the safeguarding board. The board has 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 the impact on individuals, is evident from previous high profile cases in other areas, which in turn carries legal, political, reputational and financial risks to the partner agencies involved.

23. The current identifiable risks to the effectiveness of the board continue to be financial, as the need for contributing partners to identify savings continues, and organisational as the uncertainty of future board structure remains. The financial risk is currently mitigated by the boards holding modest reserves, combined with recent efficiency savings being identified, and the organisational risk comes from the amended statutory guidance being expected towards the end of 2017, which may have a significant impact on safeguarding children boards.

24. The HSCB, together with the Herefordshire Safeguarding Adults Board and Herefordshire 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

Appendix 2 – HSCB Business Plan 2017/19

Background papers

None

HSCB Annual Report 2017-18

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Foreword from Independent Chair

I am pleased to introduce this annual report for Herefordshire Safeguarding Children Board covering the year 2017-18, at the end of my third full year as its Independent Chair. This is a public report which sets out the work of the Board and its view of the effectiveness of safeguarding arrangements across the county. The report aims to give everyone who lives and works in Herefordshire a sense of how well local services and people in the community are working together to keep children safe.

As in previous years, many of the organisations which contribute to the Board's work have continued to face significant financial pressures, which have entailed difficult decisions about allocation of resources. Some have also faced significant workforce challenges at both leadership and practitioner levels, which at times has had an impact on their ability to maintain consistency and quality of services. Despite the pressures, the Board's partners have maintained a focus on developing arrangements and services which enable a quicker, earlier response to children and families who may need additional help. This is to be welcomed, and will be of continued interest to the Board in the coming year.

As previously, agencies have continued to work together in support of the vision of the Children and Young People's Partnership, focusing attention on areas which present the greatest risk to Herefordshire's children - child sexual exploitation and going missing, neglect and domestic abuse – and working more closely with other multi-agency partnerships to ensure that the most vulnerable individuals and families are identified, supported and safeguarded. As understanding increases, so efforts can be made those areas still in need of improvement. This will include, in the coming year, attention being paid to other areas of exploitation which are now becoming more evident, as well as a particular focus on children with disabilities, who can be particularly vulnerable.

The coming year will require key partners –the Council, West Mercia Police and Herefordshire Clinical Commissioning Group – to review their arrangements for safeguarding children in response to the changed legislative context that has been introduced by the Children and Social Work Act 2017. This gives greater flexibility locally whilst increasing accountability for NHS and police partners alongside the local authority, and is an opportunity to think differently about how best to safeguard children in Herefordshire. Plans will be published and consulted upon by summer 2019, in readiness for implementation by October 2019.

The children's workforce – professionals, volunteers and others – are the bedrock of safeguarding arrangements, whatever the legislative context. Every day they work to support families and keep children safe. I thank them all for their hard work and dedication.

Sally Halls

1. About this report

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

This report sets out how Herefordshire Safeguarding Children Board has worked to meet its statutory objectives during 2017/2018, 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. It is submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the chair of the Health and Well-being Board. The report provides an assessment of the performance and effectiveness of local services. It identifies areas for improvement, and the actions being taken to address them. It 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 includes lessons learned from reviews undertaken during the year and how the LSCB has used the learning to improve practice.

The report also lists the financial contribution of each partner agency and provides a budget breakdown on spending.

Finally, the report details the Board's planned priority areas for 2018-19.

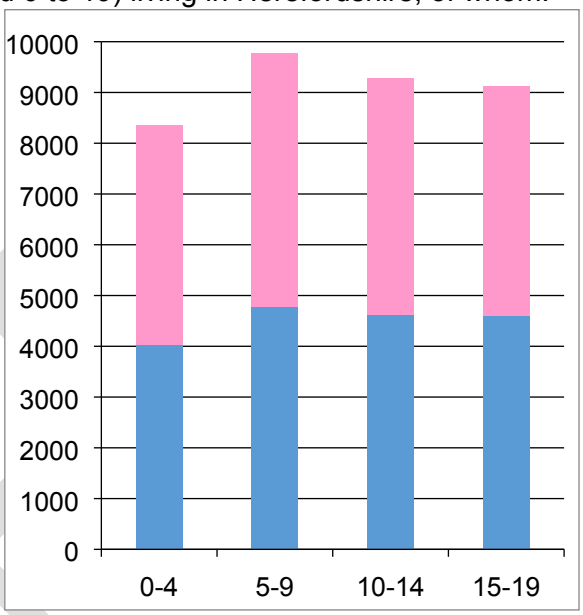
2. The local context: children in Herefordshire

The latest (mid-2017) Office of National Statistics estimate of Herefordshire's resident population is 191,060, which represents an increase of 1900 on the year before.

Herefordshire's population is scattered right across its 2,180 square kilometres, of which 95% of the land area is 'rural'. Just under a third live in Hereford city and just over a fifth in one of the five market towns, but over two-fifths live in areas classified as 'rural village and dispersed'.

There are 36,280 children and young people (aged 0 to 19) living in Herefordshire, of whom:

- 8,360 (23%) are 0-4 years
- 9,170 (25%) are aged 5-9 years
- 9,270 (26%) are aged 10-14 years
- 9,480 (26%) are aged 15-19 years



And there are also

- 11,040 young adults aged 20-24 years old.

Illustrated is number 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 2018.

3. About HSCB

Herefordshire Safeguarding Children Board (HSCB) is the key statutory body that oversees multi-agency safeguarding arrangements across Herefordshire as required under the Children Act 2004; and in accordance with statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board Regulations 2006. HSCB draws its membership from a range of organisations. It is funded by a small number of key partners (see Appendix 1 for information about partner contributions and budget).

The Board is supported by a range of subgroups that draw their membership from across statutory, voluntary and community sector agencies that work with children and families.

The HSCB structure, membership and various subgroups are detailed in Appendix 2.

The HSCB Constitution (see link below) sets out how the partnership works, its governance arrangements, and the roles and requirements of its members.

ADD LINK

HSCB meets quarterly and focuses its attention on areas of safeguarding challenge and concern and the implementation of the HSCB Business Plan.

The role of the independent chair is to hold all agencies to account. The current Independent Chair, Sally Halls, has chaired the Board since 2015. The Independent Chair is accountable to, and meets frequently with, the Chief Executive of Herefordshire Council; with the Cabinet Member for Children's Services and with Herefordshire Council's Director of Children's Services. She also meets regularly with senior leaders from partner agencies, and attends the Children and Young People Partnership and the Community Safety Partnership.

HSCB is supported by the Safeguarding Business Unit, which also provides support to the county's Safeguarding Adults Board and its Community Safety Partnership.

HSCB met five times in 2017/18; this included a development session at which priorities for the year were agreed. The attendance rates by agency are set out in Appendix 3. Partners are challenged when necessary to address the need for consistent and regular attendance at both Board meetings and subgroups. For some agencies, capacity challenges and staff turnover have caused difficulties in attendance and quality of contribution, and this is likely to continue into the coming year.

4. Assessing the effectiveness of child safeguarding and promoting the welfare of children in Herefordshire

HSCB has a statutory duty to scrutinise and evaluate the effectiveness of the safeguarding system and individual agency contributions to safeguard and promote the welfare of children. It uses a range of methods to do this.

Key elements include:

- Scrutiny of data and performance information
- Multi-agency audits
- Section 11 audit (comprising self-assessment by Board partners)
- Section 175/157 audit (of education settings)
- Assurance reporting
- Monitoring risks and issues (through risk register and challenge log)
- Capturing feedback from children and users of services
- Inspection reports

Based upon information from these activities, together with consideration of national findings and developments, HSCB partners identified a number of areas that it wished to prioritise in order to improve the effectiveness of Herefordshire's safeguarding arrangements. These were set out in the Board's business plan for 2017-19, which is included at Appendix 5. The priorities were agreed as follows:

Priority 1: Neglect.

Priority 2: Child Sexual Abuse and Exploitation (including children who go missing).

Priority 3: Safeguarding Vulnerable Children.

Priority 4: Early Help.

Priority 5: Strong Leadership, strong partnership.

These were taken forward in different ways by the Board and its subgroups. Details of subgroup activity are included in Appendix 4.

5. Progress on HSCB priorities 2017-18.

The summaries below provide information about progress and achievements and what needs to be done next.

Priority 1: Childhood Neglect

The majority of the work in relation to this priority was carried out on behalf of the Board by its Policies and Practice subgroup.

What the HSCB wanted to see achieved:

The outcomes that the Board was seeking from its work on neglect are:

- Early identification and response to childhood neglect, and prevention whenever possible.
- Appropriate, consistent and timely responses across all agencies working together.
- A clear focus on the impact of neglect on the child or young person.
- Ensuring a particular focus on the effectiveness of services to prevent the neglect of children with disabilities.

The Board therefore needed to ensure that:

- 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 identified plans are put in place to protect children from further neglect.
- Consistent and timely response across agencies
- 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. With a clear focus of the impact of neglect on children and young people.

What did we do?

- ✓ Developed and launched a multi-agency neglect strategy and development / action plan.
- ✓ Agreed the use of an evidence informed assessment tool to assist practitioners with the identification and assessment of neglect - the Graded Care Profile 2 (GCP 2).
- ✓ Commissioned and implemented a comprehensive multi-agency training programme for the use of GCP 2, to support practitioners across the partnership in identifying and assessing concerns in relation to childhood neglect and developing interventions to reduce risk and support families. As at year end 240 professionals have attended multi-agency training and an additional tranche have attended their own single agency training sessions.
- ✓ Delivered a multi-agency conference as part of raising awareness of the issue of childhood neglect and promoting the use of GCP 2.
- ✓ Revised the HSCB Threshold document / guidance to include reference to childhood neglect and the use of GCP2.
- ✓ Completed a multi-agency case audit of cases involving childhood neglect in November 2017, to act as a benchmark to support evidence of progress in identifying and responding to cases of child neglect.
    - The audit highlighted some areas of good multi-agency working and professionals working hard to improve outcomes for children and young people. There were some challenges to this, when families fail to engage and this was the most significant factor impacting on success. There is a lack of resources

to support children and young people suffering from the effects of long term neglect and this has been highlighted to the commissioners. Recognised tools have not been regularly used to evidence neglect and provide the foundation for the plans to mitigate this.

What still needs to be done and understood:

Neglect remains a priority for HSCB. During the coming year, the Board wishes to understand the impact of its work on professional practice and outcomes for children. The Board will therefore undertake the following activities, primarily through the work of its Quality Assurance subgroup:

- Evaluate the effectiveness of the GCP2 training on practice.
- Seek evidence that GCP 2 is being used systematically to identify concerns about neglect and lead to effective interventions.
- Review the development of the Early Help offer in Herefordshire to understand whether early identification and intervention where there are concerns about neglect reduces the number of children who become subject to a child protection plan under the category of neglect.
- Ensure that the views and feedback from children and families is gathered to inform evaluation of the effectives of support and future service development.
- Ensure the actions identified from previous case reviews into cases of childhood neglect are properly embedded within LSCB training and action plans are properly completed.

Priority 2: Child Sexual Exploitation (CSE) and children who go missing

The majority of the work in relation to this priority was carried out on behalf of the Board by its Child Sexual Exploitation subgroup.

What the HSCB wanted to see achieved:

The outcome that the Board was seeking from its work on CSE is that children who are vulnerable to sexual abuse and/or exploitation are effectively identified, safeguarded and supported.

The Board therefore needed to ensure that:

- The pathways for addressing concerns about cases of suspected CSE are clear.
- There is clear data relating to CSE: children experiencing and at risk of CSE, related factors including perpetrators, 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.
- Vulnerable children are effectively identified, safeguarded and supported.

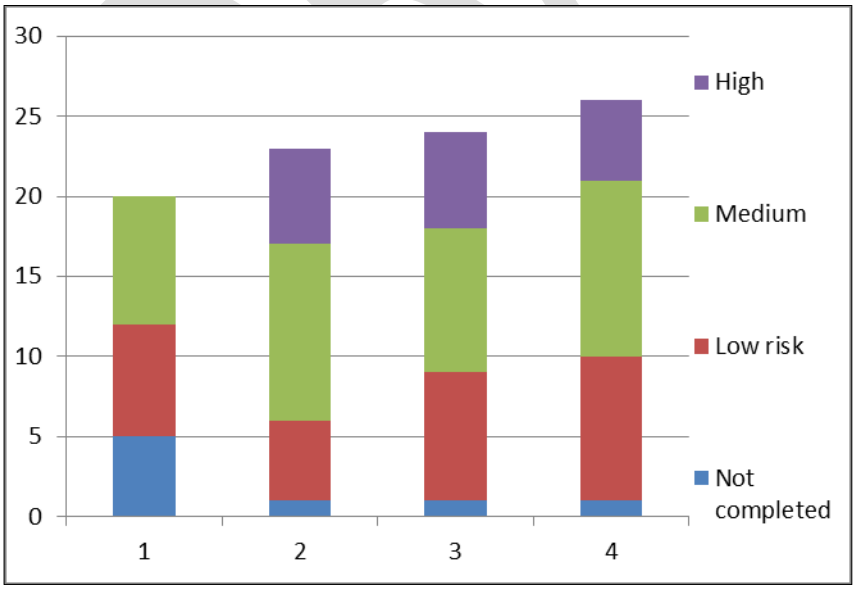
What did we do?

- ✓ Revised the CSE strategy and delivery plan to focus on effective governance; prevention and early identification; safeguarding children who are being exploited; pursuing and disrupting offending.
- ✓ Developed guidance to ensure the capture of information about children from Herefordshire placed out of authority who go missing.
- ✓ Promoted the involvement of young people in risk management meetings, with their views sought and taken account of.
- ✓ Provided raising awareness training for taxi drivers and hotel and B&B staff.
- ✓ Promoted the SELFIE programme in primary and secondary schools.
- ✓ Police delivered presentations in schools about texting and internet safety.
- ✓ Included resources on the HSCB website for use in schools and other settings.
- ✓ Developed a HSCB CSE training offer.
- ✓ Promoted community awareness through participation in national CSE awareness day and associated resources, including NWG's "Thunderclap" initiative.
- ✓ Completed a multi-agency audit in July 2017 which sought assurance that the risk of CSE was identified and responded to
    - The audit findings included the challenge in identifying emerging risks of CSE to children and young people outside of our County boundaries, the prominent risk of use of social media in CSE, there are good multi-agency meetings although there are challenges in ensuring representation from all agencies, these meetings lead to effective disruption processes locally.

What has been learned and achieved?

The Board now has a more detailed understanding of child sexual exploitation in Herefordshire.

- The number of CSE cases / assessments has been consistent, around 20 to 23 each quarter.



Assessments completed and level of risk

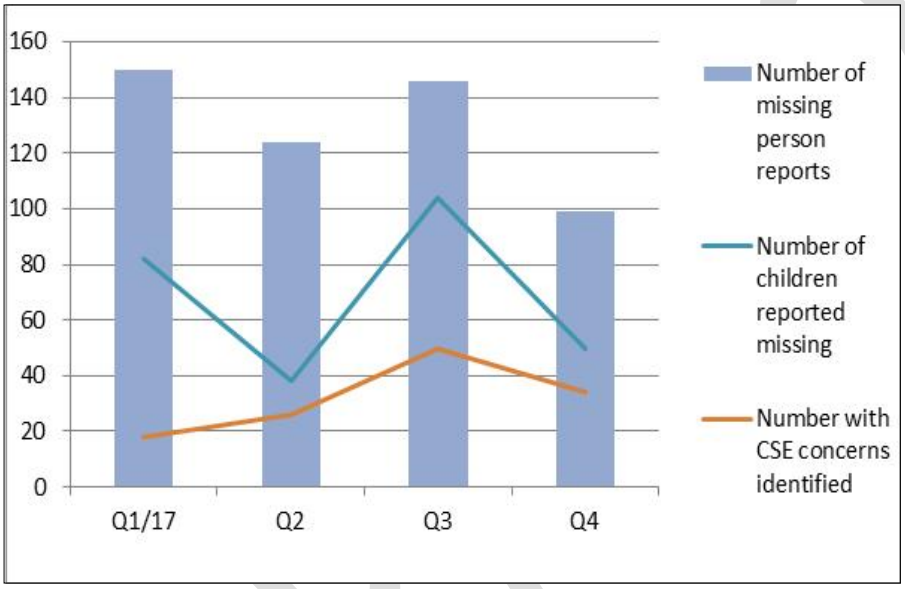
- Cases involved a higher proportion of children and young people living at home.
- Hereford City figures higher than other areas of Herefordshire.

- The most prevalent age of children at risk of/ experiencing CSE is around 15 years old.
- It is predominantly females that are identified

From the evidence of known cases Herefordshire are not seeing gangs or grooming activity for financial gain. Elements of the "party model" have been noted in as much as groups come together and drinking can be involved that leads to young people being exploited. The picture appears to be more young people involved in inappropriate relationships with older adults.

However some of this relates to changes in categorisation that took place.

- Most missing episodes are from Hereford City
- Most prevalent age is around 15
- There are more males than females reported missing
- Return home interviews are completed.



Awareness raising, prevention and disruption work across Herefordshire has included:

- Public and professional awareness raising through published materials, websites etc. and across all partner agencies (this is done on a regular basis to coincide with CSE awareness week)
- Programmes in school and other materials for schools to use
- Multi-agency training for staff across partners
- Training of taxi drivers and hoteliers and B&B staff. Safeguarding questions linked to taxi licences, information about who to contact and notices in taxis.
- Issuing of child abduction notices
- Responding to identified "hot spots."

What difference have we made?

- ✓ Increased number of child abduction notices issued;
- ✓ Improved identification and response to hot spots and areas of concern;
- ✓ Practice guidance and systems in place to identify and safeguard children from CSE.

What still needs to be done and understood:

- Consider the vulnerabilities of children missing education

- Review the numbers of younger children (although this is low) identified as experiencing CSE to seek assurance that we are not missing any issues in understanding the profile of CSE in Herefordshire.
- There has been improvement in the collecting of data in relation to understanding CSE, and that there are proper responses. This information needs to remains current and informative.
- Review indications emerging that CSE may be linked to other factors in terms of children and young people's vulnerabilities and risk of exploitation, such as County lines and "gang" type activity, and seek assurance that partner agencies are responding effectively to this.
- The views of children and families about the effectiveness of services in responding CSE.

CSE and children who go missing will remain a priority for HSCB in the coming year. The scope of the subgroup will be developed to also focus on other areas of exploitation such as Child Trafficking, County Lines, Modern Slavery and on line exploitation – more recently referred to as 'contextual safeguarding.'

Membership of the subgroup will be reviewed to reflect this focus along with a revised strategy and action plan.

Priority 3: Safeguarding vulnerable children

The majority of the work in relation to this priority was carried out on behalf of the Board by individual partners, and the Board's Quality Assurance subgroup, complemented by work across all other subgroups in relation to training, policies and procedures, case reviews, and specific risk areas.

What the HSCB wanted to see achieved:

The focus of the Board's work on this priority was in seeking evidence and assurance that vulnerable children are identified and safeguarded, and their wellbeing promoted.

What did we do?:

- ✓ Maintain up to date LSCB procedures that align with regional arrangements and statutory guidance to inform the journey of the child through the child protection process
- ✓ Develop the focus on 'hidden harm' and the increased risk to children with disabilities within multi-agency training
- ✓ Use multi-agency performance data to ensure the effectiveness of local safeguarding practice, specifically the application of LSCB thresholds, and the quality of child protection plans
- ✓ Ensure learning from case reviews was being appropriately used to improve the journey of the child through the child protection process
- ✓ Secure feedback from children and young people who are subject to a child protection plan or who are looked after, to understand the effectiveness of the local safeguarding system.
- ✓ Undertook a multi-agency audit that sought assurance of the effectiveness of practice in identifying, assessing and planning for the emotional and mental health of looked after children between the ages of 10 and 15.

- The findings of the audit included the perceived barriers to effective working practices between social care and mental health provider, children and young people can be disadvantaged by having to be moved out of County, the commissioners of replacement services should ensure there is an effective handover of historical records to ensure children and young people do not slip from service

The Board also sought assurance 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 at risk of suffering significant harm are identified, safeguarded and wellbeing promoted

What has been achieved and learnt:

The end of 2017 saw an increase in the number of section 47 investigations, 40% higher than the rest of the year. The local authority carried out audits of cases to ensure the correct decisions were being made.

There was a corresponding increase in numbers of child protection (CP) conferences. This was following a period of lower numbers of Initial Child Protection Conferences (ICPCs), the end of 2017 showed a significant increase in the numbers held. During the 3rd quarter, there were 56 ICPCs held, a 75% increase on the numbers held in quarter 2.

In January 2018 a dip sample audit of ICPCs found that the threshold of significant harm was not evidenced in 40% of cases examined, with reference to the HSCB significant harm threshold guidance.

There was a corresponding 'spike' in children subject to CP plans, but still not reaching the high figures in 2015/16.

Length of child protection plans remained low with 8% of cases subject to a plan over 9 months. Numbers of children on a second or subsequent CP plan are also low. The HSCB was assured that practice, processes and decision making at these key points are being subject to regular review and scrutiny.

The Board scrutinised the strategic approach to tackling domestic violence and abuse, which in Herefordshire is led by the Community Safety Partnership (CSP). Based on evidence that there appeared to be little evidence of impact of the current strategy, a number of concerns were raised with the CSP about the current strategic approach. It was also noted that budget constraints have led to a reduction in preventative activity being undertaken by the current provider (West Mercia Women's Aid). A review of Herefordshire's Domestic Abuse Strategy is scheduled and should incorporate the issues raised by the HSCB. The teaching of healthy relationships (PSHE) in schools was noted as a positive way to make a difference for the future, and it was recommended as an area for development.

At a practice level, there remain concerns about the volume of contacts made to the Multi-Agency Safeguarding Hub (MASH) from the police which relate to incidents of domestic abuse

but do not provide an effective assessment of risk. This results in considerable duplication of activity and a heightened risk of high priority cases being missed due to the volume of low level activity being undertaken.

What still need to be done and understood:

The Board is particularly interested to see development in the following areas during the coming year:

- Programmes and interventions for victims of domestic abuse, including children and young people (noting the support to teenage children identified in the DVA action plan)
- The development and implementation of intervention programmes for perpetrators of domestic abuse
- Consideration of different and innovative approaches given the continuing prevalence of domestic abuse
- The recognition and response to domestic abuse at the early help stage.
- Intervention with children and young people through schools (noting the GREAT project referred to in the action plan)
- The pathway for referrals, particularly with regard to cases that do not reach the criteria for level 4 intervention, and may be managed through early help.
- The views of children and their families being sought to help provide assurance about the effectiveness of safeguarding practice and processes.

Further work is also required on the performance scorecard and associated reporting to assure the board that children with disabilities are safeguarded effectively; any risks are identified and responded to.

Whilst safeguarding children remains a core area of activity for the Board, and scrutiny of multi-agency arrangements will continue, the Board decided that this priority area should in future be incorporated as 'business as usual'. However, following consideration of evidence and information regarding the particular vulnerabilities of children with disabilities, the Board decided to include safeguarding children with disabilities as a priority area from April 2018.

Priority 4: Early Help

The Children and Young People Partnership has been leading the development and delivery of Herefordshire's early help strategy.

What the HSCB wanted to see achieved:

The outcome that the Board was seeking from its work on early help was assurance that children and their families are receiving effective help at the right time which promotes their wellbeing.

The Board therefore needed to satisfy itself that:

- Early help services effectively identify needs and concerns relating to children and families, and that 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.
- 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 so that children and their families receive effective help at the right time.

- Early Help Assessments are taking place within timescales and are effective in identifying needs of children and 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 on the continuum of need.

What did we do?

- ✓ Ensured LSCB procedures support the early help strategy and address the impact 'hidden harm' has on children and young people, for example children living with substance misuse and domestic abuse within the family.
- ✓ Evaluated the availability and effectiveness of early help support, particularly in relation to children living with neglect and domestic abuse, and children with disabilities.
- ✓ Worked with the Children and Young Person's Partnership to ensure LSCB training products promote understanding of the early help offer with practitioners, to include overhaul of Working Together training sessions, and use of evaluation process to monitor effectiveness.
- ✓ Sought feedback from children, young people and their parents/carers about their experience of accessing and receiving early help (including Families First).
- ✓ Audited to assess the impact of threshold decisions on those children who are not stepped up to higher levels of intervention.
    - The audit findings included evidence that the early help process is well embedded into schools, localised arrangements have a significant benefit on the effectiveness of early help support, the extent to which families engage and contribute to both planning and intervention is the most significant factor on the success of professionals involvement, mental health services have not had the opportunity to be effectively engaged where they are supporting individual family members and have committed to improving this situation ongoing.

What has been learned and achieved?

- ✓ In October 2017. There were 587 active Common Assessment Framework (CAF) assessments where there is an agreed support plan and the family have a lead professional regularly reviewing the progress being made against the outcomes.
- ✓ Staff from primary schools, secondary schools and health visitors make up the majority of Lead Professionals.
- ✓ The Families First programme forms a central pillar of the Early Help approach with a target of: 1,090 families to be identified and worked with in Herefordshire for the period 2015 -2020. Progress to date:
- ✓ 677 families have been identified and engaged.
- ✓ 147 families have been claimed for as achieving sustainable change for at least 6 months.
- ✓ Early help triage has been developed and an early help information and advice line put in place for families and professionals.
- ✓ A refreshed Early Help Assessment model to make it quicker and easier for families with emerging needs to be identified and access support, and including additional areas to be monitored within early help e.g. 'neglect' and 'children at risk of sexual exploitation'.
- ✓ An Early Help score card has been developed identifying numbers of cases opened, closed, stepped down, length of time open and by area.
- ✓ Multi-agency case audits have led to action plans to improve multi-agency safeguarding practice.
- ✓

What still needs to be done and understood:

The Board has decided to retain early help as a priority for the coming year, and will want to be assured that services consistently identify needs and concerns relating to children and families, address these needs through effective planning and interventions, enabling families to function effectively and meet their children's needs.

The Board will therefore undertake the following activities:

- Update relevant practitioner guidance, including on thresholds for services, and ensure that particular regard is given to how LSCB procedures address certain vulnerabilities in relation to children and young people's safety and well-being (e.g. children living with substance misuse, domestic abuse within the family, children with disabilities)
- Raise awareness of early help support available and appropriate referral routes
- Through audit, assess the quality, effectiveness and availability of early help support and interventions, to establish whether early help services are recognizing and responding to early safeguarding concerns, reducing the risk of children suffering significant harm
- Seek assurance that early help staff are engaged in the GCP 2 training and are using the tool in practice
- Review, analyse and then report to the Executive and Board in relation to performance data provided through early help services.

Priority 5: Strong Leadership - Strong Partnership

What we want to achieve:

Board members wanted to work together to lead the safeguarding children agenda in Herefordshire, challenges the safeguarding work of their own and partner organisations, and commit to an approach that learns lessons and embeds good practice. Given the anticipated new legislation regarding arrangements for safeguarding children, members also wanted to ensure that the partnership has effective plans in place for maintaining the effectiveness of safeguarding in the future.

Agreed indicators of effectiveness included:

- Full engagement by all partners in all the processes of the HSCB
- Attendance and representation, as agreed in terms of reference and constitution, at Board meetings; executive, subgroups and task and finish groups.
- Open and informed reporting to the HSCB from partner agencies on safeguarding responsibilities, strengths and areas for improvement. Involvement in audits and case reviews and provision of performance information as appropriate.

What has been achieved and learnt:

Whilst there has been evidence of engagement and some very good involvement between partner agencies, such as through the CSE and Neglect strategies, agencies are experiencing resource issues and constraints on capacity. There have been periods of poor attendance at subgroups, and changes have been made to try and improve this such as extending the period between meetings. There have also been examples of agencies not being available to be involved in practice learning reviews or case audits.

Details are given elsewhere in this report.

What still needs to be done:

These matters should be “business as usual” for effective multi safeguarding arrangements. A review has been commissioned (following the Children and Social Work Act and the draft “Working Together to Safeguard Children” guidance (2018) to consider what will work best for Herefordshire, in the light of information and evidence about effective multi-agency safeguarding arrangements and achieving positive engagement and improvement. The outcome of the safeguarding review will inform future arrangements.

6. Case reviews

An important function of LSCBs is to undertake reviews. Working Together (2015) states that:

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

The different types of review include:

- Serious case reviews
- Child death reviews
- A review of a child protection incident which falls below the threshold for an SCR (in Herefordshire, these are called practice learning reviews (PLR); and
- Review or audit of practice in one or more agencies

1) Serious case reviews

A serious case review (SCR) is undertaken for every case where abuse or neglect is known or suspected and either a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

A Serious Case Review has recently been commissioned by the HSCB, with initial themes of neglect, information sharing and CSE. This SCR is in the very early planning stages and will, therefore, be reported in full under the 2018/19 report.

2) Practice Learning reviews

The Joint Case Review sub group has undertaken 2 Practice Learning Reviews (PLR's) in 2017/18.

The first PLR was referred due to concerns regarding the likelihood of severe neglect of a child's developmental needs.

The themes from the first PLR report, finalised in June 2017 were: Neglect, Parental mental health & alcohol misuse and escalation.

An Action Plan was compiled and its progress is being regularly monitored by the JCR sub group. Recommendations include:

1. Review training in place to support practitioners in engaging difficult to engage families/individuals and consider linkages to Levels of Need documentation.
Action: Amendments to Levels of Need document considered and multi-agency neglect conference will have a specific workshop of "difficult to engage" families.

2. Ensure that the HSCB Neglect strategy is implemented and the implementation plan is monitored by HSCB Executive and Board.
Action: HSCB's Neglect Strategy has been finalised, GCP2 training is being rolled out and the implementation plan is regularly monitored.

3. Update the current HSCB Escalation Policy.

Action: The Escalation Policy has now been renewed and refreshed by the HSCB's Policy and Practice Sub Group.

The second PLR focussed on a child with disabilities who experienced avoidable neglect and harm over a period of time whilst remaining in the care of parents who were unable to meet the needs of their child.

The themes from the second PLR mirrored the PLR above and the Action Plan is currently being finalised.

The third PLR has been commissioned as an adult review, however, the issues cut across both children and adult transitional services. Additional themes from this review are: Children with Disabilities, mental health and information sharing.

The Learning Day has been held for this review, however, the report is expected to be finalised in June 2018.

A Serious Case Review has recently been commissioned, with initial themes of neglect, information sharing and CSE. This SCR is in the very early planning stages and will, therefore, be reported in full under the 2018/19 report.

What we have learned

In addition to the local reviews, the JCR sub group has also reviewed the learnings from the Derbyshire SCR for "Polly".

The learnings from all of the reviews have been disseminated throughout the Board's partner agencies and have been the focus of a multi-agency Practitioner Forum.

Feedback from attendees included:

- A really interesting session – need more information on referral pathways
- Fantastic session - Will help with referrals
- It got me thinking about my practice
- I am now motivated to learn more

The 7 Minute Learning Guides are also produced as an additional visual cue of the learnings and themes.

An overarching 7 minute guide, which picked out the themes from all local reviews this year, was produced for the Board's Development Session to provoke thought as to whether the HSCB still has the right priorities.

With one of the recurring themes being Children with Disabilities, it was agreed that this should now become a Board priority for 2018/19.

3) Child Death Overview Panel (CDOP)

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP. The CDOP has a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant

professionals to discuss certain types of death as and when appropriate. Through the year, Herefordshire's CDOP was chaired by a Consultant in Public Health.

CDOP publishes an annual report, which is obtainable via the HSCB website (ADD LINK)

A total of nine deaths occurred within the review period, April 2017 – March 2018, six of which are still awaiting completion of review as of March 2018.

There were six deaths signed off at the CDOP meetings within this review period, three of which died in the previous twelve months. This Annual Report focuses on the deaths signed off within 2017/18.

Six deaths from this review period have not yet been signed off. Four are awaiting Inquest and one death was delayed due to a delay in Form B submission from another Hospital Trust. The investigation of the remaining outstanding death is being undertaken by Gloucestershire CDOP, as the mother and child received all care, both pregnancy and post-partum, in that Trust. We await Form C outcome.

The majority of deaths were signed off within the statutory 6 month period. Delays are associated with prolonged investigation (RCA, Post Mortem, Inquest, etc) but there was also a delay with a return of a Form B in an isolated case. This was highlighted as an issue in last year's Annual Report, and whilst we have seen an improvement, this will remain an area of further work. Other CDOP areas experience similar issues.

Modifiable Factors

Of the deaths considered this year, three were reported as having modifiable factors. These are factors that the panel have decided may have contributed to the death but that local or national actions could have been taken to prevent that death or future deaths.

- Recommendation to Primary Care to ensure that consideration is given to any female of child bearing age, presenting with abdominal pain, to whether pregnancy is a possibility, and tested as such. A letter from CDOP was written to Primary Care.

- Clarification of risk of Sudden Unexplained Death in Epilepsy (SUDEP) should be made to all relatives of patients with epilepsy.

- The balance of adverse effect versus benefit of drugs should be considered. Continued vigilance for continued side effects through continuous monitoring. The yellow card scheme was alerted to this modifiable factor.

Rapid Response

One rapid response was undertaken during the year for a child who died at home. A modifiable factor was noted, however, the death was not avoidable. A further Rapid Response was also undertaken for a neonatal death in hospital. The Rapid Response and subsequent review triggered CDOP to recommend to Children's Social Care that the case for this family be reviewed, as it was due to be closed.

What we have achieved

CDOP successfully recommended a review of a Children Social Care case where the remaining child of the family was thought to be at risk due to the circumstances that were identified through the CDOP review process.

Neonatal deaths continue to be considered and discussed in open multi-professional forum with feedback to the CDOP.

WVT are supporting recently bereaved families in their “Born Sleeping” appeal. The appeal is to raise funds for a room in the hospital dedicated to recently bereaved parents.

CDOP and CDR continue as a positive process for Herefordshire with active multi agency involvement in meetings.

In light of Working Together 2018 guidance, new arrangements for a wider CDOP footprint, covering 60 deaths will be arranged as soon as possible in the next review period.

7. Safeguarding Board statutory functions and other activities undertaken

LSCBs have a number of statutory functions. These are:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Where they have not been covered in other areas of this report, they are recorded in this section.

Private fostering

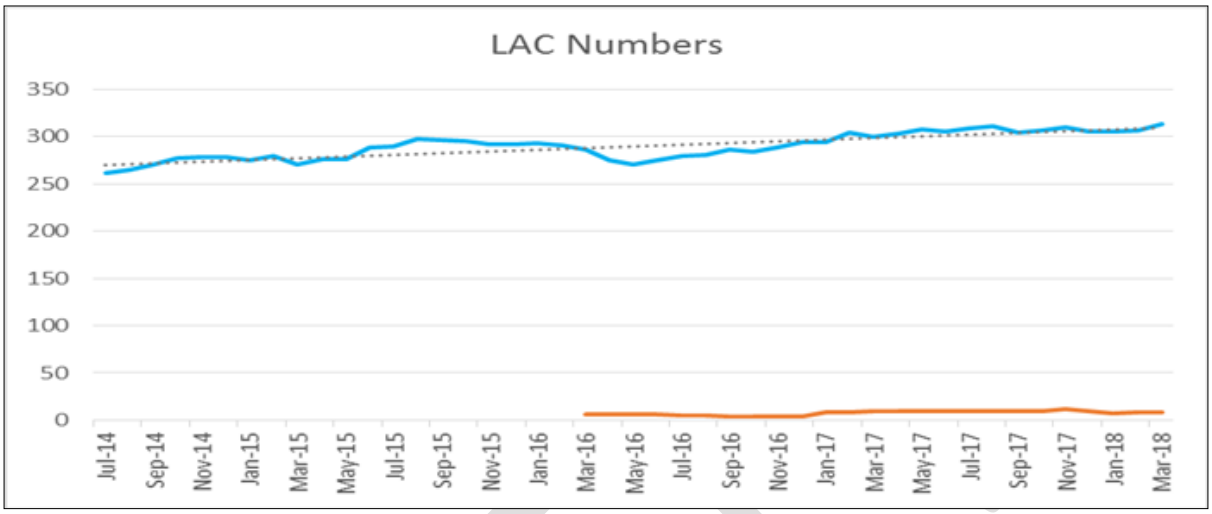
Since 1st April 2017 the Council has been notified of or identified 11 private fostering arrangements for children and young people ranging between 4 and 15 years of age.

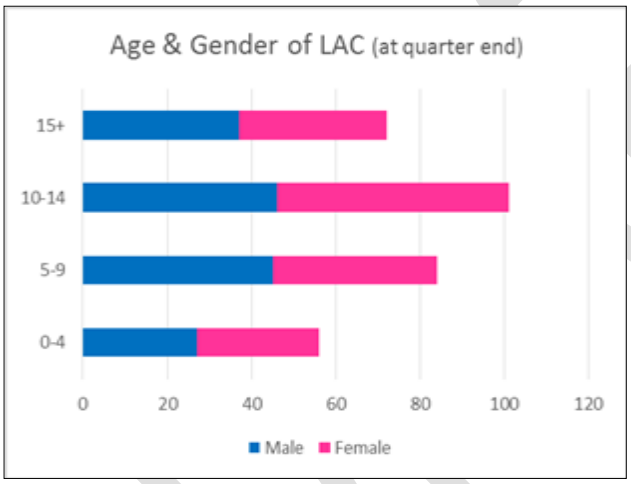
There are two main categories of children who are subject to private fostering arrangements. One is students from abroad taking part in school exchange programmes and the other is children and young people where there has been a breakdown in relationships with their parents/carer and they have chosen to live with alternative carers.

The number of Private Fostering arrangements that the Council have been notified of is low. There is concern that other children and young people will be living in private fostering arrangements that have not been assessed and this could leave children vulnerable. Therefore there is a need for on-going work to raise awareness within the community and amongst professionals to identify children who may be living in a Private Fostering arrangement and of their responsibility to notify the Authority if they believe a child is living in such an arrangement. It is pleasing that schools have made a number of referrals this year and understood the need to notify the local authority of private fostering arrangements. This would seem to be in response to increased awareness raising by the fostering team with schools

Looked after children (LAC)

As at the end of March, the number of LAC children stood at 313. This number has remained relatively static for the past 12 months now. Comparisons with statistical neighbours, English averages and authorities rated by Ofsted as good/outstanding shows that Herefordshire's rate of LAC is high.





Safety of the children's workforce (LADO)

Currently going through LA governance

Unaccompanied Asylum Seeking Children

In July 2016, Herefordshire Council's Cabinet agreed that Herefordshire would join the National Transfer scheme (NTS) for unaccompanied asylum seeking children (UASC) and committed to caring for up to 25 UASCs at any time.

The first young person was transferred to Herefordshire in October 2016 and to date 10 young people have transferred. In addition a further 2 UASCs have presented directly within Herefordshire to request asylum since this time.

As at 9th February the council are caring for a total of 8 looked after UASCs and 10 care leavers.

Young people are placed in a range of placements including foster placements, supported lodgings and supported housing. When it was agreed for Herefordshire to join the NTS the intention was for all young people to be placed in Herefordshire. Our fostering team had a specific recruitment campaign and were successful in recruiting carers motivated to care for UASC's. Colleagues in housing were able to offer a 3 bedroomed house within the city and a provider was commissioned to provide support to the young people placed there.

There have been a number of challenges to meeting needs of young people placed through the NTS and some have expressed a great deal of unhappiness about being placed in Herefordshire. Several young people have expressed concerns about access to ESOL provision, college/education opportunities, access to church or mosque that are held in their own language and feeling isolated and very visible as Black young people in an area that lacks cultural diversity. Some young people requested moves to larger conurbations and initially these were refused on the grounds that we could meet young people's needs within Herefordshire albeit we could not meet all of the young people's expectations. However following one young person going missing and presenting himself to a support provider in Liverpool we sought legal advice and were advised that if a suitable placement was available elsewhere that taking into account the wishes and feelings of a young person we should support them to live elsewhere. Subsequently a number of young people have requested placement moves - 3 have been placed in larger cities and 2 others are due to move shortly.

This creates a number of further challenges. These young people remain the responsibility of Herefordshire but it is more difficult to ensure young people are supported appropriately when they are living at a distance in an area where support services are not known. This makes it more difficult for social workers and personal advisors to build trusting relationships with young people and ensure young people's needs are met. The resource required to support young people at a distance is greater both because of the time required to visit them and because placements have to be through independent providers rather than in-house provision.

The impact of this for young people and the council has been raised through the West Midlands Strategic Migration Partnership with the Home Office. In the meantime we are exploring opportunities to increase support within the county to UASC and to better match young people through the NTS so that they understand the area that they are being asked to move to.

Assessment of the effectiveness of safeguarding arrangements in Herefordshire

Overall, the way the HSCB and its partners have worked together to keep children safe in Herefordshire has shown some improvements over the past year. Many children and families are receiving more effective services, often at an earlier stage than previously. The Board is better sighted on the quality and effectiveness of safeguarding arrangements. However, there is still work to do across the partnership to improve the quality and consistency of services, to strengthen early help arrangements, to promote improvement in key areas such as neglect and the exploitation of children, and to understand the impact of local safeguarding arrangements on outcomes for children. This will include stabilising the children's workforce in key partner organisations, which have had challenges in recruiting and retaining experienced staff.

A brief analysis of the effectiveness of local arrangements is set out in the summary below.

There is regular and effective monitoring and evaluation of multi-agency frontline practice to safeguard children; Case audits, including joint case file audits, are used to identify priorities.

The Quality Assurance subgroup has conducted audits into frontline practice which has resulted in identification of improvements required and outcome focused actions to be taken. Follow up work has been undertaken to assess progress.

Details of the subgroup's activity are given in the appendix.

More needs to be done in the coming year to strengthen the Board's understanding and scrutiny of performance information, and to follow through systematically on the impact of its QA activity in practice and on outcomes for children and families.

Partners hold each other to account for their contribution to the safety of children.

Board meetings are held quarterly and include highlight reports which enable scrutiny of HSCB subgroup activity and progress against the Board's business plan. Issues and risks are monitored and recorded on a risk register and action taken to address them is agreed by the Board.

Some partners have been more willing than others to challenge and be challenged. The increased engagement of more senior leaders at HSCB meetings is supporting improvements in this area.

Safeguarding is a demonstrable priority for all the statutory members.

Engagement and commitment by SSCB members and other agencies to Board meetings, subgroups and Board activities (e.g. conferences, the annual development day) demonstrates the priority given to safeguarding children. Whilst capacity and budget reductions are clearly having an impact, commitment remains high.

There is a strong learning and improvement framework in place.

The HSCB undertakes a wide range of activity aimed at identifying and promoting learning, including engaging directly with practitioners, learning from feedback from children and families, and drawing on learning from local and national reviews and research.

More could be done in this area, and investment in additional capacity to commission and deliver relevant training is desirable. This is an area which could usefully be specifically considered as future safeguarding arrangements are developed.

The Board ensures high quality policies and procedures are in place.

HSCB works with other LSCBs across West Mercia and the West Midlands to provide a consistent framework of policies and procedures, which are regularly updated. To support this, task and finish groups are established as required in order to work on specific issues, e.g. the pre-birth guidance.

In addition, the Policies and Practice subgroup has taken the lead in the development of the neglect strategy, which has been highly beneficial for the partnership. It is likely that this subgroup will be similarly used in future.

The Board is working to understand the nature and extent of the local issues in relation to children missing and children at risk of sexual exploitation.

The Board has a subgroup which leads on this aspect of its work:

- the CSE subgroup monitors the action plan and reports to HSCB on progress;
- the Board routinely poses challenge to ensure that risks are effectively identified and the safety of vulnerable children remains a priority;
- return home interviews increased over the last year
- the Strategy is regularly reviewed and updated to reflect increased knowledge and understanding of risks and information.

The scope of the subgroup has been increased for the coming year, in order to extend successful approaches to other forms of exploitation.

The Board is an active and influential participant in informing and planning services.

The HSCB is influential through its strategic involvement with Herefordshire's partnership boards - the Health and Wellbeing Board (HWBB), Children and Young People Partnership, Safeguarding Adults Board and Community Safety Partnership.
HSCB scrutinises assurance reports and strategy documents requested from other Boards and partnerships. Through attendance at key partnership meetings, the Independent Chair challenges other Boards and shares information to help influence planning for services for Children. Through sharing of annual reports (including the HSCB annual report) the HSCB challenges evidence and impact and influences the setting of priorities to support service planning for children.

The Board ensures high quality multi-agency training is available and evaluates impact and effectiveness.

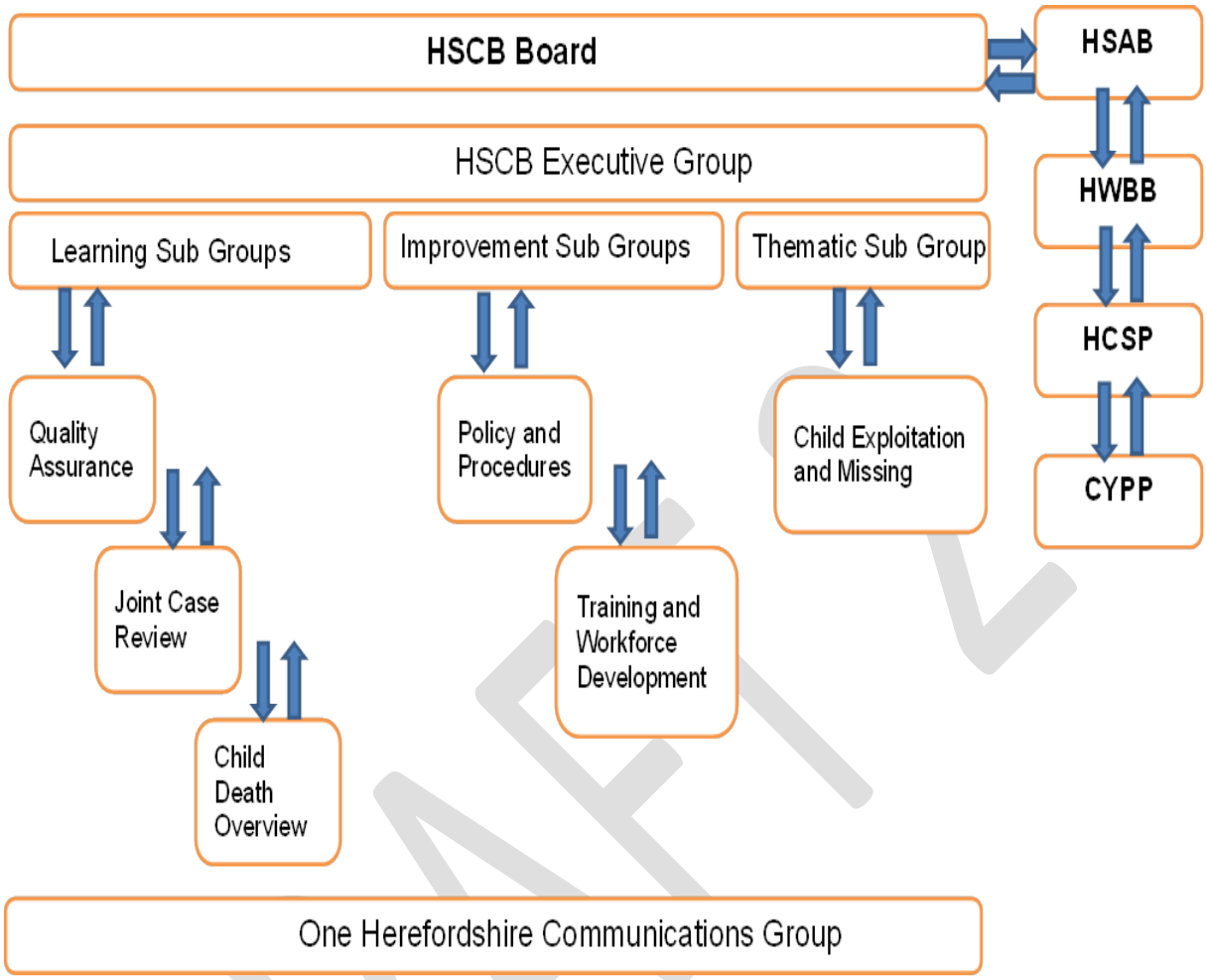
The Board commissions and provides specific multi-agency training, which supports its priorities. However, this area is under-utilised and partner agencies should promote this within their organisations. A recent initiative has been to robustly scrutinise the impact of training output and outcomes upon practice

Appendix 1: Budget and contributions

AGREED BUDGET FOR 2017/18	
Children's Wellbeing	130,017
Adults Wellbeing	103,000
Other Council Departments	7,365
CCG	80,190
Police	53,510
Probation	6,136
CAFCASS	550
YOS	1,144
TOTAL GROSS BUDGET	**374,547**

Awaiting final spend figures

Appendix 2: Structure and membership



Appendix 3: HSCB attendance

Agency/ person	Board meeting 25/4/17	Board meeting 10/7/16	Board meeting 9/10/16	Board meeting 15/1/17
Independent Chair	✓	✓	✓	✓
Lay Member	✓			✓
Herefordshire Council Children's Wellbeing	✓	✓	✓	✓
Herefordshire Council Adult Safeguarding				
2gether NHS Trust	✓	✓	✓	✓
Wye Valley NHS Trust		✓	✓	✓
NHS Herefordshire Clinical Commissioning Group	✓	✓	✓	✓
National Probation Service	✓		✓	
Youth Justice Service		✓		✓
Community Rehabilitation Company			✓	
West Mercia Police	✓	✓	✓	✓
CAFCASS				
Lead Herefordshire Council Member for Children's Wellbeing		✓	✓	✓
Education representative – Primary Schools			✓	✓
Education representative – Secondary Schools	✓		✓	✓
Education representative – Special Schools	✓	✓		✓
Education representative – Further Education Colleges		✓		✓
Education representative – Early Years	✓		✓	
Voluntary and community representative	✓	✓	✓	✓

Appendix 4: HSCB subgroup activity

This section sets out the activities and achievements of the subgroups of the HSCB in progressing the business plan and core business of the board.

Child Sexual Exploitation and Missing subgroup

Revised strategy and delivery plan focusing on:

- Effective Governance
- Prevention and early identification
- Safeguarding children who are being exploited
- Pursue and disrupt offending

Guidance to ensure we capture information about children from Herefordshire placed out of authority who go missing

Young people more regularly involved in risk management meetings and their views sought and taken account of

Raising awareness. Training for Taxi drivers and Hotel and B&B staff.

SELFIE programme in primary and secondary schools

Police presentations in schools about texting and internet safety

Resources on the HSCB website for use in schools and other settings.

HSCB CSE training offer

Participation in national CSE awareness day and associated resources, including NWG's "Thunderclap" initiative

What we have achieved:

Increase in the issuing of child abduction notices; identification and response to Hot Spots and areas of concern; practice guidance and systems in place to identify and safeguard children from CSE.

What next:

CSE and children who go missing will remain a priority for safeguarding children in the coming year. The scope of the subgroup will be developed to also focus on other areas of exploitation such as Child Trafficking, County Lines, Modern Slavery and on line exploitation.

Membership will be reviewed to reflect this focus along with a revised strategy and business plan

Policies and Practice subgroup

Member of regional safeguarding polices group, a consortium of West Midlands based professionals producing key safeguarding documents.

Commissioned new software provider to host policies and procedures and successfully transitioned in April 2017

Introduction of policies including:

- Children who harm others
- Sexually active children and young people
- Child death overview
- Resolution of professional disagreements
- Pre-birth assessment chronology guide
- Child protection medicals and health assessments

Redesign of key Herefordshire documents:

- Levels of need guidance
- Multi-agency referral form

Dissemination of information on:

- GDPR
- Early help strategy

Provided support to schools in relation to new government advice on Peer on peer Abuse

Temporary redesign of the P and P group into the Neglect Task and Finish Group which has successfully implemented the HSCB Neglect strategy and trained over 300 professionals in the use of NSPCC's Graded Care Profile 2 training

What we have achieved:
The successful implementation of the neglect strategy and a programme of multi-agency training for professionals to support this.
Delivery of a conference in respect of neglect that was well received by professionals
Delivery of a number of regional and local policies that have been disseminated across agencies

What next:

- **Continue to embed of the use of GCP2 in practice, developing guidance and reviewing policy and practice**
- **Continue in the review of multi-agency policies**
- **Continue to be an active member of the regional safeguarding policy group and contribute where required**
- **Work with the other subgroups of the board where common areas for improvement are identified i.e. following audits.**

Quality Assurance subgroup

Undertaken 4 multi-agency audits in line with Board priorities:

- Early help
- Child sexual exploitation
- Neglect
- Looked after children

All resulting in recommendations for practise improvement which are monitored by the subgroup

Production of thematic scorecards to support qualitative audit activity

Introduction of new audit methodology, supported by standardised audit tool and report for consistency

The “Voice of the Child” has successfully been included in audit activity

Audit findings have informed improvements to the information and guidance available on the safeguarding

Monitoring of multi-agency safeguarding data, highlighting outliers and trends to the Board

Audit findings have been used to inform changes to policy and practise

Audit highlighted 3 cases that were escalated to other services

Good multi-agency attendance at audits

Better dissemination of audit findings

Improve communications with GPs to improve audit activity

Improve quality and analysis of performance information

Ensure all recommendations from audit, both single and multi-agency are SMART (Specific, Measurable, Attainable, Realistic, Timely.)

Ensure appropriate representation from agencies at meetings

Workforce development subgroup

Development and delivery of the Graded Care Pathway 2 (GCP2) training including:

- Training of 20 trainers
- Over 300 professionals now trained in use of GCP2

Initial feedback from those professionals has been positive

Delivery of Safeguarding Practitioner Forums to a multi-agency audience

Subjects this year have included:

- Learning disability and dementia project
- Impact of sexual exploitation on families
- Updates on policies
- CSE services in Herefordshire

Training material is constantly evolving to reflect both local and national changes.

Findings from reviews and audits are included in training

Hosted domestic violence conference which was attended by … delegates

Practitioner forums have reached 90 practitioners over 31 agencies

Impact evaluations following training show that we are making a difference to professional practice

Clear reporting back from professionals to Board about front line practice

- **To further embed knowledge of competency framework into providers**
- **Promote the training validation process across training providers**
- **Continue to pursue opportunities for multi-agency training**
- **Ensure competency framework is included in contracts and is used by monitoring officers**

Numbers attending HSCB multi-agency training courses 17/18

Course	Numbers
Child Protection Conference	20
DVA Children & Young People	8
DVA Coercive Control	11
DVA Conference Silent Victim 2	88
HSCB/HSAB Practitioner Forums	87
MARAC Awareness	62
Neglect & GCP2	240
Targeted Child Sexual Exploitation	46
Universal Child Sexual Exploitation	13
Targeted Course Understanding Neglect (superseded)	4
Targeted Working Together to Safeguard Children 1Day	107
Targeted Working Together to Safeguard Children Refresher Half Day	82

Joint Case Review subgroup

Completed two Practice Learning Reviews (PLRs) and commissioned a third involving a case that transitions between childrens and adults services
Actions identified to date include:

- Amendments to Levels of Need document
- Priority given to implementation of Neglect strategy
- Escalation policy to be refreshed

One Serious Case Review (SCR) has been commissioned. The initial themes include Neglect, Information Sharing and Child Sexual Exploitation (CSE).

The group have reviewed the learnings from national SCRs and used the learnings to inform local policy and practise

Agencies are referring cases in appropriately

There is healthy debate about thresholds

Action plans are routinely monitored

Learning from all reviews have been shared at Practitioner Forums
7 minute learning guides have been introduced as an additional visual cue of the learnings and themes of an individual review
An overarching guide which consolidated themes from all reviews has been produced for the Board to consider whether the priorities were still valid, as a result of this Children with Disabilities has become a priority

- **Ensure a renewed commitment to the PLR process**
- **The new Working Together regulations mean that a full review of the Terms of Reference is required**
- **A new "Lessons Learned" feedback sheet to be added to the Case Review Toolkit for partners to evidence how findings are disseminated throughout their organisation**

Appendix 5: HSCB business Plan 2017-19

Strategic Priority	Outcome	We will do this by;
1. Neglect.	Early identification and response to childhood neglect, and it is prevented whenever possible. Appropriate, consistent and timely responses across all agencies working together. A clear focus on the impact of neglect on the child or young person.	1.1. Implementing the childhood neglect strategy and action plan. 1.2. Delivering a launch event for the HSCB childhood neglect strategy and associated changes to business practice. 1.3. Delivering high quality multi-agency neglect training, to include use of common assessment tool and shared understanding of Levels of Need in relation to childhood neglect. 1.4. Evaluating the effectiveness of that training. 1.5. Assessing the effectiveness of the use of the assessment tool, and the extent of the understanding of neglect between partner agencies against JTAI standards. 1.6. Ensuring the learning from previous SCR's and PLR's is properly embedded. 1.7. Ensuring a particular focus on the effectiveness of services to prevent the neglect of children with disabilities.
2. Child Sexual Abuse/ Exploitation& children who go missing.	Children who are vulnerable to sexual abuse and/or exploitation are effectively identified, safeguarded and supported.	2.1. Ensuring the delivery of the CSE and Missing strategy and action plan. 2.2. Assessing the effectiveness of support services for victims of CSE in Herefordshire, and influencing commissioning of those services. 2.3. Ensuring a co-ordinated response with Community Safety Partnership to reducing sexual abuse of children. 2.4. Gaining assurance of the effectiveness of risk management planning in relation to individual children and young people at risk of CSE within risk management meetings. 2.5. Gaining assurance on the arrangements for and frequency of missing children interviews. 2.6. Supporting ongoing local and national CSE awareness campaigns and improving knowledge and understanding of CSE toolkit within agencies in Herefordshire. 2.7. Reviewing the 'Children who abuse others' procedure and ensuring appropriate guidance is available to practitioners within Herefordshire. 2.8. Checking the effectiveness of the response to previous CSE audit findings, the quality and availability of post abuse support to victims of CSE and the quality of intelligence relating to CSE, and the effectiveness of its sharing and use.

Strategic Priority	Outcome	We will do this by;
3. Safeguarding vulnerable children.	Vulnerable children are identified and safeguarded, and their wellbeing promoted.	3.1. Maintaining up to date LSCB procedures that align with regional arrangements and statutory guidance to inform the journey of the child through the child protection process. 3.2. Developing the focus on 'hidden harm' and the increased risk to children with disabilities within multi-agency training. 3.3. Using multi-agency performance data to ensure the effectiveness of local safeguarding practice, specifically the application of LSCB thresholds, and the quality of child protection plans. 3.4. Ensuring learning from SCR's and PLR's is appropriately used to improve the journey of the child through the child protection process. 3.5. Securing feedback from children and young people who are subject to a child protection plan or who are looked after, to understand the effectiveness of the local safeguarding system.
4. Early Help	Children and their families receive effective help at the right time which promotes their wellbeing.	4.1. Ensuring LSCB procedures address the impact 'hidden harm' has on children and young people, for example children living with substance misuse and domestic abuse within the family. 4.2. Assessing the impact of threshold decisions on those children who are not stepped up to higher levels of intervention. 4.3. Ensuring that the HSCB procedures support the early help strategy. 4.4. Evaluating the availability and effectiveness of early help support, particularly in relation to children living with neglect and domestic abuse, and children with disabilities. 4.5. Working with the Children and Young Person's Partnership to ensure LSCB training products promote understanding of the early help offer with practitioners, to include overhaul of working together training sessions, and use of evaluation process to monitor effectiveness. 4.6. Assessing the quality, effectiveness and availability of early help support and interventions in relation to those families where childhood neglect is a risk or present. 4.7. Securing feedback from children, young people and their parents/carers about their experience of accessing and receiving early help (including Families First).

Strategic Priority	Outcome	We will do this by;
5. Strong leadership, strong partnership.	HSCB leads the safeguarding agenda, challenges the safeguarding work of partner organisations, and commits to an approach that learns lessons and embeds good practice. The partnership has effective plans in place for maintaining the effectiveness of safeguarding in the future.	5.1. working with partners to deliver successfully against the Business Plan and associated work plans set for HSCB and its subgroups / working groups 5.2. continuing to strengthen the governance interface between HSCB and other key strategic forums 5.3. communicating and raising awareness about safeguarding to individuals, organisations and communities 5.4. maintaining HSCB's Learning & Improvement Framework, facilitating, promoting and embedding learning from evidenced based practice, including SCRs and local learning reviews, and assessing impact of learning activity 5.5. scrutinising and challenging the individual and collective performance of partner organisations in safeguarding and improving outcomes for children, particularly those who are most vulnerable 5.6. engaging with children, young people and families to capture their views and experiences, influence the partnership's work and evaluate the impact of partner activity on their outcomes 5.7. engaging with practitioners to ensure they are supported to work effectively with children and their families.

Appendix 6: Single Agency Assurance Reports.

This section contains the single agency reports from the Board partners.

Introduction

Safeguarding for children and adults means protecting a child or children's; as well as adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the child or adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action ('VOICE of the CHILD' and 'Making Safeguarding Personal' for adults).

Therefore, the purpose of the Safeguarding Annual Report for 2017-18 is to provide assurance to the Governing Body on how HCCG is meeting its statutory requirements for Safeguarding Children and Adults at Risk of abuse and neglect;

Provides an overview of the progress made during the year 2017-18, and the key challenges to be addressed to ensure the CCG and it's commissioned health providers are compliant with National and local requirements including those set by NHS England.

The report illustrates how HCCG has continued to improve outcomes for Children and Adults at Risk through governance and assurance processes; with an overview and summary of safeguarding activities across NHS Commissioned Health Services and within the CCG during 2017-18 and reduces the following;

- The risk in relation to safeguarding children is that failure to meet statutory responsibilities including NHS England safeguarding monitoring tool (SATs) will lead to poor quality of care.

- The risk in relation to adults is that failure to sustain compliance with the Care Act 2014 implemented 2015; and NHS England Assurance Framework across all the services that we commission.
- The risk Mental Capacity Assessments (MCA) and Deprivation of Liberty Safeguards (DOLs) not being applied or implemented in clinical practice; impact being treatment interventions not in the patient's 'Best Interests'.

Background

Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (NHS Commissioning Board 2013 and NHSE June 2015).

The framework describes the Safeguarding roles, duties and responsibilities of NHS England, Clinical Commissioning Groups, NHS providers and various other bodies in the health economy.

Therefore, this report aims to provide assurance in regards to the framework; and highlight areas of improvement and or risks and how these will be mitigated for.

Key Achievements (2017-18);

1) Partnerships and multi-agency working

During 2017/18 Herefordshire CCG have further strengthened its governance and assurance arrangements regarding safeguarding across Herefordshire; through further developing our relationship working with commissioned providers, NHS England, Local Authority, CQC and NHS Improvement colleagues and wider health economy organisations. Partnership approaches with Local Authorities, other Arm's Length Bodies and emerging STPs/ICSs have continued, and do so as we move into next year's schedule of work.

2) Leadership and Accountability

The CCG has strengthened its structure with clear leadership e.g. Chief Nursing Officer as the Executive lead for safeguarding; Head of Safeguarding/Designated Nurse for Safeguarding and supporting safeguarding specialist nurses and leads. The CCG also has a presence in the MASH which strengthens information sharing and support for the commissioned services i.e. Wye Valley Trust and 2Gether Trust.

The HCCG over the reporting year have successfully completed section 11 for safeguarding children compliance; the adults safeguarding self-assessment using 6 principles; and the NHS England Safeguarding Assurance Tool and have action plans where there are identified ambers as reflected below in the key objectives for 2018-19.

3) Governance

The CGG has internal safeguarding integrated meetings weekly with the Quality team which enables sharing information; discussing key themes and concerns and how these are being supported. This meeting then reports to the Quality and Safety Committee which then reports to the CCG Governing Body.

Externally CCG leads on a BI-monthly health Leads meeting where information is shared including lessons learnt from e.g. SCRS/DHRs and or SARs. This meeting enhances learning and communication between CCG and providers of services including discussions around new legislation and guidance.

The CCG effectively engages with the local HSAB/HSCBs and their sub-groups. However, there is further work to be done to ensure the CCG engage with sub-groups where they add value working with the whole health economy to ensure effective resource management.

4) Enablers

HCCG supports commissioned service providers Named Nurses and Safeguarding Leads including LAC with safeguarding supervision and training for GPs as well as Continuing Health Care staff (CHC). This has been impacted on slightly over the reporting year due to resource implications.

Key Objectives for 2018-19

1. To develop a safeguarding training strategy for CCG and ensure training compliance is monitored.
2. For providers Wye Valley and 2Gether to produce a Training Needs Analysis that supports training compliance including Prevent
3. Review safeguarding structure to ensure effective support for commissioned services; and engagement with safeguarding Boards and their sub-groups
4. Implement safeguarding supervision structures for commissioned Named professionals
5. Support the implementation of CP-IS in WVT
6. Develop effective pathways for LAC especially out of area placements
7. Develop pathways for Nursing Homes safeguarding referral processes
8. Review NHS England SATs action plan and complete

Conclusion

Safeguarding is everybody's business driven by effective Leadership; Accountability; Governance and clear enablers.

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.

Safeguarding is central to quality of care and patient safety. The effectiveness of the safeguarding system is assured and regulated by a number of bodies and mechanisms. Wye Valley NHS Trust has an established safeguarding children quality framework which includes a safeguarding children performance dashboard and an annual audit plan. This assurance framework is monitored by the Trust's Safeguarding Committee, chaired by the Director of Nursing, the Executive Lead for Safeguarding children

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.

During 2017-18 WVT have continued to support the HSCB providing safeguarding team trainers for GCP2 training for Neglect as one of the HSCB priorities. WVT also contribute and are active participants of HSCB sub groups. There is regular participation in Multi-Agency Audit work carried out via the Quality Assurance sub-group. The WVT rep (Vice Chair) takes responsibility for facilitating and encouraging frontline practitioners to attend.

Ongoing continuous improvements within WVT are evidenced by improved safeguarding audit processes internally in relation to paediatrics and SCBU, thanks to the additional role within the WVT Safeguarding Children Team of a Specialist Safeguarding Advisor based on the paediatric ward, but providing support to all staff as needed, including supervision.

Changes in the delivery of mandatory safeguarding children training, whilst working within Intercollegiate Guidance, means that all clinical staff needing Level 2 are now trained at Induction. Levels 1,2 and 3 are all above 80%.The HSCB's priorities are embedded into all Levels of Safeguarding Children training. CSE, Children with Disabilities, Early Help Assessment and Neglect all have an emphasis.

WVT and CAMHS :

A business case was submitted to ensure the children and young people in our local population, who experience mental health crises are admitted to the Children's ward, receive the right care, at the right time, first time. Working together with the local Children and Adolescent Mental Health NHS Trust and scoping the services both nationally and within the west Midlands had resulted in a Champions model being implemented from existing staff members. A business case enabled additional staff to support children and young people in mental health crisis throughout their journey

As part of the Herefordshire Children and Young People's Plan 2015-18**,** Wye Valley Trust and 2gether Trust have been working together with the CCG to improve the care pathway for children and young people in mental health crisis. The introduction of additional Duty CAMHS Practitioners in May 2017 facilitates support and advice between 8am-8pm Monday to Friday. In June 2017 this support was further extended to include telephone and duty cover between 9am-5pm at weekends. These developments have not currently allowed children to be assessed in the Emergency Department which means that every child requires admission to the Children's Ward until their mental health is assessed by a Duty Practitioner from 2gether NHS Trust. However, the improvements have reduced the length of stay especially over the weekend period for those patients not requiring medical intervention. This

coupled with the development and introduction of a risk assessment tool, the CAMHS Champion model and additional staff training has successfully changed the culture and experience for children and young people in the acute setting. Ultimately, the changes have dramatically improved how children, young people, other patients and staff are safeguarded both in the Emergency Department and on the Children's Ward.

*As an addendum the business case was successful and staff have recently been appointed.

Young Ambassadors 2018

A number of Ambassadors have recently transitioned to adult care , so the paediatric teams have been recruiting more members over the year. The new Young Ambassadors have thoroughly enjoyed being part of the group and they have been working on small projects to ensure Hereford children's ward is a very special place. They have met the 'Well being' Ambassadors from the CLD Trust to understand how to improve the child's journey when in mental health crisis. One development suggested by the group was to have a quiet room to provide a 'time out' space. They are currently working to decorate and furnish the room appropriately. The Young ambassadors were also involved in recruiting our new Paediatric Consultants, Specialist Nurse for Children in Care and Complex health Nurse in Education.. The aim is to ensure that the role of a young Ambassador is rewarding and enjoyable, resulting in a very valuable tool for improving our children's services.

Caron Shelley
Named nurse safeguarding

2g continues to play an active part and is fully committed to multi-agency working, with all partners at the Herefordshire Safeguarding Adult and Children Board, in order to safeguard children and adults at risk of abuse or neglect.

Achievements 2017/18

2g has continued to improve the take up of training for safeguarding adults and children within a 'Think Family' approach. This involved Making Safeguarding Personal (*MSP*) and incorporated safeguarding children within the adult's social network.

2g has contributed to the Safeguarding Boards' training pool; jointly delivering training on recognising neglect in families, and has included level 3 Prevent e-learning as statutory training requirement.

Staff working within Adult Teams, have received improved access to internal safeguarding supervision via the Trust's Safeguarding Team. This is modelled on reflective practice as advocated within children's safeguarding and includes formal group and one to one sessions.

In line with the Boards' objectives, 2g has specifically shared learning from Safeguarding Adults Reviews, Serious Case Reviews and other learning models, and shared learning from multi-agency and single agency (internal) audits. 2g particularly focussed on Modern Day Slavery, improving documentation of safeguarding activity, Self-neglect, MAPPA and the Prevent agenda.

2g has actively participated in Board and subgroup activity, ranging from chairing subgroups to front line staff keenly partake in learning events / audits.

Priorities for 2018/19

2g plans to continue working in partnership to improve overall safeguarding activity. This will involve participation in all subgroups, focusing on learning from multi-agency and internal single agency audits; learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Serious Case Reviews and other learning models (e.g. Practice Learning Reviews). 2g will also concentrate on increasing the provision of safeguarding supervision to teams working with children and adults; improving the quality of safeguarding referrals for adults by evidencing 'MSP' and children (evidencing Levels of Need guidance); increase awareness around Domestic Abuse and Sexual Violence; Prevent, MAPPA - and to include early help for children and families.

In order for us to ensure we have the capacity to deliver all requirements we have recruited substantively for another Specialist Safeguarding Practitioner within the Safeguarding team.

Safeguarding Children and Adults remain a priority in the delivery of Mental Health services, irrespective of financial demands and constraints in the current economic climate.

Quality Assurance - 2g will continue to provide assurance to the Board that Safeguarding Priorities are in line with best practice and evidences positive outcome for families. Through our own internal Safeguarding Subcommittee we will monitor our objectives to ensure they are delivered in line with the Safeguarding Board strategic agenda.

Alison Feher
Named nurse - safeguarding

West Mercia Police are committed to their vision to protect people from harm. To achieve this, our focus and priorities puts the public at the centre of everything that we do. A key priority, along with safer homes and safer roads, is firmly towards safer children. Whilst all elements of safeguarding children are a focus, there is specific attention to Child Sexual Exploitation (CSE) and children involved in Serious and Organised Crime (SOC). Both of these can be from either a victim or offender perspective.

A vulnerability strategy under the corporate branding of 'see past the obvious' encourages Officers and Staff to be professionally curious in situations where children may appear vulnerable for a whole range of reasons. A range of training opportunities has given staff the confidence to be able to respond appropriately to individual needs and to work in partnership with other agencies.

An innovative mobile phone application is available to staff to have ready access to legislation, information and tools to assist them in their daily work including how to signpost to other agencies who may be able to offer support. It gives clear guidance on how and when to share information which is vital for early intervention to ensure that a child is safeguarded at the earliest opportunity. It provides practical guidance on matters such as child abuse, CSE and neglect.

Our whole emphasis is to ensure that protecting and safeguarding children is everyone's responsibility. An appropriate response and ownership of a case is considered within a model known as THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement) and often specialist officers are required who have the necessary skills in child abuse investigations and interviewing children. The staff in our dedicated Harm Assessment Unit work with their colleagues from other agencies (e.g. health, education) within a Multi-Agency Safeguarding Hub (MASH) to ensure that information is shared and brought together to get a full picture of the background of a child.

Recent developments within our teams have seen a dedicated officer as the single point of contact for children within care homes which has subsequently seen a reduction in children going missing. In addition, we have dedicated officers to bring together cases of children involved in CSE who are able to maximise information sharing through co-location with the CSE lead from the local authority.

We are supported by a Strategic Vulnerability team who are able to undertake environmental scanning and dissemination of learning from Serious Case Reviews and driving activity in response to HMIC inspections and feedback which further enhances the learning organisation culture.

Sue Thomas
Superintendent

National Probation Service

The National Probation Service (NPS) is responsible for all sentencing assessments and proposals as requested by the Courts. Following sentence, the NPS manage all high risk of harm cases and all MAPPA (Multi Agency Public Protection Arrangements) cases. High risk cases in the community are supervised once a week as a minimum expectation of National Standards, though this can be daily if assessed as necessary.

Each offender managed by the National Probation Service is assessed via the Offender Assessment System (OASys) and the level of risk posed, including triggers and also stabilising factors, is identified. Risks to others, including children, are considered in each case and checks are made with other agencies such as Children's Services – external agency involvement related to the case is clearly recorded so that duty officers can assist with the case in the absence of the supervising officer.

The NPS has a clear practice framework which requires all staff to take responsibility to safeguarding children and adults. Child safeguarding training, Adult safeguarding training and Domestic Abuse training is mandatory for all staff at all levels and must be completed at a minimum of once every three years.

To ensure that all staff have access to the most up to date policies and processes, a national system called EQuiP has been introduced and access levels are monitored. EQuiP is essentially process mapping software that includes attachments and hyperlinks so that all information is relevant, up to date and accessible from one location.

In the last year, the National Probation Service has also invested in a new role for each cluster (for context, West Mercia is one of 8 clusters in the Midlands). The new role is a Quality Development Officer (QDO). The QDO delivers briefings, conducts 1:1 work to support staff development and facilitates case audits.

David Cookson
Deputy Head of Service

Warwickshire & West Mercia Community Rehabilitation Company PROBATION

Warwickshire and West Mercia Community Rehabilitation Company (WWMCRC) has a duty to carry out the sentences and orders of the courts; to protect the public and to rehabilitate offenders. It also has a duty under the Safeguarding Children Act 2004 for ensuring staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children.

The last 12 months have been particularly challenging as we implement the changes demanded by the Transforming Rehabilitation agenda, recruit staff and meet the quality of work expected by Her Majesty Inspectorate of Probation (HMIP).

Safeguarding Children and Adults is a priority for WWMCRC and this is reflected in our local service plan. I am proud to lead Hereford LDU in providing such a vital public service and immensely proud of the team who have performed to a high standard, working tirelessly to ensure communities are safe and to transform lives.

We manage adult offenders so that the risk they present is reduced by skilful assessment, well targeted interventions and robust risk management plans. Regular audits and assurance exercises relating to the identification and management of offenders where a risk to children and/or vulnerable adults has or should be identified have been undertaken. Though there has been evidence of excellent work, improvements are required so that all cases are appropriately flagged, risk assessed, risk managed and monitored to ensure that the protection of children and vulnerable adults is maintained to the highest quality standards. We are committed to ensure that we meet the improvements required.

WWMCRC will face challenges and future changes in the coming years as the Ministry of Justice has launched a consultation 'Strengthening probation, building confidence' to stabilise probation services and improve offender supervision. We aim to make a significant contribution to the consultation document and at the same time continue to improve service delivery to safeguard children and protect the public.

George Branch
Assistant Chief Officer

West Mercia Youth Justice Service has a key role in safeguarding young people, in terms of assessing and reducing the risk of harm to young people either from their own behaviour or the actions of others (safeguarding) and reducing the risk of harm they may pose to others (public protection).

Work has continued during 17/18 to improve the quality of assessments following the implementation of a new assessment and planning framework during 2016/17. Audit data demonstrates continuous improvement. Improvement work will continue in 2018/19 particularly in respect to planning.

During 2017/18 the service reviewed its management of risk policy and procedures introducing a revised planning and reviewing process, high risk panels, for young people assessed as high risk in terms of safeguarding or public protection. Work is planned for 2018/19 to better secure the engagement of other agencies in high risk panel meetings.

In 2017/18 was invited to take part in research to identify the prevalence of adverse childhood experiences (ACEs) in young people who are in the justice system. The research,

which continues into 18/19, will inform the implementation of trauma informed practice within the service.

HSCB BUSINESS PLAN 2017-19

This document sets out the strategic objectives for Herefordshire Safeguarding Children Board (HSCB) for 2017-19. It refreshes the strategic business plan (2016/18). These strategic priorities will inform the development of the business / action plans of the HSCB sub groups. The HSCB's multi-agency performance dataset, audit programme and other associated learning and improvement activity will enable the HSCB to evaluate the impact of this plan on improving practice and outcomes for children and young people in Herefordshire. The impact of the plan will be reported in the HSCB Annual Report 2017-18 and any further areas of improvement will also be identified.

Strategic Priorities	NEGLECT: Identification and response to childhood neglect.	CHILD SEXUAL EXPLOTATION: Identification, prevention and response to Child Sexual Exploitation/ children who go missing.	EFFECTIVE SAFEGUARDING: Ensure effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm	EARLY HELP: 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.	Strong Leadership - Strong Partnership: The HSCB seeks assurance, challenges and support partner agencies in safeguarding children. The board ensures that lessons are learnt and improvements are made and embedded.
Key Outcomes	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 identified plans are put in place to protect children from further neglect. Consistent and timely response across agencies	The pathway for addressing concerns about cases of suspected CSE are clear. There is clear data relating to CSE: children experiencing and at risk of CSE, related factors including perpetrators, 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	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.	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 (is this still the correct terminology?) so that children and their families receive effective help at the right time. Common Assessments are taking place within timescales and are effective in identifying needs of children and families and planning interventions (there is clear multi agency engagement in this process).	Full engagement by all partners in all the process of the HSCB: Attendance and representation, as agreed in terms of reference and constitution, at Board meetings; executive, sub groups and task and finish groups. Open and informed reporting to the HSCB from partner agencies on safeguarding responsibilities, strengths and areas for improvement. Involvement

Strategic Priorities	NEGLECT: Identification and response to childhood neglect.	CHILD SEXUAL EXPLOTATION: Identification, prevention and response to Child Sexual Exploitation/ children who go missing.	EFFECTIVE SAFEGUARDING: Ensure effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm	EARLY HELP: 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.	Strong Leadership - Strong Partnership: The HSCB seeks assurance, challenges and support partner agencies in safeguarding children. The board ensures that lessons are learnt and improvements are made and embedded.
	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. With a clear focus of the impact of neglect on children and young people	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. Vulnerable children are effectively identified, safeguarded and supported	Child protection plans are effective in reducing/ eradicating the risk of significant harm to children. Children at risk of suffering significant harm are identified, safeguarded and wellbeing promoted	Lead professionals are identified in each case deemed level 2 or 3 on the continuum of need.	in audits and case reviews and provision of performance information as appropriate. HSCB leads the safeguarding agenda, challenges partners and commits to an approach that learns lessons and embeds good practice. The plans and work of the board is aimed to maintain the effectiveness of multi-agency work top safeguard and promote the welfare of children now and in the future.

:

What will we do to deliver the five strategic priorities

Strategic Priorities	NEGLECT: Identification and response to childhood neglect.	CHILD SEXUAL EXPLOTATION: Identification, prevention and response to Child Sexual Exploitation/ children who go missing.	EFFECTIVE SAFEGUARDING: Ensure effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm.	EARLY HELP: 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.	Strong Leadership-Strong Partnership; The HSCB seeks assurance, challenges and support partner agencies in safeguarding children. The board ensures that lessons are learnt and improvements are made and embedded.
Policy and Procedures **(RAG)**	Develop and implement a Childhood Neglect strategy Particular focus on embedding an effective childhood neglect assessment tool: Graded Care Profile 2 (GCP2), *and* GCP2 links with the Threshold / Levels of Need Guidance.	Review 'Children who abuse others' procedure and ensure appropriate guidance is available to practitioners within Herefordshire.	Maintain up to date LSCB procedures that align with regional arrangements, legislation and statutory guidance to inform the journey of the child through the child protection process.	Update of MARF and Threshold of need guidance Particular regard should be given to how LSCB procedures address certain vulnerabilities in relation to children and young people's safety and well-being, for example children living with substance misuse, domestic abuse within the family, children with disabilities HSCB procedures support the early help strategy.	Partner agencies to assure the HSCB that their staff are aware of and can access the multi-agency procedures, and that they have effective single agency safeguarding procedures and guidance in place,
Communications NOTE: The HSCB link in with the "One Herefordshire Communication and Engagement Group"	Deliver a launch event for the HSCB Childhood Neglect Strategy and associated changes to business practice.	Support ongoing local and national CSE awareness campaigns.	To inform about and promote multi-agency procedures and guidance, when they have been reviewed or updated.	Raise awareness of early help support available and appropriate referral routes,	Partner agencies can demonstrate that safeguarding messages are disseminated effectively through their organisations. On receipt of information and briefings from HSCB (e.g. updates of procedures messages from audits, events etc.) agencies ensure this is fully disseminated in

					their organization.
CSE and Missing		Based on the latest CSE needs assessment and other reviews and audits revise the CSE/ missing strategy and develop a delivery plan for the strategy. NOTE: The **CSE / missing** delivery plan details actions that the CSE / missing sub group should act upon as their business plan.	That there is assurance of the effectiveness of risk management planning in relation to individual children and young people at risk of CSE within risk management meetings. (linked to QA sub group)		
Training and Workforce Development	Deliver appropriate multi-agency neglect training, to include use of shared assessment tool (Graded Care Profile 2), and understanding of Levels of Need in relation to childhood neglect. Evaluate the effectiveness of the training of an assessment tool and impact on practice.	Improve knowledge and understanding of CSE toolkit within agencies in Herefordshire through inclusion in the multi-agency CSE training,	When reviewing multi-agency safeguarding training, ensure that this reflects the most up to date procedures and guidance. Ensure that training includes reference to procedures and guidance that supports practice in understanding the additional vulnerabilities of some children and young people. Ensure that multi-agency training reflects learning from case reviews and audits.	Early Help Practitioners to attend HSCB training	Partner agencies can demonstrate effective single agency safeguarding training (This will be audited through section 11 audit), and that staff attend multi-agency safeguarding training as appropriate.
Performance and Audit	Through case audit and performance information, report on the use of the GCP2 assessment tool and the extent of the understanding of neglect between partner agencies.	Develop the quality of commentary accompanying the CSE scorecard. Through audit: Check the effectiveness of the response to previous CSE audit findings. Understand the quality and	Routinely use multi-agency performance data to understand local safeguarding practice and audit: The application of LSCB thresholds, and; The quality of child	Through audit, assess the quality, effectiveness and availability of early help support and interventions. Early help services are recognizing and responding to early safeguarding concerns, reducing the risk of children	Partner agencies: Provide performance information when requested in relation to safeguarding children that also includes a narrative analysis. Provide clear and detailed

	Case audits to pick up on findings from SCR/ PLR's in relation to childhood neglect	availability of post abuse support to victims of CSE. Ensuring the quality and findings from intelligence relating to CSE and children who go missing (NOTE: some data will come from CSE Panel and RMM's). Identifying messages and lessons from case audits to improve practice	protection plans	Suffering significant harm. Early help staff are engaged in the GCP 2 training and are using the tool in practice. To review, analyze and then report to the Executive and Board in relation to performance data provided through early help services.	assurance reporting when requested that evidences that they are fulfilling their duties and responsibilities to safeguard and promote the welfare of children, identify any concerns and risks and what is being done to improve this. Engage fully in multi-agency case audits as identified.
Case Review (including child death reviews and serious case reviews)	Ensure the actions identified from previous SCR's and PLR's into childhood neglect cases are properly embedded within LSCB training (link to workforce development sub group) and, action plans are properly completed.	Identify opportunities to review Herefordshire partnership response to 'peer on peer' abuse and identify/disseminate any learning for partner agencies.	Ensure learning from SCR's and PLR's is appropriately used to improve the journey of the child through the child protection process.	Use Child Death Overview Panel learning to influence partnership activity to address modifiable risk factors to reduce the likelihood of future child deaths.	Partner agencies: Refer appropriately to the JCR cases that they think may fit the criteria for a case review. Respond in a timely manner to requests for information in relation JCR and CDOP Produce high quality IMR's when requested, and in a timely manner Engage fully in the case review process and lessons to learn and actions identified.

The Voice of the Child and Family: in all areas of working with children and families the board wants to be assured that the voice of children and families is heard, recorded and taken account of in the provision of services.

ALL sub groups as appropriate: **Voice of the child/family**	The evaluation of the GCP2 should include the views and experiences of children, young people and their families.	Secure qualitative feedback from victims of CSE and their families in relation to the services received/experience of agencies to inform improvement in service.	Receive feedback from children and young people who are subject to a child protection plan or who are looked after, to understand the effectiveness of the local safeguarding system.	Receive feedback from children, young people and their parents/carers about their experience of accessing and receiving early help (including Families First).	The HSCB will expect partner agencies to feed back to the board any views of children and families regarding services they have received, and what agencies have done as a result of this (this may be through sec 11 audits, assurance reporting or other mechanisms agreed by the board). HSCB multi-agency case audits; case reviews, and other HSCB activity where appropriate, will include analysis of the voice of the child / family.

In addition to the priorities noted above discussions at the HSCB Executive Group, following the HSCB development day agreed for an additional area to be included in the Boards Strategic plan, the topic being **Strong Leadership; Strong Partnership**, details of this are outlined below:

Strong Leadership- Strong Partnership:

All partner agencies in Herefordshire have a duty to safeguard and promote the welfare of children and young people in their area. It is a given, through findings from enquiries, inspections and research, and outlined in "Working Together to Safeguard Children" (2015), that the best way of achieving this is through effective joint working. To fulfil the duties to monitor and ensure that joint working is effective we do this through the mechanism of the HSCB. For this reason all the HSCB partners wanted to be assured that this system was working as effectively as possible and there was full engagement in all the essential processes. The key outcomes and actions in this plan are designed to help us demonstrate **Strong Partnership**, which is an essential part of ensuring strong and effective working together to safeguard children and young people.

Herefordshire Council

Meeting:	**Children and young people scrutiny committee**
Meeting date:	**Monday 1 October 2018**
Title of report:	**Referrals to the Multi Agency Safeguarding Hub**
Report by:	**Director children and families**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To inform the children and young people scrutiny committee of the number of referrals that are made into the Multi Agency Safeguarding Hub (MASH).

To allow the committee the opportunity to review and make recommendations in respect of how the number of referrals can be reduced.

Recommendation(s)

That:

(a) The children and young people scrutiny committee review the referral rates outlined within the report and determine any recommendation it wishes to make to the executive or responsible partner agency to secure improvement.

Alternative options

1. There are no alternative options; it is the function of the committee to make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive.

Further information on the subject of this report is available from
Liz Elgar, email: liz.elgar@herefordshire.gov.uk

Key considerations

2. The purpose of a contact made to the Multi-Agency Safeguarding Hub (MASH) is to express a concern about child. Not all Children's Services agencies across the country have MASH arrangements, but all are charged with having processes in place to respond to concerns about the safety of children under the Working Together to Safeguard Children guidance 2018.

3. Herefordshire Children's Safeguarding Board has developed threshold guidance to assist professionals in making decisions as to whether the concern they have regarding a child or children should be referred into the MASH. This guidance was revised in August 2017 and is due for review this month, September 2018.

4. The guidance is very clear in identifying four levels of need, Level 4 being the threshold to refer to Children's Social Care. (appendix attached)

5. It is underpinned by the following:

   "when thresholds are understood by all professionals and applied consistently this will ensure the right help is given to the child at the right time".

6. It has become apparent that there have been a number of referrals that are being received into the MASH that are not meeting the levels defined and agreed within the threshold document by all partner agencies.

7. The Ofsted report published July 23rd 2018 stated as follows;

   "a significant number of contacts are signposted away from children's social care which means that too many children are being referred who do not need this level of support. A number of children who would benefit from early help services experience delay because thresholds are not appropriately applied or understood."

8. The level of referrals received into the MASH in August 2018 are shown in the table below:

	Contacts	Percentage of contacts	Referrals	Percentage of Referrals	Percentage of referrals NFA'd
Anonymous	0	0.0%	13	3.3%	92%
Education Services	0	0.0%	2	0.5%	100%
Health services - A&E	0	0.0%	16	4.0%	69%
Health services - GP	1	0.4%	13	3.3%	54%
Health services - Health Visitor	3	1.1%	5	1.3%	0%
Health services - Other eg. hospice	2	0.7%	12	3.0%	92%
Health services - Other primary health services	2	0.7%	46	11.6%	41%
Health services - School Nurse	0	0.0%	2	0.5%	100%
Housing or housing association	0	0.0%	0	0.0%	0%
Individual - acquaintance eg. neighbours / child minders	0	0.0%	5	1.3%	80%
Individual - family member / relative / carer	31	11.2%	18	4.5%	67%
Individual - other Individuals e.g. strangers / MPs	0	0.0%	4	1.0%	100%
Individual - self	0	0.0%	0	0.0%	0%
LA services - external eg. from another LAs	2	0.7%	6	1.5%	83%
LA services - Other internal department eg. youth offending	0	0.0%	6	1.5%	33%
LA services - Social care eg. adults social care	0	0.0%	45	11.3%	31%
Other - eg. children's centres / independent agency providers / voluntary organisations	8	2.9%	27	6.8%	74%
Other Legal Agency - incl. courts, probation, immigration, CAFCASS or prison	8	2.9%	39	9.8%	56%
Police	218	78.7%	131	33.0%	76%
Schools	1	0.4%	4	1.0%	25%
Unknown	0	0.0%	3	0.8%	0%
Total	**276**		**397**		**62%**

9. It has been found that;

   - there was an increased number of contacts and referrals being received;
   - that the threshold guidance was not being applied consistently;

10. As can be seen in the table the majority of the referrals into the MASH are from the Police and work is due to commence to understand why this is the case and to work with partner agencies to ensure that the thresholds are implemented and applied in a consistent manner.

11. Discussion with Police has commenced between Liz Elgar, AD Safeguarding and Family Support, and DCI Neil Austin, and a meeting is booked for 10th October 2018 to continue to address the issue of over referral by Police into MASH.

Community impact

12. In accordance with the adopted code of conduct Herefordshire achieves its intended outcomes by providing a mixture of legal, regulatory and practical interventions. Determining the right mix of these is an important strategic choice to make to ensure intended outcomes are achieved. The council needs robust decision-making mechanisms to ensure our outcomes can be achieved in a way that provides the best use of resources while still enable efficient effective operations. Decisions made need to be reviewed periodically to ensure that achievement of outcomes is optimised.

13. The council must ensure that it has an effective performance management system that facilitates effective and efficient delivery of planned services. Effective financial management, risk management and internal control are important components of this

performance management system. Herefordshire Council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review.

14. It is a priority of the corporate plan to 'Keep children and young people safe and give them a great start in life'. The safeguarding of children and the child protection process is fundamental to this aim.

Equality duty

15. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

    a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

16. Protected characteristics and reasonable adjustments are considered for all children who are subject to child protection arrangements. Such consideration enables Herefordshire Council to meet its obligations under the Equality Act 2010.

Resource implications

17. None associated with the recommendation. Any resource implications of recommendations the committee may determine will inform the executive's response to those recommendations

Legal implications

18. The Human Rights Act 1998 provides under Article 8 that:

    a. Right to respect for private and family life.
    b. Everyone has the right to respect for his private and family life, his home and his correspondence.
    c. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

19. The reduction in numbers of children on the child protection register reflects the authority implementing this principle. The department needs to be alert to children being repeatedly referred through to the multi-agency safeguarding hub (MASH) as this may reflect on going systemic family problems which need to be addressed.

Risk management

20.

Risk / opportunity	Mitigation	M
Inappropriate application of threshold which may lead to children being subject to a plan unnecessarily OR children not being made subject to a plan and left at risk	Refreshed multiagency awareness of the Threshold Document and put in place additional checks which included the employment of an independent reviewing officer	
Missed opportunity to work with families at a more appropriate lower level	As above	

Consultees

21. None

Appendices

Appendix 1 – Threshold guidance

Background papers

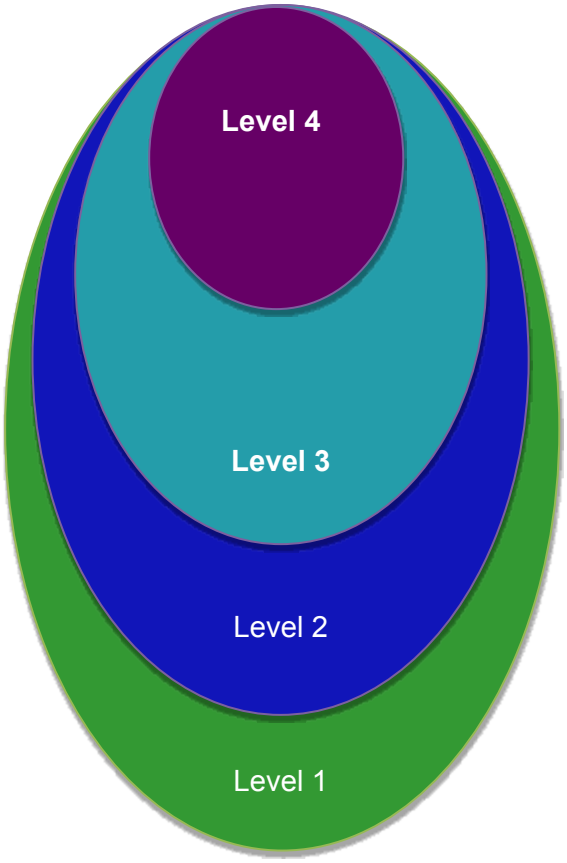
None identified

Herefordshire

Safeguarding Children Board

Herefordshire Levels of Need Threshold Guidance

Multi - agency guidance on meeting the needs of children, young people and their families in Herefordshire.



Written by	**Herefordshire Safeguarding Children Board**
Date written	**August 2014**
Approved by	**Herefordshire Safeguarding Children Board**
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Appendix 1: Level of Need Examples

Universal (Level 1) No additional support beyond that which is universally available 8

Early Help (Level 2))Children and young people where some concerns are emerging and who require additional support, usually from professionals already involved with them (Threshold to Consider EHA) 9

Targeted Early Help (Level 3) Children and young people who are causing significant concern or where concerns recur frequently (Threshold to initiate EHA) 11

Specialist) (Level 4) Children and young people who are very vulnerable. (Threshold to refer to Children's Social Care) 13

Appendix 2: Glossary / Abbreviations

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Introduction

The vision of Herefordshire Safeguarding Children Board is that children and young people in Herefordshire grow up in an environment in which their well-being needs are met and where they are safe from harm. Herefordshire Safeguarding Children Board's aspiration is that children, young people and families receive the right support at the right level at the right time.

This guidance replaces all previous guidance and meets the requirements of the statutory guidance in Working Together to Safeguard Children, 2015 which states:

> The Local Safeguarding Children's Board (LSCB) should publish a threshold document that includes:
>
> - the process for the early help assessment and the type and level of early help services to be provided;
> - the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under:
> - section 17 of the Children Act 1989 (children in need);
> - section 47 of the Children Act 1989 (reasonable cause to suspect children suffering or likely to suffer significant harm);
> - section 31 (care orders); and
> - section 20 (duty to accommodate a child) of the Children Act 1989.
> - clear procedures and processes for cases relating to the sexual exploitation of children and young people
>
> LSCBs with youth secure establishments in their area should ensure that thresholds and criteria for referral and assessment take account of the needs of young people in these establishments.

This document is intended to support practitioners at all levels, working in statutory, public, voluntary and independent sectors working with children, young people and families. It allows them to make decisions about how to respond to the needs of children and young people and their families they are working with. The framework is designed to help everyone to:

- Focus on the lived experience of the child and hear their voice
- Understand the child and young person in the context of their family and the wider community
- Think clearly and achieve a holistic approach
- Develop relationship based practice
- Be non-discriminatory on the grounds of age, ethnicity, religious belief, faith, culture, class, sexual orientation gender or disability.

When thresholds are understood by all professionals and applied consistently this will ensure that the right help is given to the child at the right time. However the levels of need are not prescriptive and allow for practitioner judgement and decision making nor does it replace assessment analysis and planning. Throughout the electronic version of this document you will find links to Herefordshire's to support your decision making around a case, as well as supporting guidance from alternative sources.

Commented [LM1]: Is there some wording missing from here?

A Shared Responsibility

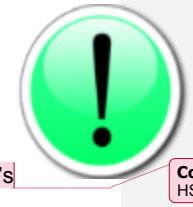
Working Together to Safeguard Children states that ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.

All staff who are aware of concerns about the welfare or safety of a child should know:

- What services are available locally
- How to gain access to services
- Who to contact in what circumstances
- When and how to make a referral to Children's Social Care.

When you have concerns you should:

- Discuss with a manager or designated lead in your agency/service
- Discuss with the child/family where it is appropriate to do so (unless this will lead to risk of significant harm)
- Seek consent to disclose and share information
- Talk to other agencies/services involved
- Discuss an Early Help Assessment with the child/family



If you are concerned that a child is suffering, or is at risk of suffering, significant harm always contact the Multi Agency Safeguarding Hub (MASH) -Tel: (01432) 260800

MASH contact details are available on the 3 Steps to Safeguard Children page of HSCB's website.

Commented [LM2]: Full title would be better rather than HSCB's

What is a threshold?

For this guidance a threshold is a point at which something might happen, stop happening or change, in relation to support services for children and families. For example it describes the step when professionals are determining whether the criteria are met for statutory intervention in family life, or when a child should be receiving a specific type of support. It is also a way of describing transitions between different levels of needs and types of services.

The Herefordshire 4 Levels of Need Threshold

There are four levels of need described which range from Thriving (no unmet needs); May need extra help (which is usually available from professionals already involved); May need further help (which is required from a number of services), and, In need of serious help (requiring statutory and specialist services). This is illustrated in the diagram on page 7, and Appendix 1 gives more detail about the model including examples.

How to use the Herefordshire 4 levels of need framework: The majority of parents and carer's are able to meet their child's needs accessing universal services, such as health and education as required. These services are often able to identify and offer additional support if the child develops additional needs or the family circumstances change. The Herefordshire 4 Levels of need should be then be used;

- To consider and discuss the child and family's situation as an individual practitioner or as part of an Early Help Assessment or Team around the family
- To consider whether to make a referral to Children's Social Care
- To understand if an Early Help Assessment should be initiated
- To support a referral by helping describe concerns about a child, complemented where necessary by specific risk identification tools e.g. around CSE; FGM; Domestic Abuse referrals.
- To challenge the practice or decision making in another agency and support the escalation of your concerns.
- As a reflective tool when measuring the change in a child and family's situation, to understand if the intervention has had an impact on the child's outcomes, if the child's needs have been met and the risk managed and reduced.
- To consider if the risk identified has been managed so that the case can be 'stepped down' to a lower service response.

To identify where a managed 'step-up' to a more intensive response is required as the risk to the child or young person has increased. It should be read in conjunction with HSCB's Multi Agency Child Protection Procedures and used in conjunction with the Multi Agency Referral Form Guidance.

Wherever possible please refer to the electronic version of this document available at Multi Agency Referral Form Guidance

Child Sexual Exploitation

Where a Child Sexual Exploitation concern has been identified a pre-checklist will need to be completed which can be found at https://herefordshiresafeguardingboards.org.uk/herefordshire-safeguarding-children-board/child-sexual-exploitation-and-missing-sub-group/ accompanied with guidance? Please see the corresponding actions below:

Child Sexual Exploitation - Regional Procedures

Child Sexual Exploitation – Local Procedures

Child Sexual Exploitation Risk Assessment – Local Procedures

	Description	Associated actions
☐	**No/Low risk** A child who is at risk of being groomed for sexual exploitation.	1. Liaise with Agency Designated Safeguarding Advisor for any advice/guidance. 2. Inform CSE Coordinator of young person considered at risk of CSE (so information about the extent and profile of CSE is captured by LSCB). 3. Work with child, young person and family to develop an awareness of the risks that can lead to a situation in which they may be exposed to sexual exploitation - delivered on a single agency basis or integrated into existing multi-agency plan. . 4. Ongoing review of risk required particularly if there are any changes in circumstances.

☐	**Medium risk** A child who is targeted for abuse through exchange of sex for affection, drugs, accommodation and goods etc. The likelihood of coercion and control is significant	1. A multi-agency approach will be needed to promote child's safety and well-being. 2. Follow local procedures including referral to MASH who will lead the completion of a specialist CSE Risk Assessment on a multi-agency basis. If concerns are substantiated, a CSE Risk Management meeting should be held to devise a safeguarding and support plan or such activity should be integrated into an existing multi-agency plan. The plan should include actions in relation to disrupting, investigating and prosecuting perpetrators. Risk should be closely monitored and regularly assessed as part of the risk management process. 3. Inform CSE Coordinator of young person considered at risk of CSE (so information about the extent and profile of CSE is captured by LSCB).
☐	**Significant risk** A child who is entrenched in sexual exploitation, but often does not recognise or self denies the nature of their abuse often in denial, and where coercion/control is implicit.	1. A multi-agency approach will be needed to promote child's safety and well-being. 2. Follow local procedures including referral to MASH who will lead the completion of a specialist CSE Risk Assessment on a multi-agency basis. If concerns are substantiated, a CSE Risk Management meeting should be held to devise a safeguarding and support plan or such activity should be integrated into an existing multi-agency plan. The plan should include actions in relation to disrupting, investigating and prosecuting perpetrators. Risk should be closely monitored and regularly assessed as part of the risk management process. 3. Inform CSE Coordinator of young person considered at risk of CSE (so information about the extent and profile of CSE is captured by LSCB).

Resolution of Professional Disagreements

Occasionally situations arise when workers within one agency feel that the decision made by a worker from another agency on a child protection or child in need case is not a safe decision. The safety of individual children is the paramount consideration in any professional disagreement and any unresolved issues should be addressed with due consideration to the risks that might exist for the child.

All workers should feel able to challenge decision-making and to see this as their right and responsibility in order to promote the best multi-agency safeguarding practice. This procedures provides a means to raise concerns about decisions made by other professionals or agencies by:

a) avoiding professional disputes that put children at risk or obscure the focus on the child

b) resolving the difficulties within and between agencies quickly and openly.

Effective working together depends on an open approach and honest relationships between agencies. Problem resolution is an integral part of professional co-operation and joint working to safeguard children.

This additional guidance has been produced to support the West Midlands Procedures for the Resolution of Professional Disagreements.

CHILD OR FAMILY'S SITUATION		HOW PROFESSIONALS RESPOND	
…IN NEED OF SERIOUS HELP	Level 4 Immediate intervention or Assessment required from MASH	REALLY CONCERNED, AND NEED TO TALK TO THE MASH TEAM	Children or young people with very complex needs or I am extremely concerned for their safety based on evidence of abuse or neglect or disclosure by the child. Referral to MASH.
…COMPLEX NEEDS – WILL NEED FURTHER HELP	Level 3 Multiple Agency Intervention Required	NEED TO WORK WITH OTHER AGENCIES	Children or young people with identified vulnerabilities and needs that require a multi- agency co-ordinated approach. Undertake an Early Help Assessment.
…ADDITIONAL NEEDS - MAY NEED SOME EXTRA HELP	Level 2 Relevant Agency Intervention Required	NEED TO OFFER SUPPORT, CAN DO THIS WITHIN OUR AGENCY	Children and young people with emerging vulnerabilities whose needs require targeted support. Consider an Early Help Assessment.
…THRIVING	Level 1 No Intervention or Support Required.	NO EXTRA SUPPORT REQUIRED	Children making good overall progress in all areas of their development, broadly receiving appropriate universal services such as health care and education. They may also use leisure and play facilities, housing or voluntary sector services.

Level 1: Thriving - No additional support needs beyond those which are universally available

Level 1 of vulnerability:

Children and young people making good overall progress in all areas of their development, broadly receiving appropriate universal services such as health care and education. They may also use leisure and play facilities, housing or voluntary sector services. They may be living in circumstances where there may be worries, concerns or conflicts but these are infrequent, short lived and quickly resolved by the family or with support from extended family, community or the professionals with whom they usually have contact.

Universal services, working with communities, are those most likely to identify that a problem is emerging for the child or within a family.

CHILD

- Child is accessing universal services, such as schools, leisure centres, GP surgeries, other primary health care services, youth centres, etc.
- Child is accessing and being included in social activities
- The child has a secure relationship and is shown warmth and consistently is praised and encouraged
- The child is physically / psychologically healthy
- Has a nutritious diet, has appropriate clean clothing and is taken to health and dental appointments
- No substance misuse
- Sexual activity/ behaviour appropriate to age
- Good attendance at nursery, school and college or other educational setting.
- Age appropriate independent living skills
- Child is meeting their developmental milestones, including speech and language

PARENTS/CARERS

- The family unit usually functions well even during times of crisis
- The unborn is a wanted child, with parent(s) accessing ante natal care and preparing for the birth and is unaffected by parental substance misuse/ domestic abuse or mental ill health
- Parents / Carers provide appropriate guidance and boundaries to help protect the child from harm and to develop appropriate values.

HOME / ENVIRONMENT

- The facilities and hygiene within the child's accommodation are appropriate

Level 2: Additional Needs - Consider an Early Help Assessment to identify additional needs and how best to meet them.

Early Help Assessment Guidance

Level 2 of Vulnerability:

Children and young people with emerging vulnerabilities whose needs require additional supporting the form of advice, direction and sometimes planned intervention or additional resources; these would usually be provided by professionals who are already involved such as health, early years or education staff .

Potential Indicators – this is not an exhaustive list	Further Policy and Guidance
CHILD **Health** • Slow in reaching milestones including delayed speech and language • Missing occasional routine health checks/appointments • Persistent minor health problems • Pre-natal health needs • Issues of poor bonding /attachment • Minor concerns re healthy diet/hygiene/ weight /dental health • Children with Disabilities **Education and Learning** • Occasionally unpunctual or absent from school • Escalating behavioural issues • Not reaching educational potential / expected attainment • Limited opportunities for social interaction and play **Emotional and Behavioural Development** • Signs of deteriorating mental health /self-harm • Poor self-esteem /withdrawn unwilling to engage • Some concern / occasional substance misuse • Some difficulty with peers- May be experiencing bullying or bully others	

Parents and Carers • Inconsistent boundaries – parents require advice on parenting issues • Can behave in anti-social way • Relationship between carers and child not always stable • Acrimonious relationships impacting upon the child • Parental health difficulties / additional needs or vulnerabilities • Poor home routine • Child has caring responsibilities • Poor / inappropriate housing • Low income / unemployment • Low level parental substance misuse	
HOME /ENVIRONMENT • Environment not always appropriate • Family isolated socially and / or geographically	

Level 3: Complex Needs - Threshold to initiate an Early Help Assessment (EHA): Multiple Agency Intervention Required

Early Help Assessment Guidance

Level of Vulnerability: Children or young people with complex vulnerabilities and needs that require a multi-agency co-ordinated approach supported by a clear co-ordinated action / care plan.

Undertake the Early Help Assessment and develop a co-ordinated package of intervention

Potential Indicators – this is not an exhaustive list	Further Policy and Guidance
CHILD	
Child/young person who is consistently failing to reach their developmental milestones and concerns exist about their parent's ability to care for them	Recognising Neglect and using the Graded Care Profile
Experiencing chronic / life limiting health condition	
Children with Disabilities	Recognising Neglect and using the Graded Care Profile
Unsafe sexual behaviour / at risk of CSE	Child Sexual Exploitation Risk Assessment (local) Child Sexual Exploitation (National) Sexually Active Children & Young People (Including Under Age Sexual Activity)
Failure to attend medical appointments on a regular basis	
Problematic substance misuse	
Persistent truanting / short term exclusion / poor school attendance	Children missing from care, home & education
Appearance reflects poor care / hygiene despite offering of advice and support	Recognising Neglect and using the Graded Care Profile
Child is expected to undertake caring role for others in the family	
Missing from home on occasions	Children missing from care, home & education
Puts self or others in danger	Self-harm and suicidal behaviour

Non engagement with ante natal appointments	
Conception under 16 years	
Education and Health Care plan required.	
Children who are young carers and wish to access their right to an assessment	
PARENTS/CARERS	
Parents or carers are experiencing, on an on-going basis, one or more of the following problems significantly affecting their parenting: mental ill-health, substance dependency or domestic abuse / potential honour based violence / forced marriage / learning disability	Recognising Neglect and using the Graded Care Profile (Local) Neglect (Regional)
Parents negative, critical or rejecting	
Parental involvement in crime	
Chronic / serious relationship problems between carers	Domestic Violence and Abuse
HOME /ENVIRONMENT	
Family is socially excluded / very isolated	Recognising Neglect and using the Graded Care Profile (Local) Neglect (Regional)
Overcrowded housing	
Risk of eviction / homelessness	
Home in poor state repair / poor hygiene within home	
Debts / poverty	
Family seek asylum / refuge	

If help and support is refused, consideration must be given as to whether this will adversely impact the child's safety, health and / or development and, therefore, meet the threshold for Statutory Assessment at Level 4.

Level 4: Threshold to refer to Children's Social Care:

Immediate Intervention or Assessment Required from the Multi Agency Safeguarding Hub (MASH)

Multi-Agency Referral; Reporting Concerns (MARF)

Level of Vulnerability:

Children or young people with very complex needs OR I am extremely concerned for their safety based on evidence of abuse or neglect or disclosure by the child. The child's health and development is being adversely affected.

Potential Indicators – this is not an exhaustive list	Further Policy and Guidance
Children where there has been a disclosure / allegation of harm or where children are identified at risk of suffering serious harm through physical, sexual, emotional abuse and neglect	Recognising Neglect and using the Graded Care Profile Bruising non mobile babies Strategy Discussions / Meeting Quick guide to CP medicals and CP health assessments Child Protection Procedures – Additional Guidance
Children where the following is suspected:	
Fabricated illness	Fabricated or induced Illness
Allegations of harm by a person in a position of trust	Person posing risk to children Allegations about a Colleague / Professional Allegations against Staff or Volunteers
Female genital mutilation (FGM)	Female Genital Mutilation
Honour based violence	Honour based violence
Forced marriage	Forced marriage
Sexual exploitation and trafficking	Child Sexual Exploitation Risk Assessment Trafficked children ESafety: Children exposed to abuse through digital media
Sexual activity under age of 13 years	Child Sexual Exploitation Risk Assessment (local) Child Sexual Exploitation (National) Sexually Active Children & Young People (Including Under Age Sexual Activity)

Children whose parents are unable to provide care, for whatever reason	Children of parents with mental health problems Parental substance misuse, hidden harm and the impact on children and young people Domestic Violence and Abuse
Children who disappear or are missing from home or care regularly or for long periods	Children missing from care, home & education
Children who are in contact with persons who have been assessed as Posing a Risk to Children (PPRC)	Person posing risk to children
Children whose health and development are adversely impacted / significantly impaired because parenting is compromised as a consequence of: ○ Mental health issues; ○ Substance misuse ; ○ Domestic abuse ○ Learning difficulties ○ Poverty ○ Prolific offending / in custody ○ despite interventions and support at Level 2 and 3	Children of parents with mental health problems Parental substance misuse, hidden harm and the impact on children and young people Domestic Violence and Abuse Recognising Neglect and using the Graded Care Profile Neglect (Regional)
Children whose behaviour is so extreme they are at risk of removal from home e.g. control issues, risk taking, dangerous behaviour	Children affected by gang activity & youth violence Self-harm and suicidal behaviour
Children who are experiencing extreme forms of bullying that adversely impact upon their health and development	Bullying Self-harm and suicidal behaviour
Children who are abandoned, rejected , become subject of police protection or Children aged 16 and 17 who present as homeless Adoption breakdown	
Children whose health and development is being adversely impacted through parental non-engagement with services despite interventions at Level 2 and 3 including parents who are unable to protect their	Recognising Neglect and using the Graded Care Profile Families who resist change including disguised compliance

children and to prioritise the needs of their children above their own	
• Where a pre-birth assessment has identified an unborn child's health or development is being adversely impacted • Unborn to parents unable to care for previous children	Quick guide to CP medicals and CP health assessments Pre Birth Assessment Recognising Neglect and using the Graded Care Profile
• Children with Disabilities requiring significant support	Children with disabilities
• Children who are Privately Fostered	Children living away from home
• Children subject to care proceedings including children / young people subject to care order, wordship, EPO, supervision order or remanded to LA care	
• Unaccompanied Asylum Seeking Children	Children from abroad
• Children Who Harm / abuse Others	
• High Risk / Experiencing CSE	Child Sexual Exploitation Risk Assessment (local)
• Persistently displays extremist views / radicalisation	Safeguarding Children and young people against radicalisation and violent extremism

Support will be offered to children and families at Level 3 as part of the Step-Down Process from Level 4

Children and Young People Scrutiny Committee

1 October 2018

Work Programme 2018/19

Meeting date: 14 May 2018 – **10.15 a.m.**		Despatch: 3 May	
Item	Description	Report Author	Form of Scrutiny
Learning Disability Strategy 2018 - 2028	To preview the draft learning disability strategy before it is presented to the cabinet for approval. The committee is asked to agree recommendations and comments to submit to the cabinet member health and wellbeing for consideration during the finalisation of the strategy.	Adam Russell	Pre-decision call-in
Children's Safeguarding and Family Support Performance Data	To receive a quarterly performance report on safeguarding measures.	Vicki Lawson/Chris Jones	Performance review
Briefing	NEETs – current level of NEETs, new data recording system; and breakdown of statistics around rural/urban/market towns/gender/traveller community. Regional Schools Commissioner – briefing note on role of the RSC and areas of overlap with the council. Provision of children's rights and advocacy service	Louise Tanner Lisa Fraser Sandra Griffiths	
Meeting date: 16 July 2018 – **2.00 p.m.**		Despatch: 6 July	
Children and Young People Plan	To receive the draft children and young people plan ahead of its presentation to Cabinet and Council. To make recommendations on the draft plan.	Richard Watson, Amanda Price	Pre-decision call-in
Adoption Service and Fostering Service annual reports	To receive the annual reports from the adoption and fostering services and consider the outcomes and recommendations. To make recommendations to the cabinet member on the operation of the services during 2018/19.	Gill Cox	Performance review

Child Protection Numbers	To receive an update on the number of children currently subject to child protection arrangements and to make any necessary recommendations to the Cabinet Member.	Jane Hoey	Performance review
Meeting date: 17 September 2018 – **10.15 a.m.**		Despatch: 7 September	
Youth Justice Plan	To endorse the Youth Justice Plan 2018/19 for approval by full Council and consider whether there are any comments the committee would wish to make that would inform the production of the Plan for 2019/20.	Keith Barham	Pre-decision call in of Policy Framework Item
Education Strategy	To preview the draft education strategy before it is presented to the cabinet for approval. The committee is asked to agree recommendations and comments to submit to the executive for consideration during the finalisation and approval of the strategy.	Lisa Fraser	Pre-decision call in
Implementation of the Corporate Parenting Strategy action plan	To consider the updated action plan to the corporate parenting strategy and receive a performance report against the objectives	Gill Cox	Performance review
Briefing paper	Autism Strategy update		
Meeting date: 1 October 2018 – **2.00 p.m.**		Despatch: 21 September	
Herefordshire Safeguarding Children's board annual report	To consider the annual report and any recommendations contained within it. To assess if the report provides assurance and make comments and recommendations to the council and cabinet.	Sally Halls/Ann Bonney	Performance review
Referrals to the Multi Agency Safeguarding Hub	To receive a report concerning referrals to the MASH from agencies and in particular the Police.	Liz Elgar	Performance review/policy review and development
Ofsted action plan	To consider the action plan established following the Ofsted inspection in June 2018. To make recommendations to the executive on those actions identified.	Chris Baird	Pre-decision call-in

Meeting date: 12 November 2018 – **10.15 a.m.**		Despatch: 2 November	
Budget and Medium Term Financial Strategy (MTFS)	To seek the views of the committee on the draft medium term financial strategy (MTFS) 2017-21 and the budget proposals for 2017-18 relating to Children's Wellbeing.	Andrew Lovegrove, Audrey Harris	Pre-decision call-in/Policy review and development
Childcare sufficiency report	To preview the draft childcare sufficiency report before it is presented to the cabinet for approval. The committee is asked to agree recommendations and comments to submit to the cabinet member young people and children's wellbeing for consideration during the finalisation of the strategy.	Andrew Hind, Julia Stephens, Nicola Turvey	Pre-decision call-in
Scrutiny Panel – LAC reduction savings	To receive a report of the outcomes of the scrutiny panel to provide an oversight of progress against the savings proposal to reduce the number of looked after children.	Chris Baird	Performance review
Section 20 Task and finish group – recommendations and outcomes	To present the final report of the task and finish group to the Children and Young People Scrutiny Committee.	Chairman of T&F	Policy review and development
Recommendations from the Spotlight review	To consider and approve the recommendations emerging from the spotlight review concerning dental health and childhood obesity.	Democratic Services Officer	Policy review and development
Meeting date: 4 March 2019 – **2.00 p.m.** **(Potential alternative venue)**		Despatch: 8 February	
Young Carers Service	To consider an update report on progress with the implementation of the young carers service. To involve evidence from Young Carers.	Danielle Mussell	Performance review
School Examination Performance	To consider school performance of summer 2018 and make recommendations to cabinet on how the effectiveness of the school improvement framework and strategy could be enhanced.	Lisa Fraser	Performance review
SEND Provision Task and finish group – recommendations and outcomes	To present the final report of the task and finish group to the Children and Young People Scrutiny Committee.	Chairman of T&F	Policy review and development

PRU Referrals Task and finish group – recommendations and outcomes	To present the final report of the task and finish group to the Children and Young People Scrutiny Committee.	Chairman of T&F	Policy review and development
Briefing paper	Improvement Plan – six monthly report of progress against the improvement plan. Update on the Herefordshire Children and Young People Mental Health and Emotional Wellbeing Transformation Plan 2015 – 2020		
Meeting date: 25 March 2019 – **10.15 a.m.**		Despatch: 5 March	
Work Programme 2019/20 and meeting dates	To agree the Committee's work programme and meeting dates for 2019/20.	Matt Evans	

Scrutiny Panel – a panel of two members of the committee is currently in operation to provide an oversight of progress against the savings proposal to reduce the number of looked after children. Councillors Gandy and Seldon comprise the Panel.

Task and Finish Groups – Section 20 Orders – two meetings undertaken to date – final meeting on 4 October 2018 with recommendations reported to committee on 12 November 2018.

– SEN Provision – Four meetings arranged with recommendations reported to committee in March 2019.

– PRU referrals – Three meetings arranged with recommendations reported to committee in March 2019.

Spotlight review – Dental Health and Childhood Obesity – took place on 17 September 2018. Recommendations to be reported to committee on 12 November 2018 .

Business to allocate – Bereavement Services
– 12 month report of progress against the improvement plan
– Public Health nursing update

Appendix – recommendation tracker 2018/19

Appendix a

Schedule of Children and Young People Scrutiny Committee recommendations made and actions in response

Meeting	item	Recommendations	Action	Status
5 July 2017	Corporate Parenting Strategy 2017 – 2020	- The committee welcomes the strategy, supports the priorities identified and agrees to provide a summary of comments and recommendations to the cabinet member; - The committee requests annual performance reports relating to the action plan in the strategy; - The committee provides a forum, where appropriate, for children and young people in care and care leavers to hold their Corporate Parents to account; - The members of the committee facilitate training, with officers, on corporate parenting to all members of Herefordshire Council; - The committee recommends that the cabinet member reviews the measures for success and outcomes sought in the action plan on a regular basis to see whether any measures need to be strengthened; - The committee recommends that procedures are introduced to ensure that significant decisions of the council take account formally of likely implications for looked after children; - The committee recommends that members undertake a mentoring role, where	Response of executive: The draft strategy was discussed at the children's scrutiny committee on 5 July 2017; they are supportive of the strategy and associated action plan and have requested that an annual update on its implementation is presented to the committee. The recommendations have been considered by the cabinet member young people and children's wellbeing and as a consequence children's scrutiny is referred to in the action plan: Corporate Parenting Action Plan 2017-20	Action plan implementation update to be scheduled for 16 July 2018.

		appropriate, for looked after children to share skills and experience to help enhance personal development and there is consideration of how this is best facilitated and publicised; and - The committee recommends that methods and strategies are investigated to engage partners and businesses in corporate parenting.		
	Annual reports for the fostering and adoption services	Resolved – that: a) the committee notes the annual reports from the adoption and fostering services and agrees to feedback comments to the cabinet member; and b) the adoption and fostering reports are considered as separate agenda items in future years.	Adoption service and Fostering service annual reports allocated to the draft work programme 2018/19 for committee on 16 July 2016.	Completed
2 October 2017	Commissioning intentions for universal and early help services for children, young people and families	Resolved - That the committee: supports the extension of the family befriending services contracts with the existing providers to the end of March 2018; has significant concerns about the commissioning exercise proposed. The cabinet members for health and wellbeing and young people and children's wellbeing are asked to have regard to the committee's concerns, particularly: - i) The reported lack of consultation concerning safeguarding arrangements and engagement	Response of executive: i) The intention to re-procure health visiting and school nursing services has been in the public domain since August 2016. CCG colleagues have been involved in steps taken thereafter to inform future commissioning intentions. There has been an opportunity to raise any issues or questions regarding procurement, during this time. A generalised concern regarding safeguarding arrangements had been	Completed. Committee may wish to request an update report on the implementation of the contract.

		with the Herefordshire Safeguarding Children's Board; - ii) The provision of services in rural areas; - iii) The requirement for additional detail in the report, in particular the contract specification ; and - iv) A reported lack of communication with the CCG. requests that, before a decision is taken on the proposal, the cabinet members share additional information with the committee, including the contract specification.	raised by the CCG very recently prior to the scrutiny committee meeting and reassurances were provided to the CCG that discussions to understand the detail would be welcome and these have since been initiated. Issues relating to *safeguarding* commissioning responsibilities are resolvable through further discussion. There is no requirement to present the commissioning proposal to the Herefordshire Safeguarding Children's Board, because the service will be required to adhere to all national and local policies, guidance, standards and procedures. Further discussion and an agreed way forward have been made with the Chair of the Children's Safeguarding Board, including a request to include reference to safeguarding within this paper (see para 7). ii) It is recognised that there are challenges in delivering timely and accessible services across a rural county and this has been reflected in the draft specification. To respond to those challenges, the provider will be required to ensure that access is available via drop-in sessions (which could be held in any community facility or venue), clinics, home visits, telephone contact, texting and other formats appropriate for the families and community. Broadband	

			coverage across the county is currently 83% (30Mbps) so the provider will need to demonstrate how they will work with families who currently have no access to broadband or where phone signals are not available. The provider will also be expected to be organised around geographical areas/localities and pragmatically structured in line with local children's centre reach areas. The provider will also identify a named public health nurse link to each GP practice, children's centre and school, in order to facilitate local liaison, information-sharing and joint working in the best interests of families. iii) the draft specifications for the commissioning of 0-25 PH Nursing services and family mentoring services, to which have been added the requested additional detail relating to targets and outcomes and key issues outlined in the JSNA, have been made available, by exemption, to council members of the Children's Scrutiny Committee iv) This concern is not accepted and a summary of engagement activity is provided below: • Representatives from the CCG have been engaged since August 2016 when CCG requirements were reviewed; • a public online survey was launched	

			in November 2016; • stakeholder engagement events To which GP and CCG representatives were invited were held during December 2016 through to end of January 2017; • feedback events were held in February 2017; • an early years review/scoping workshop held in May 2017; • Soft market testing was undertaken June/July 2017; • Updates have been provided to a Joint Commissioning Board which includes representatives of the CCG and reports to the CCG Board in August/September 2017; • Engagement/information session with GPs on key principles to be incorporated into the specification, was held in October 2017.and ongoing engagement agreed re implementation arrangements.	
	Herefordshire safeguarding	Resolved – that:	Update from Chair of HSCB containing *Model Initial Parish Action Plan for*	Completed

	children's board (HSCB) annual report 2016/17 and business plan 2017/19	a) The annual report and effectiveness of the safeguarding arrangements for children and young people in Herefordshire as assessed by the Board are noted; and b) The strategic priorities identified by the Board are noted.	*Promoting a Safer Church* and latest detail with reference to work on the role of Parish Councils in safeguarding children.	
	Outcomes of casework peer review	Resolved – that the committee notes the report and offers congratulations to the teams involved in the review for the positive feedback received.		Completed
	Children's Wellbeing self-assessment	Resolved – that the committee notes the draft self-assessment document for the Children's Wellbeing Directorate.		Completed
4 December 2017	Children and Young People Mental Health Partnership	That the committee: supports the response of the CCG to the task and finish group recommendations; supports the objectives of the Herefordshire Children and Young People Mental Health and Emotional Wellbeing Transformation Plan 2015 – 2020; and requests an update report on the implementation of the plan in 2018.	To determine the timing an update on the implementation of the plan in 2018.	Ongoing
	Children's Wellbeing self-assessment – update	That the Committee: endorses the self-assessment in its current form; and agrees that the comments raised by the committee are circulated to the cabinet member.	Excerpt of minutes detailing the discussion sent to the cabinet member for Children and Young People.	Ongoing

5 February 2018	School Examination Performance	Resolved – that the committee: Recognises positive attainment in a number of areas of school examination performance but in particular in the field of phonics; Requests a briefing note on the current level of NEETs, the new data recording system and a breakdown of statistics to include indicators around rural/urban/market towns/gender/traveller community; Requests a briefing note on the role of the Regional Schools Commissioner and a focus on areas of overlap with the Council; and Agrees to write to government to express concern regarding the lack of regulation and monitoring in respect of home schooling. The correspondence should include reference to the potential impacts of home schooling upon the educational achievements of children and safeguarding responsibilities of the Council.	Correspondence sent to Nadhim Zahawi MP, Parliamentary Under Secretary of State for Children and Families. Copied to Jesse Norman MP and Bill Wiggin MP. Response received.	
	Children and Young Peoples Plan	Resolved - that the committee: Supports the inclusion of: obesity; dental health; mental health and wellbeing; transport; and youth facilities as key areas of focus for the plan; Supports the implementation of a robust monitoring framework for the new version of the Plan; and Asks for the draft Plan to be presented to the	Allocated to the committee's draft work	Completed

		committee ahead of consideration at Cabinet and full Council.	programme 2018/19 for committee on 16 July 2018.	
16 April 2018	Autism Strategy for Herefordshire 2018 – 2021	Resolved – that: (a) the significant successes achieved in the first Herefordshire autism strategy published in 2014 be recognised; (b)the outcomes identified by the strategy and the means in the action plan to achieve these ends be supported but noting that the committee would like to see more detailed milestones; (c) it be requested that as the action plan evolves additional base line data is included in the action plan to ensure tangible and quantifiable measures of performance and success, particularly in respect of improving diagnosis rates; (d) the executive be asked to investigate the development of a system/process to ensure an accurate picture of the incidence of autism across Herefordshire can be produced; (e) efforts to improve diagnosis rates and the recording of autism within GP patient records be supported and Herefordshire Clinical Commissioning Group asked to take this initiative forward as a matter of priority; (f) the executive be asked to take steps to work more closely with independent and private schools in Herefordshire to share data regarding enrolled autistic pupils to enable the production of comprehensive statistics of pupils in the county with	Resolutions of the Committee sent to the Executive for a response. Resolution (e) sent to the Herefordshire CCG for consideration.	Awaiting Executive Response. Strategy to be presented to Cabinet later in 2018

		autism; (g) the executive be asked to consider methods to promote employment at the council to people with autism; (h) the executive be asked to consider contacting key local organisations, such as Halo leisure, to ensure they promote autism-friendly service provision; (i) the executive be asked to ensure that the Herefordshire branch of the National Autistic Society and the Hereford Autism Partnership are consultees during the planning process to ensure that new housing and public access buildings have autism-friendly design considerations; (j) the executive be asked to investigate proposals to ensure that new and existing council buildings and facilities are autism-friendly; and (k) the executive be asked to consider autistic-awareness training for new members of staff and elected members of the Council and ensure that all members are able to disseminate good practices within their local communities.		
	LGA Safeguarding Peer Review Feedback	Resolved – that: (a) a report be submitted on the referrals to the MASH, in particular those by West Mercia Police, for review by the Committee; (b) it be requested that corporate parent training for all members be made mandatory;	(a) scrutiny arrangements to be determined at work programming session for 2018/19. (b) corporate parenting is a mandatory training module and must be completed within three months of being elected.	Ongoing Completed

		(c) progress on actions in the finalised improvement plan is reported to the Committee, at 3, 6 and 12 months to enable it to be monitored; and (d) the Committee's recognition and support of the work of staff in this challenging area be noted.	(c) briefing notes for progress at 3 and 6 monthly intervals added to the work programme. The 12 month progress report to be allocated to the first committee in the new term.	Completed
14 May 2018	Learning Disability Strategy 2018 – 2028	Resolved – that the committee: (a) supports the strategy and requests the missing information, concerning health and wellbeing outcomes and social impact, and the implementation plan is shared with the committee when available; (b) requests that the executive prioritise the incorporation of improved metrics in the strategy to measure progress and provide evidence that objectives are realising desired outcomes; (c) requests that the executive considers making updates on the development and implementation of the strategy available through an appropriate forum e.g. the corporate budget and performance report; (d) asks the executive to provide a report to the committee, in due course, on the re-modelling of the Learning Disability Partnership Board; (e) asks the executive to consider appointing a member champion for learning disabilities;	Executive response, 7 June: (a) Agreed. The information will be circulated to committee members by 01 October 2018 and it will be for the committee to determine whether to include further consideration in its work programme; (b) Agreed. This will form part of the first years activity in the implementation plan. (c) Agreed. Progress will be reported through the quarterly corporate performance reporting process. (d) Agreed. The information will be circulated to committee members by 31 December 2018 and it will be for the committee to determine whether to include further consideration in its work programme (e) Agreed. A draft role profile will be prepared and the Leader of the Council will consult with political group leaders before making an appointment.	

		(f) asks the executive and the CCG to investigate methods of utilising learning disability registers, held by GP surgeries, to provide evidence for those with learning disabilities to more easily obtain bus passes; (g) asks the executive to investigate the promotion of a scheme, similar to the Gloucestershire 50/50 strategy, in Herefordshire to encourage employment opportunities for people with learning disabilities; and (h) ensures that following the adoption of the strategy, the CCG and the 2gether Trust are held to account for those elements of the strategy for which they are responsible.	(f) Not agreed. Whilst the problem is recognised, there are still complex issues with accessing and sharing learning disability registration data in order to achieve this specific outcome. The requirement for and provision of qualifying information for exemption schemes will be considered across the whole of the health and wellbeing pathway. (g) Agreed. Knowledge gained from the Gloucestershire 50/50 learning disability employment strategy will be incorporated into planned work to promote employment opportunities for people with learning disabilities in Herefordshire and that this will form part of the 2018-19 implementation plan; (h) This is not a function of the executive. The scrutiny committee may review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and make reports and recommendations directly to the relevant body.	
	Children's safeguarding and family support performance data	Resolved - that a report concerning referrals to the MASH is added to the work programme for the committee in September to include an invitation to Sally Halls to participate in the item and access to comparative data from other local authorities.	Item added to the Committee's work programme for 17 September.	

16 July 2018	Minutes of the previous meeting (14 May)	*'f. asks the executive and the CCG to investigate methods of joint working with GP surgeries to assist those with learning disabilities to more easily obtain bus passes'* RESOLVED: that subject to the change outlined above the committee approves the minutes of the meeting on 14 May 2018.		
	Fostering and Adoption Annual reports	RESOLVED: that the committee: 1) Expresses concern regarding the lack of progress in joining a regional adoption agency and the executive is requested to undertake any available actions to expedite membership of Adoption Central England; 2) Requests clarification regarding how the overspends of the fostering service and external fostering budget in 2017/18 have been addressed; 3) Asks the executive to approach local cultural and leisure providers to attempt to secure concessionary rates for looked after children; and 4) Notes the annual reports 2017/18 for the	Executive response 1) The council has been working in line with the DfE expectations in joining a regional adoption agency and has recently received guidance on the requirements for the next stage, which involves providing a submission to ACE for their consideration. The council aims to join ACE by 31st March 2019 pending agreement by ACE and Cabinet. 2) The budget for 2018/19 was adjusted to provide more resource for anticipated spend in these areas when the budget was set. Work to reduce the numbers of children and young people in the care of the authority continues. 3) Agreed.	

		fostering and adoption services.		
	Children and Young People Plan 2018 - 2023	RESOLVED: that the Committee recommends that the Plan includes reference to: a) the impact of poverty and deprivation on children and young people; b) refugee and migrant children and families; and c) the issue of County lines under the *be safe from harm* priority.		
17 September 2018	Youth Justice Plan 2018-2019	RESOLVED: that the Committee: a. endorses the Plan for presentation to full Council; b. notes the improvement in the rate of first time entrants across West Mercia but recognises further progress is required to reduce the rate in Herefordshire; c. supports an increase in the use of informal responses, such as community resolution, to divert young people from the formal justice system and recommends that this is progressed as a priority; d. expresses concern regarding the persistently high level of reoffending in Herefordshire and recommends that the General Scrutiny Committee review the reducing youth		

		offending delivery plan, being produced by the Herefordshire Community Safety Partnership, and also scrutinises the CSPs approach to youth crime and anti-social behaviour; e. agrees witnesses from the police, the CSP and other relevant partners such as Addaction will be invited to participate in the committees future consideration of the Youth Justice Plan; and f. requests that the Plan incorporates clarity regarding why it is produced, to whom it is aimed and the communities it serves.		
	Corporate Parenting annual Update	RESOLVED: that the Committee: a. notes the update and recognises the progress made; b. asks the executive to encourage all members to use local contacts to identify employment and work experience opportunities for LAC; and c. agrees to write to local cultural providers to request concessions for LAC.		
	Education, Development and Skills Strategy 2018-2021	RESOLVED: that the Committee: a. supports the Strategy as a high level statement of intent and requests that further detail on the individual projects are circulated when available; and b. requests that the committee is involved in the review of the SEND strategy.		