Herefordshire
Safeguarding Children Board

Annual Report

1 April 2014 - 31 March 2015

The effectiveness of work to safeguard and promote the welfare of children in Herefordshire

Information about this report

The statutory objectives of the Local Safeguarding Children Board are set out in Section 14 of the Children Act 2004 as:

"to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and to ensure the effectiveness of what is done by each such person or body for those purposes"

The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report is an account of the effectiveness of the LSCB and this report is published in relation to the financial year 2014-2015. 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 annual report should provide a rigorous and transparent assessment of performance and effectiveness of local services. It identifies areas of weakness, the causes of those weaknesses and the actions being taken to address them. The report includes lessons learned from reviews undertaken in this timeframe and how the LSCB has used the learning to impact on practice.

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

Finally the report outlines evidence based priorities for 2015-2016.

Date of publication: November 2015

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Foreword from Independent Chair

I am pleased to report on the work of Herefordshire's Local Safeguarding Children Board (HSCB) during 2014-15. I took up the post of Independent Chair on 1st April 2015 following the departure of its previous Chair, Dave McCallum.

The HSCB is a partnership that works to safeguard and promote the welfare of children in Herefordshire.

The year was one of scrutiny, review and gradual improvement. The Ofsted inspection early in the year found that *There are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help and care for children, young people and families*.

Overall, Ofsted judged services to be 'requiring improvement'. It made the same judgement about the LSCB, and gave a number of pointers to areas which require strengthening.

Recognising the significant improvements that have been achieved in the way in which children in Herefordshire are safeguarded, the Department for Education lifted the Improvement Notice served in 2012. However, there is both ambition and need to increase further the effectiveness of the Board and its partners in order to ensure that children in Herefordshire are effectively safeguarded and receive consistently good services when they need them. In the coming year, the Board will need to embed the changes it has put into place to ensure improvement is sustained. All partners are experiencing serious challenges in relation to funding and workforce stability, but nevertheless they will continue to need resilience and a relentless focus on improving the safety and wellbeing of children and young people in Herefordshire.

Both Dave McCallum and I would like to record our thanks to all engaged in safeguarding children in Herefordshire for the tireless and deeply worthwhile work that they are doing, and to the young people who are increasingly contributing to the work of partners and the LSCB.

Sally Halls
Independent Chair
Herefordshire Safeguarding Children Board

Context and strategic overview

About Herefordshire

Herefordshire is a predominantly rural county, with the 4th lowest population density in England. It is situated in the south-west of the West Midlands region bordering Wales. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington. Herefordshire's 82,700 homes and 184,900 residents are scattered across its 842 square miles – which poses a particular challenge for service delivery and access. Almost all its land area falls within the 25 per cent most deprived in England in terms of geographical barriers to services; the Golden Valley in the south-west and the Mortimer locality in the north-west are particularly affected. Compounding the physical access issue, access to broadband, mobile phone services and other service infrastructure is an issue for some residents and businesses in rural areas. In general the county has a relatively large proportion of employment in sectors that tend to attract lower wages such as 'wholesale and retail' and 'agriculture', which affects the overall productivity of the county (as measured by a low GVA). Self-employment is more common than nationally, particularly in 'agriculture', 'arts, entertainment and recreation. (*Understanding Herefordshire 2014, An integrated needs assessmentl*)

The ethnic composition of Herefordshire's population has changed in the last decade, with the percentage of residents from an ethnic group other than "White British" growing from 2.5 per cent in 2001 to 6.3 per cent in 2011. 6.6 percent of the child population is from Black and Asian Minority ethnic groups, which is low in comparison with the national rate of 24.2%. 0.4% of children are from "White Gypsy or Irish Traveller" families.

About children in Herefordshire

This year saw the development of Herefordshire's first Children's Integrated Needs Assessment providing a comprehensive range of demographic information on children.

There are 39,000 children and young people living in Herefordshire, of whom:

- 9,800 (5%) are aged under five
- 21,700 (11%) are aged 5-15 years
- 8,300 (5%) are aged 16-19 years and
- 11,500 (6%) are aged 20-25 years old.

The overall number of children is predicted to rise to 40,400 by 2031, whilst the number of under 5's is predicted to decline by 2031 to 9,200.

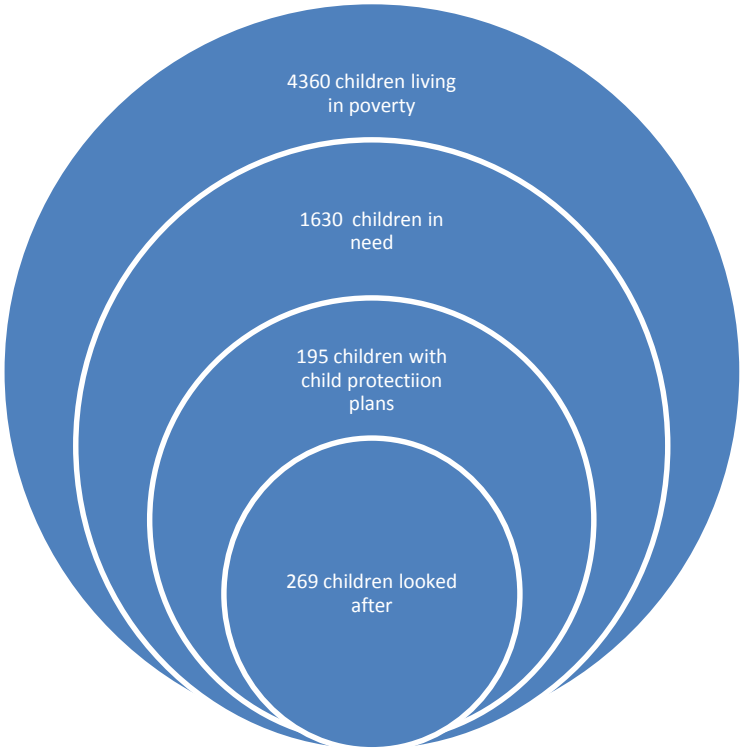
The majority of primary and secondary school aged children live in rural areas, hamlets and isolated dwellings.

The majority of children aged under 5 live in Hereford and Leominster (urban areas).

The higher birth rate in the county is attributed to women from the EU (Poland and Lithuania).

Live births are between 1,800 and 1,900 each year - the highest level since mid-1990s; over half of all babies are born to women aged 25-34 years.

About children in Herefordshire (March 2015)



The number of children with child protection plans decreased in comparison with 2013-2014.

The children and young people's plan

The vision of the Herefordshire Children and Young People's Partnership (CYPP) is children and young people to grow up healthy, happy and safe within supportive families and carers. It aspires to have good safeguarding services in all agencies and to have local education and health outcomes within the top 25% nationally by March 2018.

The Partnership is developing a children and young people's plan which sets out how this aspiration will be achieved. The HSCB will play its part by holding all partners to account for their contribution to safeguarding and promoting best outcomes for children and young people.

Challenges for the public sector

The public sector continues to face the twin challenges of financial restriction and increasing demand for services. This requires all partners to rise to the challenge of maintaining a proactive approach by focusing on the development of services which families can access early, with the aim of addressing poor parenting and avoiding the need for more intrusive and expensive interventions later on. Listening to the voices of children and young people whilst doing this will be vital in order to ensure that we are doing the right thing. Over the year, the Board will be encouraging partners to 'shrink together' in order to maintain and improve services and best outcomes for children.

Challenges for partners

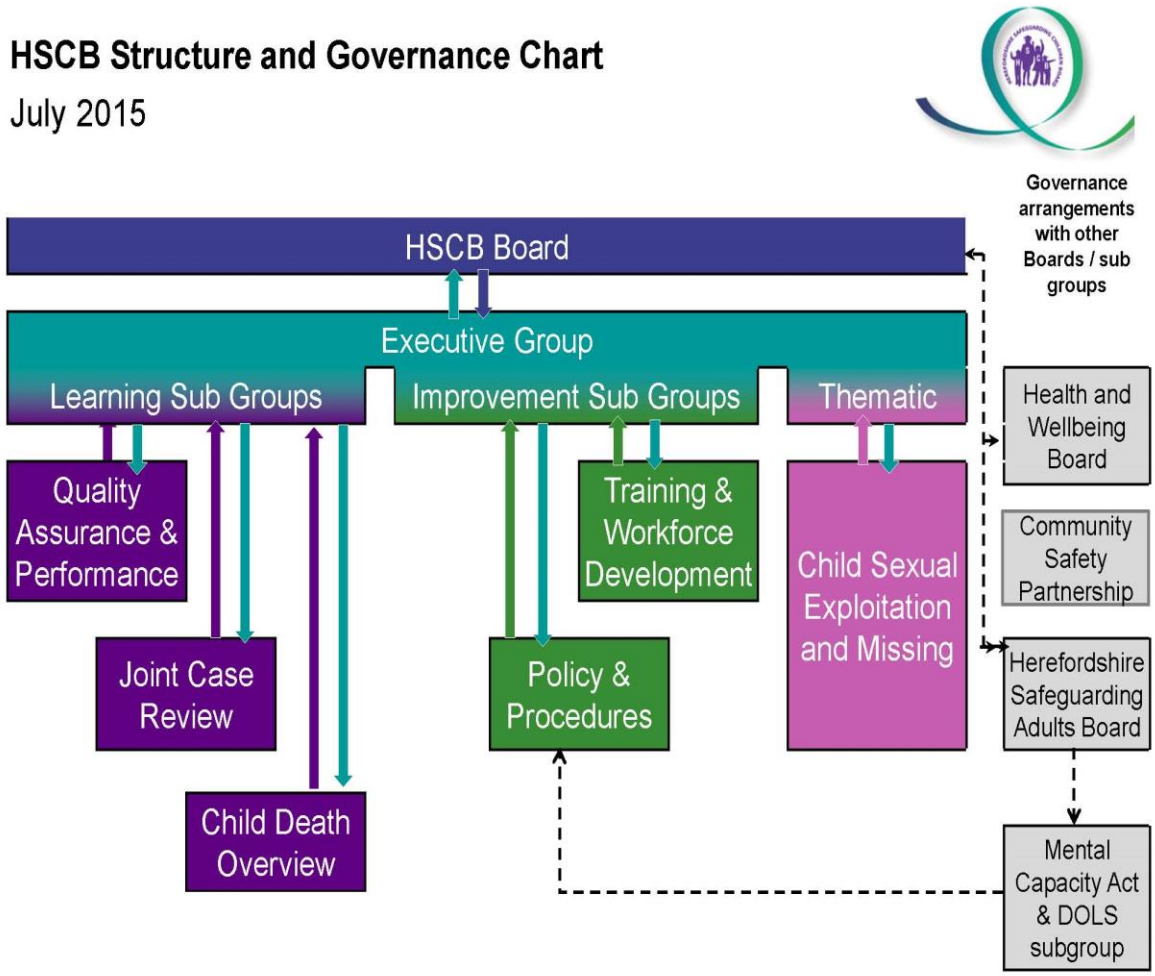
In their contributions to the LSCB throughout the year, partner agencies have identified the key challenges that they are facing and the steps that they are taking to respond to them. They are focusing on maintaining robust safeguarding arrangements within the context of budgetary pressures and organisational change and restructure.

There is a clear commitment across the partnership to:

- Ensuring that the experience and views of children and young people inform the development of services;
- Engaging with and listening to the views of front line practitioners and managers;
- Learning from Serious Case Reviews and learning reviews are embedded in practice;
- Further developing robust audit processes and quality assurance processes to monitor the quality of practice and evaluate its impact on outcomes for children and young people;
- Ensuring that staff continue to have access to comprehensive and high quality safeguarding training.
- Tackling the issues which blight the lives of so many children and young people by:
    - Improving the recognition and response to child sexual exploitation (CSE) and missing children and young people;
    - Safeguarding and promoting the welfare of children and young people who are abused and/or neglected
    - Supporting increased resilience in individuals, families and communities.

The LSCB

HSCB is a statutory body whose objectives, functions and membership are specified in the statutory guidance *Working Together* (2015). It undertakes its work primarily through a series of subgroups, which are led and supported by staff from partner agencies, who also contribute to serious case and learning reviews and participate in the QA and audit programme. This structure is set out below:



Lay members and representatives from the voluntary sector provide appropriate challenge and are actively engaged in a range of LSCB activities. The Council's Lead Member for Children's Services is engaged in the work of the LSCB providing constructive leadership and challenge. The LSCB chair is a member of the Children and Young People's Strategic Partnership as well as the Health and Wellbeing Board.

The development of a protocol to consolidate and formalise relationships with the Health and Wellbeing Board, the Community Safety Partnership, and the Local Adult Safeguarding Board is underway.

The Board is supported through contributions from partners. Details are set out in Appendix A.

The effectiveness of safeguarding arrangements in Herefordshire

The child's journey in Herefordshire

This section analyses performance using key indicators in relation to child protection. It examines key decision making milestones, from the point of contact/referral through to child protection plans. It aims to help understand the flow of cases through early help and referral and assessment within the context of multi-agency working. Below are the numbers of children at various stages in the helping system (*provisional data for end of March 2015).*

The data points to the positive impact of MASH and the successful widespread communications on the new "levels of need" document.

Early Help

Family support continues to work with vulnerable families at levels 3 and 4 on the Herefordshire levels of need pathway. The service is made up of family support workers; youth support workers; information & assessment Coordinators (Common Assessment Framework (CAF) Coordinators and a young person's substance misuse worker. They work with families who need support with parenting, setting boundaries, getting their children to school, behavioural issues, relationship problems, substance misuse issues, domestic violence etc. In the last quarter October to December 2014 the service worked with 380 cases[1].

The service is constantly evolving to meet the needs of families. This has included revising the 'Step down to CAF' procedures to ensure that as families step down from involvement with social care they have access to a range of continued support and their case is more closely managed by the information & assessment coordinators within the multi-agency group meetings during this crucial period.

Referrals to the service come from MASH, CIN and CLA teams and from multi-agency group meetings where it is deemed that if support isn't put in place the family may require social care intervention.

[1] Annual Data not available

Outcome data

Outcomes are measured by the worker, on progress made by outcome stars at the beginning, middle and the end on a scale of 1-10.

Average scores of progress in key areas by the end of interventions are as follows:

Parenting – basic care, boundaries etc:	6.2
Behaviour management:	5.0
Home conditions:	5.0
Routines:	4.5
Socialising/ friendships:	4.5
Keeping safe:	4.3

The lowest 'distance travelled' was:

Living a healthy lifestyle:	2.6

Feedback from service users

Feedback is collected from children, young people and parents/carers at the end of the intervention and collated on a quarterly basis. The latest quarterly data:

87.5% felt **really happy or happy** following the intervention of family support with their family.

95% had a **good or very good** relationship with their worker.

91% felt the advice and guidance they received from their worker was either **good or very good**.

Comments received

"Helps me to get along with my family better"

"Helped Mum and Dad set up rules"

"Being better, helped me to control my temper"

"Happy"

"It's really good because I get lots of help"

"I felt I could say anything and B would be able to help me out"

"Felt happier, felt listened to, get on better with parents/carers, going to school/college more, feel less angry, learnt to control my behaviour more."

Referral rates

(This is important is it measures workflow volumes-it indicates professional confidence in referral processes-a "contact" refers to the initial information sharing)

There are an increased proportion of contacts proceeding to referral with the average rate at 42.5% in 2014/15, compared to 25.38% in 2013/14, which reflects increased confidence and awareness or the new Levels of Need threshold documentation.

The reasons for referral were:

Child Protection	**121**	5.44%
CYP Missing	**10**	0.45%
For Information Only	**16**	0.72%
Homeless Young Person	**6**	0.27%
Information Request	**9**	0.40%
NULL	**121**	5.44%
PPRC	**1**	0.04%
Private Fostering Assessment	**4**	0.18%
Request for Assessment	**1936**	87.05%

More referrals are meeting the threshold for formal intervention than those made last year. The average proportion of referrals which were re-referrals in 2014/15 is 22.05% compared to last year's average of 22.10**%.** These figures are in line with the national English average of 23.4% for 2013/14.

The above, while showing increased volume also provides early indicators of positive improvement in relation to the impact of the new MASH arrangements and is an indicator of the success of the publication of the LSCB "levels of need" document as professionals are more aware of threshold criteria and how to refer.

Assessment timescales; *(These are important as they indicate the impact of workforce stability as well as management oversight, capability and capacity.)*
The Munro review of children protection (DfE 2011) recommended that the distinction between initial and core assessments should be removed. In Herefordshire, there have been unique workforce challenges so a focus on timeliness of assessment has been retained until such time as we can demonstrate embedded improvements.
The timescale for initial assessments carried out within 10 days has improved as on average 63% of children were assessed on time. In April and May 2014 this was as high as 87% and 80% respectively in comparison to the average rate for 2013/14 which was 75.17%

The average rate of core assessments carried out on time was 69% in 2014/2015 in comparison to the average rate for 2013/2014 which was 41%.

Referral rates

There was an increased proportion of contacts proceeding to referral, with the average rate at 42.5% in 2014/15, compared to 25.38% in 2013/14. This suggests increased confidence and awareness of the new Levels of Need threshold documentation as more referrals are meeting the threshold for formal intervention than those made during the previous year. The average proportion of referrals which were re-referrals in 2014/15 is 22.05% compared to last year's average of 22.10**%.** These figures are in line with the national English average of 23.4% for 2013/14.

The above, while showing increased volume, also provides early indicators of the positive impact of the new MASH arrangements and is an indicator of the impact of the publication of the LSCB "levels of need" document as professionals are more aware of threshold criteria and how to refer.

Children with Child Protection Plans

At the end of the financial year 2013/2014, there were 231 children subject to Child Protection Plans in Herefordshire. The figure at 31st March 2015 has reduced to 193, a decrease of 19.6%. This reduction brings Herefordshire in line with its statistical neighbours and reflects a growing confidence with respect to securing appropriate and timely outcomes for children. This is also borne out by the reduction in children subject to Child Protection Plans beyond 2 years. The rate at the end of 2013/14 was 4.5%, and at the end of this financial year is now 2.3%. The number of Child Protection visits that were completed within timescale in 2013/14 95.12%, compared to on 63.81% in 2014/15. Performance in this area has been compromised by staff turnover, new/agency staff familiarising themselves with FWI in terms of recording visits, and newly qualified social workers, along with overseas social workers, not being permitted to undertake CP visits.

In addition to this, over the holiday period workers when on leave would have their visits covered by a duty social worker and some families have refused to see a different worker. Host local authorities where families have gone on holiday have been unwilling to undertake CP visits on Herefordshire's behalf.

Performance in this area is now being tightly managed by the Head of Service Fieldwork, and performance at the end of Sept 2015 and beginning of Oct 2015 has improved to over 70%.

Breakdown of children subject to a CP Plan as at 31.3.15

Age	0-1 yrs	2-4 yrs	5-9 yrs	10-15 yrs	16+ yrs
	32	28	63	62	8

Gender

Male	**98**	**Female**	**95**

Ethnicity

White	**179 (93%)**
Dual Heritage	**7 (4%)**
Other Ethnic Groups	**3 (1%)**
Asian or Asian British	**2 (1%)**
Not Stated	**2 (1%)**
Disability	**8 (4%)**

Children with child protection plans for a second time

The rate of children with a repeat child protection plan at any time previously in their lives, as at March 2015, was 23.2%. This is an increase on the rate for 2013-2014 (17.8%). It is also higher than Herefordshire's statistical neighbours (which was 18.53% in 2013-14), higher than the all England average for 2013-14 (15.8%) and well above the local target of 10-15%. This is of concern.

Due to similar concerns in 2013-14, the local authority carried out an audit of all 66 cases (from 33 families) of children with repeat child protection plans and found the following recurring features:

- children in this cohort were more likely to have their parenting compromised by parental substance misuse, and the substance of choice was more likely to be heroin than for the general population of children subject of a CP plan;
- there was an increased incidence of adults presenting a risk to these children and these adults were usually extended family members;
- the children's parents were more likely to have suffered abusive childhoods and to have additional learning needs;
- robust action was not always taken in a timely way when the CP plan was not working;
- management oversight was not always evidenced (11 cases were referred to senior managers for immediate attention).

The audit provided challenge to practice around drift and delay and in all cases these were rectified by the operational team managers with successful outcomes for the children. Thematic findings and actions were presented to the LSCB QA group. Further audit and improved management oversight should sustain improvement. Regular audit and challenge to practice will continue, to ensure that learning is being applied and is having an impact as the numbers with repeat child protection plans has seen a gradual reduction current performance as at 31 March 2015 is 1.12% and so this indicates the learning has been implemented.

Impact of audits

- The audits have been extensively shared with teams across the Children's Wellbeing Directorate, and teams have contributed to the audit action plan. The audit has been shared at the local authority Heads of Service meeting and has informed the basis of a discussion with West Mercia Women's Aid in respect of domestic abuse findings and discussions with Community Safety Partnership in respect of domestic abuse and alcohol misuse within the Eastern European community. As a result, HSCB has agreed funding for the CRUSH programme to be delivered to young people in the 16+ service.

- 11 cases were reviewed as a result of the audit of children subject of a child protection plan for a second or subsequent time and of these cases 2 families (6 children) are now in the pre-court (PLO) process, 4 families (10 children) have been considered at Legal Gateway Panel, 3 children from 2 families are now looked after and plans for permanency are in progress.

Observations at Child Protection Conferences Nov 2014 – Feb 2015

The OFSTED inspection of Herefordshire children's services in May/June 2014 commented upon child protection conferences, and noted that they were felt to be poorly structured and long winded. A total of three review conferences were observed by OfSTED, including one which had to be run on a split basis due to the issues between the parents. Although the evidential base for the Ofsted comments was open to question it was accepted that the quality of practice needed to be established and an accurate picture gained.

In order to gain a more rounded picture, it was agreed that direct observations would be undertaken by the service manager for the safeguarding and review service and the Named Nurse Safeguarding Children for Wye Valley NHS Trust. A total of 17 conferences were observed, some jointly and some on an individual basis.

Safety

Underlying this piece of work was the fundamental question “were the decisions reached safe?” On the basis of the information available to each of the conferences, and the subsequent discussion and analysis it was felt that there were no unsafe decisions. This is not to say that there were no elements that could have been improved, but these did not compromise the safety of the decisions.

Development of the Child Protection Plan

It is the responsibility of the conference chair to ensure that an outline plan is identified by the conference, which is then developed by the core group. It was noted that Conference participants came with their information, but often seemed not to have considered the outcomes that needed to be achieved for the child or children. This impacted on the development of the plan and could result in this process being heavily led and determined by the conference chair or social worker rather than being owned by the conference as a whole. The development of the plan could be rushed, particularly where participants were under time pressure and needing to leave. In some instances it seemed that core groups did not fully understood their responsibility to amend and flesh out the detailed child protection plan.

Escalation

The operation of core groups was not part of this work, but one case was noted where it was felt that the core group should have escalated the absence of a service provision from CAMHS.

Conclusion

These observations did not support the previous external comment on conferences as being long winded or unfocused. On the contrary chairs managed conferences well and safe decisions were reached. The issue of health information being available to the conference requires further consideration elsewhere. There is a need for work within the multi-agency group to support the contribution and effectiveness.

Recommendations

Observations of conferences should be continued on a planned basis and also involve other agencies. This will give a continued emphasis to this key part of the child protection system and facilitate ongoing learning across the multiagency system.

Looked After Children

The number of ***Children looked after*** for 2014/15 is 270 compared to 237 in 2013/14. For 2013/14, the rate per 10,000 child population for Herefordshire was 67.0, statistical neighbours figure was 47.4 and the national average was 60.0 in 2013/2014. The highest number of looked after children originated from the Belmont, St Martin's & Hinton and Three Elms wards in the County.

Age	Under one year	**16**
	One	**12**
	Two	**9**
	Three	**15**
	Four	**9**
	Five	**14**
	Six	**17**
	Seven	**15**
	Eight	**13**
	Nine	**9**
	Ten	**15**
	Eleven	**14**
	Twelve	**20**
	Thirteen	**8**
	Fourteen	**16**
	Fifteen	**21**
	Sixteen	**26**
	Seventeen	**21**
	Eighteen	**0**
Ethnicity	African	**1**
	Any other Asian Background	**2**
	Any other Black Background	**1**
	Any other Mixed Background	**4**
	Any other White Background	**12**
	White and Asian	**1**
	White and Black African	**1**
	White and Black Carribbean	**2**
	White British	**246**
Gender	Male	**132**
	Female	**138**
Participation in each review	Child aged under 4 at the time of the review	**194**
	Child physically attends and speaks for him or herself	**264**
	Child physically attends and an advocate speaks on his or her behalf	**15**
	Child attends and conveys his or her view symbolically (non-verbally)	**20**
	Child physically attends but does not speak for him or herself, does not convey his or her view symbolically (non-verbally) and does r	**1**
	Child does not attend physically but briefs an advocate to speak for him or her	**20**
	Child does not attend but conveys his or her feelings to the review by a facilitative medium	**229**
	Child does not attend nor are his or her views conveyed to the review	**117**
Legal Status	Interim Care Order	**147**
	Full Care Order	**38**
	Placement Order granted	**1**
	Single period of accommodation under Section 20	**75**
	Under police protection and in LA accommmodation	**6**
	On remand, or committed for trial or sentence , and accommodated by LA	**3**

Type of Placement	Foster placement with relative or friend	45
	Foster placement with relative or friend - long term fostering *NEW CODE*	**1**
	Foster placement with other foster carer	177
	Foster placement with other foster carer - long term fostering *NEW CODE*	**1**
	Foster placement with other foster carer - not long term or FFA/concurrent planning *NEW CODE*	**2**
	Placed for adoption with placement order not with current foster carer (under S21 of the Adoption and Children Act 2002) or with a freeing order where parental/guardian consent was dispensed with under S18(1)(b) of the Adoption Act 1976	**1**
	Homes and hostels	**4**
	Residential Care Home (previously not used)	**2**
	NHS/Health Trust or other establishment providing medical or nursing care	**5**
	All residential schools, except where dual registered as a school and children's home	**5**
	Temporary periods in hospital	**1**

As at 31 March 2015, 94.30% of LAC reviews were held within timescales, compared to 85.25% in the previous year. Children participated in their LAC review in 85.81% of cases during the year 2014-15.

During 2013-14, 15 Herefordshire children were adopted. This equates to 17% of the looked after population and is the same as the all England figure of 17%. In 2014-15 there was an 80% improvement in the number of children adopted compared to the previous year, with 10 children being adopted.

Health

Health indicators for the Children in Care Team from Wye Valley Trust is listed below.

Children in Care Team WVT				
Indicator	2014 Quarter 1	2014 Quarter 2	2014 Quarter 3	2014/2015 Quarter 4
Total statutory medicals attended - herefordshire team activity	65	83/87 (96%)	91/104 (87%)	90/91 (99%)
Refused Medical		2	3	1
SHA all Hfd children including those placed OOC done elsewhere	5	20	5	26
SHA Hfd Children placed OOC completed by Hfd	9	2	5	11
SHA Out of county children placed into Hereford	13	13	14	15
SHA Hfd Children placed OOC completed externally	7	5	5	15
IHAs attended	22	33/41 (80%)	40/51 (78%)	23/24 (95%)
IHAs in timescale	15/22 (69%)	12/33 (36%)	25/40 (63%)	16/19 (84%)
Attended RHA	39/39 (100%)	50/50	44/45 (98%)	67/67 (100%)
RHA within timescales	33/39 (85%)	42/50 (84%)	37/44 (84)	52/67 (77%)
DNA rate overall	13/63 (21%)	4/87 (4%)	13/104 (12%)	2/91 (2%)
Immunisations up to date total	52/59 (82%)	76/83 (92%)	74/84 (88%)	66/86 (77%)
Immunisations up to date IHA	19/21 (91%)	28/33 (85%)	31/40 (78%)	14/19 (73%)
Immunisations up to date RHA	33/38 (86%)	48/50 (96&)	43/44 (98%)	52/67 (77%)
Compliant dental Kpi total	52/59 (89%)	67/83 (81%)	75/84 (90%)	75/86 (87%)
dental compliant IHA	18/21 (86%)	20/33 (61%)	31/40 (78%)	16/19 (84%)
Dental compliant RHA	36/38 (95%)	47/50 (94%)	44/44(100%)	59/67 (88%)
Compliant registered with GP total	58/59(99%)	67/83 (81%)	78/84 (93%)	85/86 (99%)
GP registration IHA	20/21 (93%)	18/33 (55%)	34/40 (85%)	18/19 (94%)
GP registration RHA	38/38 (100%)	49/50 (98%)	44/44(100%)	67/67 (100%)
Substance misuse identified in over 9 years	2/38 (5%)	7	6	10/53 (19%)
SDQ recorded (RHA only)	28/34 (83%)	16/30	15/ 23(66%)	25/44 (57%)
Need for CAMHS identified	16/59 (28%)	12	15	19/86 (22%)
Developmental delay identified in under 5 year old	3	15	12/28 (43%)	9/57 (16%)
Abbreviations:-				
SHA - Statutory Health Assessment				
IHA - Initial Health Assessment				
RHA - Review Health Assessment				
OOC - Out of County				
DNA - Did not Attend				
KPI - Key Performance Indicators				
SDQ - Strengths and Difficulties Questionaire				

Assurance of performance by statutory partners

Herefordshire Council: Children's Wellbeing Services

An inspection by Ofsted in September 2012 judged Herefordshire's arrangements to protect children in Herefordshire as inadequate. The council was subsequently made the subject of a statutory improvement notice, an improvement board was put into place, and considerable efforts were made across the partnership to improve services and outcomes for children and young people.

In April – May 2014, Ofsted returned to Herefordshire to carry out an inspection of services for children in need of help and protection, children looked after and care leavers and to review of the effectiveness of the local safeguarding children board. Inspectors found that *there are no widespread or serious failures that create or leave children being harmed or at risk of harm. The welfare of looked after children is safeguarded and promoted. However, the authority is not yet delivering good protection and help and care for children, young people and families.*

Social Care Workforce

There has been a significant increase in social care establishment from 59 to 114.12 WTE, although the Council has not yet been able to fill these posts without the use of agency staff in key areas of its services.

Focus is maintained on assessment timescales and change of social worker to measure impact. This is monitored by the LSCB.

Feedback from Birmingham University was received regarding the development of the social work workforce:

I thought you might also like to know that we've recently been reviewing our statistics and found that Herefordshire candidates tend to do very well across the range of our post qualifying programmes. When they are on our programmes they always feature in the top 10% of their respective cohorts; and to our mind they bring to their studies a commendable level of professionalism and a strong commitment to learning and development.

We know too that NQSWs undertaking the Herefordshire ASYE programme particularly value the support and mentoring they receive from staff associated with the SWA – they routinely speak of the high quality reflective supervision they receive and comment on how this helps them to not only make sense of the complexities and challenges they face in their day to day work but also to develop and progress as practitioners. They have a very clear sense of being supported throughout one of the most important years of their careers and Herefordshire Council and the SWA are to be congratulated on their commitment to NQSWs and to offering them a very distinctive and indeed high quality programme. We clearly see the fruits of this when your practitioners enrol on our programmes and believe that the work of the SWA plays a significant part in helping Herefordshire's NQSWs to develop into rounded, informed and confident practitioners.

NHS services

Herefordshire's health services are commissioned by the Clinical Commissioning Group and NHS England. Its two main providers are Wye Valley NHS Trust, which provides acute and community services and 2gether NHS Trust, which provides mental health, substance misuse and learning disability services.

Herefordshire Clinical Commissioning Group

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

The CCG contributes significantly to the work of the LSCB work, including by exercising leadership in subgroups. It describes itself as *committed to working in partnership with other agencies and services to improve the health and welfare of all children and young people in Herefordshire* We do by ensuring that every CCG contract with all provider organisations includes standards such as policies, staff training and supervision that we expect that organisation to meet in relation to child safeguarding, we the monitor the work of providers regularly to ensure those standards are met.

As part of their commitment to improve services the CCG is supporting a national campaign 'Speak out Safely.' *The CCG believes that every member of staff whether employed directly, in GP practices or staff employed by health and care organisations that we commission, as well as patients supported by the NHS in Herefordshire should feel able to raise concerns about wrongdoing or poor practice when they see it and are confident that their concerns will be addressed in a constructive way….the CCG has strived to improve the lives for children/young people across Herefordshire in 2014 and looks forward to continuing to support the Herefordshire Safeguarding Children Board in the year to come.*

Wye Valley NHS Trust

WVT NHS Trust (WVT) is the smallest hospital trust in England. Its commitment to protecting children and young people it cares for or has contact with and keeping them safe from abuse and harm extends from the Board to frontline staff. The Trust's Safeguarding Children Team provides safeguarding clinical supervision both formally and informally alongside daily management of safeguarding issues throughout the Trust and represents the Trust at internal and external safeguarding meetings, training events and case reviews/lessons reviews. The

Wye Valley NHS Trust has continued to support HSCB in a number of ways, including;

- Active participation within the strategic board and all subgroups, including participating in multi-agency audits and chairing of the board's training and workforce development subgroup;
- Led/contributed to the development of new multi-agency policy/practitioner guidance;
- Delivering multi-agency training on behalf of the board

The Trust has undertaken significant steps to ensure the “voice of the child” is heard and responded to and has developed a “Young Ambassadors At Wye Valley” group. One of the ways that the group is helping WVT improve services is by interviewing children on the ward to gain their thoughts about their experiences on the ward.

Following a recent serious case review, the Trust has developed transition services for young people with diabetes and is now looking at increasing transitional services for other long term health conditions.

However, WVT was assessed in June 2014 by the CQC as inadequate, with a recommendation that the Trust be put into ‘special measures.’

The inspectors found elements of good quality safeguarding practice such as;

- Good arrangements within community services to safeguard children and promote health of looked after children.
- Services well managed, staff well trained and supported to provide safe services.
- Safeguarding supervision- group and individual delivered according to need
- Good record keeping, demonstrating clear escalation and risk assessments
- Service users said they felt safe and had confidence in staff
- Staff aware of learning from serious case reviews (SCR) and significant incident learning processes (SILP)
- Engagement of children and families in service development / feedback
- Maternity services – staff clear about roles and responsibilities and up to date with their training

Inspectors also specified where improvement is required:

- Not all staff received mandatory safeguarding children training
- Concern about the environment in some areas of the Trust
- Concerns about the Alert check process within A&E
- Concerns about length of waiting time for children in A&E

The Board is monitoring and supporting the delivery of the Trust’s improvement plan. WVT is due to be reassessed by CQC in September 2015

2Gether NHS Foundation Trust

2Gether provides a range of services for adults, and also provides child and adolescent mental health services.

The Trust describes itself as *fully committed to true partnership working with Herefordshire HSCB colleagues and is immensely proud of the improvements that have been achieved in the previous 12 months. Our Trust has enjoyed the challenge of endeavouring to make real sustainable improvements for children and young people in Herefordshire. We believe that we have been a diligent and active partner in the last years HSCB work plan. Looking towards 2015/16 we are keen to assist in completing the HSCB's joint work on improving services and pathways for parental mental health. Alongside this our priorities remain aligned to the HSCB business plan, with a particular organisational focus in improving the quality of recording safeguarding information, improving access to training for professionals and work around CSE issues as part of the wider Herefordshire strategy.*

In Herefordshire 2gether NHS Foundation Trust provides community Children and Adolescent Mental Health Services.

CAMHS collects feedback about services in a number of ways and always seeks to utilise this in service development and delivery. The service is focused on developing methods of hearing and action on the voice of the child and is active in contributing to local improvement initiatives such as the development work on CSE issues in Herefordshire.

Quality Reviews

On 9th December 2014 the West Midlands Quality Review Service (WMQRS) carried out a review of services for children and young people's emotional health and wellbeing in Herefordshire and benchmarked services against agreed quality standards. This included a review of 2gether NHS Foundation Trust CAMHS service, the CLD Trust and Herefordshire Clinical Commissioning Group. The report was published in April 2015. The aim of the standards and review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services.

The review reported that
'Staff were highly committed, caring and conscientious and team working appeared good. Staff worked flexibly in order to provide the best possible care for their clients. Service users who met the visiting team were positive about the service they received and said it was caring and supportive to them.'

Education and schools

Schools are extremely important partners in safeguarding children, and are subject to a number of requirements which are set out in statutory guidance.

Schools are extremely important partners in safeguarding children and are subject to a number of requirements that are set out in the statutory guidance. These have helpfully been brought together within 'Keeping Children safe in Education'. A detailed audit for schools to self-evaluate their safeguarding arrangements has been redesigned and will sent out in the autumn term of 2015.

The HSCB has been monitoring key indicators in education during 2014-15:

1. Children Missing from Education

The tracking down of children referred as 'missing from education' has been more successful over the past 18 months with fewer children remaining as 'missing' from one quarter to the next. During 2014-15, fewer than 10 children in each quarter remained as missing from education at the end of that quarter. This is an improvement on the situation in previous years.

2. Elective Home Education

2014-15 saw a small increase in numbers in each quarter compared to previous years. This increase of approximately 10% needs to be monitored for overall numbers and the reasons for parents choosing to home educate.

3. Reporting by schools of bullying and racist incidents

Reported incidents have remained relatively static compared to the previous year. There has been an improvement in the number of schools complying with the request to submit a return although there continues to be work to be done around schools providing nil returns, i.e., no reported incidents. There would appear to be too many nil returns relative to what is known about the expected incidence of bullying.

In addition to the regular data returns to the board, there has been some good work from the school community around CSE with information being provided to Heads groups and 2 workshops for school representatives being held which were well attended.

Schools have also continued to make safeguarding a priority by renewing the financial support to employ 1.5 FTE MASH Education Officers who will provide dialogue between schools and safeguarding services. Very few local areas have made financial support available for education posts within their multi-agency safeguarding arrangements.

Criminal Justice and Public Protection

A range of statutory services are provided to young people by West Mercia Youth Offending Service (YOS), to adults and children by West Mercia Police (WMP), and to adults by the National Probation Service (NPS) and the Warwickshire and West Mercia Community Rehabilitation Company (WWM CRC)

West Mercia Police

Through its alliance with Warwickshire Police, West Mercia Police works across the four local authority areas and supports 5 LSCBs. Through the year it continued to develop MASH and the Harm Assessment Unit functions, and committed a full time Detective Inspector post to coordinate and implement the MASH model across the alliance area. This is expected to bring further opportunity to Herefordshire, in terms of scope for development and cross border working and inclusion of adult services. At the commencement of the 2014-15 financial year, West Mercia Police significantly increased funding to the LSCB's Business Unit, which now additionally supports the Community Safety Partnership (CSP) and the Safeguarding Adults Board (SAB).

A significant financial investment has been made for the recruitment and implementation of a Child Sexual Exploitation (CSE) Team, consisting of x1 Detective Inspector, x3 Detective Sergeants and x 9 Investigators across the alliance area. The team is further supported by a new 'Coordinator' post. More recently, Herefordshire & Worcestershire has been afforded the function of Missing Person Coordinator, based within the HAU command. This function identifies repeat and high-risk 'MisPers' and seeks to reduce and stop missing episodes. It ties in heavily to the local CSE strategy.

West Mercia Police have recognised that alongside heavily committed operational response to children at risk, there must be continuous development around emerging governmental initiatives and priorities and recognised local risks. There is now a team of x1 DI and x3 DS who will support this process and be a more consistent coordination for the 5 LSCB's across the alliance, including sub groups and boards.

Operation Encompass is an initiative developed in Herefordshire MASH. Police identified a process in Devon and Cornwall where schools were notified of any domestic incident reported to the police involving their pupils as victims or witness or even just present. HAU share all information and assess its significance for children and young people with up to 109 schools in Herefordshire. This provides opportunity to recognise the harm done to children through domestic abuse but also address it in the educational setting by setting up overt and covert support mechanisms and safe reporting.

Police are actively involved in the Northumbria Model sub group. The Northumbria subgroup seeks to develop a model to address holistic risk in adolescence which may include CSE. The model is still in development and terms of reference and learning from areas affectively operating the panel are being assessed.

WMP supports the work of the LSCB across its various subgroups. Performance information has consistently been offered to HSCB and products detailing local and temporal issues provided upon request as well as proactively.

West Mercia Police has been inspected a number of times by her Majesty's Inspectorate of Constabularies around the topics of Child Protection, Domestic Abuse, Custody and 'Vulnerability.' HMIC found many positives in West Mercia's approach but also highlighted areas that required development:-

- Ensuring that Child Sexual Exploitation is identified, and where it is, the cases are allocated to officers who have appropriate training for investigative development and appropriate, effective risk management plans are developed in a multi- agency setting.

- Delays in investigations due to analysis of electronic devices, submission of case files to CPS and timely advice from CPS needs to be addressed.

- Improved supervision, record keeping and direction of criminal investigations. Contributing to this is the tension between PVP supervisors' commitments to inter-agency working and investigation management.

- In relation to children and police detention, in 6 cases examined by HMIC where a LA child had been arrested following an incident in a residential home, no alternative accommodation was found for the 6 young people.

These are captured in comprehensive action plans driven by the PVP Command and strategic team. Specifically HMIC observed that there should be greater opportunity for active supervision of live cases.

The Board monitors progress with the delivery and impact of the action plan.

Probation: National Probation Service and Community Rehabilitation Company

Under the Coalition Government's *Transforming Rehabilitation Programme* the former Warwickshire and West Mercia Probation Trusts were split in to two separate organisations; the public sector National Probation Service to work with 'high risk' offenders and the private sector Warwickshire and West Mercia Community Rehabilitation Company (WWM CRC) to work with 'low and medium risk' offenders.

The National Probation Service (NPS)

The NPS's priority is to ensure public protection and it delivers its services to adults in the criminal justice system. Many of these service users are parents and have contact with children. Some service users are restricted from contact with children, and some present a positive risk of harm to them.

The NPS in West Mercia has reviewed priorities for safeguarding (West Mercia Probation Trust, 2013), and its guidance documents Probation Instruction (31/2014). Guidance to all operational staff will be refreshed by 31.5.15. Training arrangements have been reviewed and updated, ensuring that all operational staff have current required knowledge. This will be delivered locally to ensure compliance with HSCB specifications, supported by Divisional NPS training. An internal audit of safeguarding referrals, risk assessment and management is planned for NPS. NPS communications will ensure the circulation of updated staff contact details, key briefing documents eg Thresholds, Children in Need & raising awareness of further developments in probation and/or criminal justice that may impact on safeguarding of children.

Safeguarding checks at the start of contact, usually when a person appears in Court, is critical in safeguarding children, and sharing appropriate information. The Herefordshire MASH performs this function well, and will benefit from a permanent NPS presence, planned to take effect during 2015. A review of the *People Posing a Risk to* Children Policy has also taken place across NPS in West Mercia, and this has helped to clarify expectations of staff.

The National Safeguarding Inspection of Probation Work

An inspection was undertaken by Her Majesty's Inspectorate of Probation August 2014, before the reorganisation of Probation Trusts into the National Probation Service and Community Rehabilitation Companies, as part of the Government's Transforming Rehabilitation strategy. In response to the findings from mainstream inspection programmes of probation and youth offending work practice which suggested that work to protect children and young people carried out by Probation Trusts and Youth Offending Teams (YOTs) was not being consistently delivered well enough. Findings were general to all Trusts and the identified issues are likely to be relevant to general practice nationally. These included:

Strategically

- Little evidence of the contribution of Senior Management to the agenda and development of local Safeguarding Children Boards (LSCBs)
- No leadership on the issue of safeguarding in relation to offenders on standalone Unpaid Work requirements.
- Limited management oversight of safeguarding cases and issues.
- No processes in place to audit safeguarding procedures, for example, to review the number, nature and quality of referrals to Children's Social Care.

Operationally

- Systems to check with Children's Social Care whether children are known are not always robust.
- Limited understanding by operational staff of their safeguarding role and duties; no routine use of home visits to inform safeguarding assessments.
- Uncertainty about the referral process to Children's Social Care services; infrequent follow up of referrals once made.
- Inaccurate assessment of risks to children, especially in relation to experiencing domestic abuse.

An action plan has been devised and is ongoing within both NPS and CRC in relation to the national safeguarding inspection of probation work, including raising awareness with Children's Social Care staff of the role of both organisations.

West Mercia Community Rehabilitation Company

Following share sale on 1 February 2015, EOS Works is the new owner of the WWM CRC. The WWM CRC is a private sector company operating to a contract with the Secretary of State to deliver offender services in Herefordshire, Warwickshire, Worcestershire, Telford and Shropshire.

The CRC says that *a key priority for the CRC will be to continue with the good work in safeguarding children, ensuring robust arrangements are in place that reflect the importance of safeguarding and promoting the well-being of children. This is achieved through strong local partnerships, working together to reduce re-offending and to protect the public. The CRC is committed to maintaining its representation on safeguarding children boards, community safety boards and other multi-agency arrangements where working in partnership around joint priorities supports the reduction of reoffending and harm caused to children. We have undertaken case audits to ensure processes and systems are in place to share information and protect children and responded positively to a Probation thematic inspection of Probation Trusts and Youth Offending Teams to protect children and young people (August 2014). Safeguarding children is a key public protection matter and, therefore the supervision of offenders under Offender Rehabilitation Act (ORA) 2014 and Through the Gate will reflect the importance of safeguarding and promoting the wellbeing of children.*

West Mercia Youth Offending Service (WMYOS)

West Mercia Youth Offending service has continued to develop its safeguarding work over the past year. Of particular note has been the implementation of the "Aim 2" programme. This is for the assessment of young people committing sexually harmful behaviour and delivering the subsequent intervention to reduce the risks posed by these young people. This gives practical support to the focus on child sexual exploitation that was a priority during the year, which the WMYOS supports at both strategic and operational level. This development filled an important gap with a sustainable and effective positive contribution and is a good example of the continued support made by WMYOS to the HSCB in all aspects of its work.

The findings for Youth Offending Teams of the National Safeguarding Inspection of Probation Work were that they are generally well connected to children's social care services, necessary enquiries and referrals were made and information was shared.

Although there was assessment and planning by YOT staff to help to protect children and young people where necessary, it was not consistently of sufficient quality. Parents/carers were not always involved and home visits were not always undertaken. There was little joint assessment and planning by the agencies working with the child or young person. Police intelligence to assist assessment and planning by YOT staff was not always accessed or used.

Screenings to assess the vulnerability of children and young people did not pull together all the factors identified in the assessment, and vulnerability management plans were not action focused, did not make reference to parents/carers and were not integrated with child protection plans. There was little joint assessment and planning and children's social care services did not always facilitate good information sharing or encourage joint work.

There was some excellent and imaginative direct work with children and young people and their parents/ carers and some good partnership work. Again, the role of YOT staff was not always well understood by children's social care staff, and as a result their contribution was not integrated into joint child protection work. Work to combat child sexual exploitation was being developed in partnership with other agencies.

YOTs had systems in place to check if children and young people were known to children's social care services and referrals were made where a risk of harm to children and young people was identified.

Operational management oversight systems were in place but were not always effective. Strategically, effective links between Local Safeguarding Children Boards and YOT Management Boards were not in place.

A series of recommendations were made by the inspectors:

Representatives of probation services and Youth Offending Teams on Local Safeguarding Children Boards should work with other board members to:

- ensure that multi-agency arrangements for information sharing work effectively and consistently
- establish and monitor outcome data that demonstrates effective **joint** working to safeguard children and young people
- promote better understanding across social care staff of the roles and responsibilities of probation and YOT staff.

Quality assuring practice

The LSCB monitors a range of performance information and carries out a range of quality assurance activities to ascertain the effectiveness of local services. This work is set out in the Board's Learning and Improvement Framework and is primarily coordinated through the Quality Assurance (QA) subgroup, with case reviews in respect of both children and vulnerable adults coordinated by the Joint Case review (JCR) subgroup.

QA activities include:

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

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

External inspections

The Council and a number of other statutory partners have been inspected during the course of the year, with findings noted elsewhere in this report. Findings indicate that, whilst there has been improvement in some areas, children and young people are still not receiving consistently good quality services.

HSCB is monitoring closely the Council's improvement plan to ensure that progress is maintained and accelerated, and that all children and young people who need them receive consistently good quality services. Action plans in response to inspections of other partners are also being closely monitored.

Multi-agency case audits

The LSCB carried out 12 themed multi-agency audits in 2014/15. These included:

- Section 11 of the Children Act 2004 audit review (in Herefordshire the full s11 audit is completed bi-annually and agency's completion of the recommendations is peer challenged in the intervening year).
- Pre-birth planning processes (anecdotal information led the HSCB to have concerns regarding the functioning of the current guidance)
- Children with long term conditions (to review the impact of the SCR HH)
- Early help (this audit was undertaken by the LA QA team in 2015)
- An Ofsted 'as if' audit
- An Ofsted audit

Although Ofsted asks for local authority audit material only, Herefordshire agreed to complete the audits on a multi-agency basis.

The group also receives and reviews the learning from single agency audits undertaken by partners.

A selection of the findings and impact of some of the LSCB's multi-agency audit activity is given below.

(i) Ofsted Audit

18 cases were audited to assess whether the safeguarding service provided to the children/young people met their needs and whether we were able to determine through the records kept by various services what the children/young people's wishes and feelings about their situations were. Some of the cases included children/young people with child protection needs whilst others included children/young people who were living in foster care.. with information provided by West Mercia Police, Children's Wellbeing, CCG, Wye Valley Trust, 2gether NHS Trust, West Mercia Women's Aid, YOS and Education.

Out of the 18 cases audited: 7 cases were graded as *inadequate*, 9 graded as *requires improvement* and 2 as *good*.

Each audit generated an action plan which was monitored to conclusion by LAQA

Main findings were:

- Variability in recording and, in particular, chronologies not being up to date on Frameworki (FWi), confusion re child protection referrals on an open case
- In 5 out of 10 cases CLA health assessments were either out of timescale or could not be found and composite health plans were lacking
- The application of safeguarding policy and procedures was variable
- Information sharing poor at the point of referral
- Inconsistency across agencies regarding the outcome of strategy discussions (West Mercia Police recorded a conversation as a strategy which was not reflected in Children's Wellbeing's files)
- Little evidence of workers being mindful of life story work at the point of entry into care
- Varied multi-agency attendance at key meetings
- Administration difficulties re minutes being sent etc.
- 'Churn' in staff, especially social work staff

As a result of the audit findings, the following steps were taken:

- The health plans are now extracted from the health assessment paperwork and uploaded onto Frameworki (FWi) to enable social worker to access them quickly
- A 'significant event episode' has been included on FWi to replace referral on an open case
- NHS has now commissioned 1.5 wte staff to work in MASH to support information sharing
- A review of MASH functioning has taken place and regular audits undertaken to demonstrate improvements in practice
- Safeguarding and Family Support to undertake life story work
- Improved administrative support for child protection conferences.

Following a recommendation by Ofsted, the volume of audits has recently been reduced with a view to ensuring more systematic analysis of partnership working and an evaluation of impact on practice.

Serious Case Reviews

A serious case review takes place when a child has dies or been seriously harmed as a result of abuse or neglect, and there is evidence of poor multi-agency working. The Board published a SCR in early 2014 and the resulting action plan has been monitored during the year. A summary of the key learning points from this SCR are:

- Non-health professionals need to be informed that type 1 diabetes is a potentially fatal condition as this commonly not thought to be the case.
- All agencies need to recognise young people's vulnerabilities as well as their rights and responsibilities as young adults.
- Staff across all agencies must evidence that they have recognised 16 and 17 year old service users as children. There is a need to ensure that all decisions balance the needs of the young person for independence and self-determination with any need for protection.

Multi Agency and Single Agency Action plans were developed and monitored to ensure that these learnings were embedded. A series of multi agency roadshows also took place to raise awareness of the key issues and disseminate the learning, which is also incorporated into HSCB's multi agency training.

The JCR subgroup has also this year agreed an improved SCR procedure to ensure a comprehensive and robust mechanism is in place for future commissioning of reviews into significant cases, in line with the revised guidance criteria in Working Together 2015.

Key messages have been shared with practitioners via seminars and training and impact is measured through evaluation.

Key areas for development

Analysis has shown some early signs of improvement in aspects of child protection work and these must be embedded to ensure quality is consistent and improvement is sustained whilst areas of continuing weakness need to be addressed. Consistent management oversight and upholding of high practice standards is critical.

Domestic violence, poor parental mental health and substance misuse are recurring features in the analysis and case audit.

The work of child sexual exploitation needs further development, including high quality performance analysis to demonstrate impact and community awareness and engagement.

Further development of the LSCB's quality assurance activities is needed to ensure a more systematic focus of insight across the entire 'journey of the child', and feedback from practitioners and from children and their families.

The effectiveness of Herefordshire Safeguarding Children Board

During 2014-15, the HSCB Strategic Board met 6 times, with 2 additional Extraordinary meetings to discuss Ofsted findings and the Jay Report, and its Steering Group met monthly.

An attendance list for the year is provided at Appendix B. Attendance is variable across the partnership, with some agencies not fulfilling their responsibilities to the level required.

The business plan 2014-15

On the basis of a range of evidence and information, the Board identified three priorities for focus during 2014-15, as well as wishing to improve its own effectiveness and impact. Activities to support improvement in these areas were developed into a business plan and delivery was overseen by the LSCB.

In addition to improving the effectiveness of the LSCB itself, the following key areas for development in this period were identified and incorporated in the Business Plan for 2014/2015:

1) Improving the experience of children, young people and families when they are supported in safeguarding systems.
2) Improving multi-agency case work.
3) Tackling evidenced safeguarding issues in Herefordshire, including domestic violence, and child sexual exploitation and promoting awareness of private fostering.

A brief summary of progress is given below.

Area for Development	Progress
Improving the experience of children young people and families when they are supported in the safeguarding system	• The MASH was relaunched and creates the operational arrangements for the needs of children, young people and their families to be robustly reviewed on a multi-agency basis in order that their needs can be identified and met. • Levels of Need Guidance has been revised and launched to assist the workforce to identify the needs of children and young people so that support is provided at the earliest opportunity, at the right level, at the right time. • Minimum Standards for Supervision were developed to influence reflective practice as well as effective management oversight.

Area for Development	Progress
Improve multi-agency case work	• Research with professionals and parents was carried out to understand how Child Protection Conferences work. • Children's Wellbeing Services devised and implemented an action plan to improve the quality of multi-agency decision making at Child Protection Conferences. • Multi-agency attendance at Child Protection Conferences is now collected by Safeguarding and Review
Area for Development	**Progress**
Tackling evidenced safeguarding issues in Herefordshire.	• A domestic violence needs assessment was completed and services were commissioned to promote children's well-being, including a voluntary perpetrator programme. • The Missing Children and Young People's Protocol was updated. • The CSE strategy was revised and operational arrangements to manage CSE cases in the MASH were agreed. • Piloted an approach to evaluate the impact of LSCB Neglect Training.

Learning from Inspection

Ofsted reviewed the LSCB in May 2014 and found that it 'requires improvement.' A number of recommendations were made by inspectors which are detailed below, together with a summary of responses.

	Recommendation	Response
1)	Ensure that governance arrangements between the LSCB and the Improvement Board are clarified.	This was achieved (and the Improvement Board was subsequently disbanded in January 2015 following the lifting of the statutory Improvement Notice by the Minister).
2)	Ensure that LSCB policies and procedures are up to date and incorporate issues specific to Herefordshire.	The Policy and Procedures subgroup has overseen 2 updates to the West Mercia Safeguarding Board procedures. Further work is required to optimise the benefits of consistent regional procedures across the West Midlands. This is taking place in 2015-16.
3)	Ensure that the LSCB receives accurate and relevant performance information from its partners to enable it to assure itself on the quality of safeguarding work.	The Quality & Assurance subgroup has received performance information from LSCB partners. In 2015/16 the HSCB will develop a multi-agency performance scorecard.
4)	Ensure that the work of the LSCB operational groups is manageable and prioritised.	There has been a review and refocusing of LSCB priorities and from 2015/16, some subgroups have been disbanded or refocused and every subgroup has a work plan.
5)	Ensure that learning from multi-agency case audits is actioned and the impact is reviewed through repeat audits.	The Quality and Assurance subgroup re-audits learning themes as part of its work programme. Further work is needed to ensure a systematic feed through into training and practice.
6)	Ensure that robust strategies and intelligence in relation to specific vulnerable groups are developed and implemented, in particular missing children and those at risk of child sexual exploitation.	West Mercia Police completed a CSE Problem Profile and the HSCB developed a CSE Strategy. Further work is planned in 2015-16.
7)	Ensure that multi-agency safeguarding training is sufficient, taken up by partners and is robustly evaluated.	The provision of sufficient multi-agency safeguarding training remains an ongoing challenge for HSCB. This is a significant area of focus for the new joint business unit (see below) as well as for partners.
8)	Ensure that the LSCB business unit is effectively able to support	A joint Business Unit to support the work of the HSCB, HSAB and CSP was created with effect from 1st April 2015. The vision

	the work of the LSCB.	is to align priorities and activities and achieve both efficiency and effectiveness through joint working across Boards.

LSCB diagnostic

To assess progress in delivering improvements post the Ofsted inspection, the LSCB commissioned a 'LSCB diagnostic' from the Local Government Association which was carried out in November 2014. This resulted in the following recommendations:

1) Identify a small number of HSCB priorities

Response: The LSCB agreed a small number of revised priorities at its Development Day in March 2015.

2) Fund and implement a reinvigorated and fit for purpose Business Unit

Response: a newly formed Business Unit to support the work of the HSCB, HSAB and CSP was put in place with effect from 1st April 2015.

3) Streamline the Steering Group and make this a 'chair of chairs' group

Response: the Steering Group has been disbanded and a new Executive Group put into place with effect from 1st April 2015 with revised membership and terms of reference.

4) Make sure all members of the strategic board are fully engaged and understand their relationship between being on the Board, improving agency practice and achieving impact on outcomes for children.

Response: attendance is now monitored at every HSCB meeting and annual reviews with statutory board members are planned for 2015 in order to ensure appropriate agency representation and contribution.

5) Locate MASH governance sub group within Children's Services operational management structure

Response: in April 2015, the MASH subgroup was transferred into the operational management structure of Children's Wellbeing Directorate.

6) Make all agencies accountable for what they have committed to at the Board

Response: the HSCB in now systematically tracking and holding to account for what they have committed to at the Board, through use of an action log. Follow up action is taken where needed.

7) Use formal challenge by HSCB to other agencies to escalate concerns revealed through audit and feedback from the staff and families

Response: this is an area of continued focus. Most recently, for example, case studies presented to HSCB have resulted in practice issues being raised with partner agencies.

8) Evidence impact of HSCB challenge and the better outcomes that HSCB has achieved

Response: this is also an area of continuing focus and, as an example, the HSCB has recently challenged the tools used by the Local Authority to assess Child Sexual Exploitation.

9) Project manage everything especially the transition from the Improvement Board

Response: the Improvement Board and HSCB met jointly in January 2015 to ensure a smooth transition of responsibilities. A transition plan was developed and delivered, and a follow up review of progress has been commissioned from the former Chair of the Improvement Board in autumn 2015.

10) *Retain a focus on impact on outcomes for children and young people*

Response: priorities for the Board were reviewed in March 2015. The HSCB Business Plan 2015/16 identifies the impact on outcomes for children that the Board is seeking.

11) User voice will give the Board confidence and understanding of what has and has not made an impact

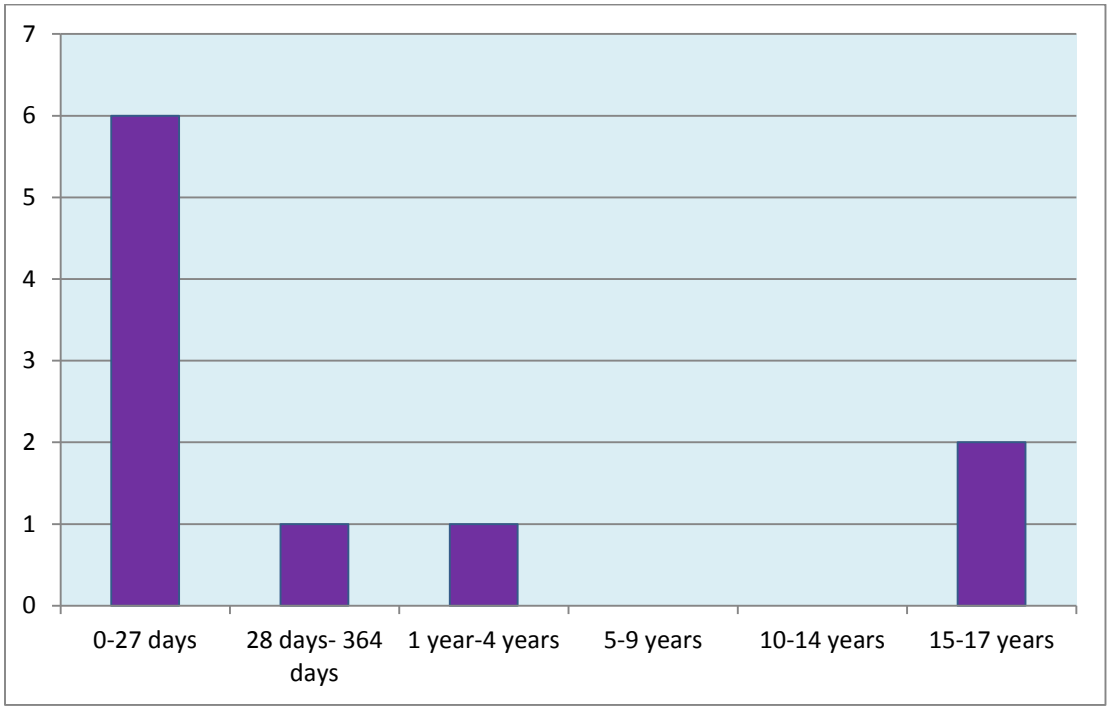
Response: This remains an area for development. It is now a standing item on each Board agenda, with a more systematic approach being put into place over 2015-16.

Child Death Overview Panel (CDOP)

The Board has a statutory responsibility to review each death of a child normally resident in the Board's area, to ascertain whether there are any individual or wider matters of concern affection the safety and welfare of children in the area. It does this through its CDOP.

There were 10 deaths reviewed by CDOP between April 2014 and March 2015. 7 were male and 3 were female. None required a rapid response.

Details of the ages of the children are shown in the graph below.



Of the ten deaths, the Panel concluded that one of the deaths could have been prevented[2] and this particular death was the subject of a Serious Case Review which was commissioned and completed in the year 2014/14. The formal child death review was completed by CDOP following the concluding of the inquest.

[2] Section 5.11 of Working Together to Safeguard children 2015 defines preventable child deaths as "those in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

Lessons Learned	Action Taken by HSCB
Following child deaths in 2013-2014, a key recommendation of the serious case review was that the safeguarding board should assess the understanding of the additional safeguarding responsibilities of working with children with long term health conditions and the provision of support across services.	A thematic audit of children with long term health conditions was undertaken by the QA subgroup. Continued Education and professional development of health professionals and across agencies in the management of long term health conditions and the medications involved.
National research into child deaths, published by The University of Warwick in September 2014, concluded that one in five child deaths are preventable.	Dr Peter Sidebotham, lead author and associate professor of child health at the University of Warwick, was invited to Herefordshire to present his findings at a multi-agency conference which was attended by 47 professionals.

Child Sexual Exploitation

An additional work stream was commissioned during the year to consider how HSCB should address the growing national and local concerns about child sexual exploitation and as a result both a strategic and operational group were formed. A CSE strategy was developed and a CSE social worker joined the MASH.

Initial work on developing Child Sexual Exploitation multi-agency pathways and a CSE self-assessment was also completed. A Child Sexual Exploitation strategy is being progressed over the next reporting period.

HSCB is aware of its responsibilities to monitor the effectiveness of the response to children and young people who go missing from home/care. This was identified as an area for improvement in the Ofsted inspection completed in 2014. A joint draft action plan between the HSCB and Herefordshire Council was devised in 2014 however it has recently been identified that the Board's oversight of the implementation of this action plan was poor. One of the consequences of the lack of oversight is that the Board did not receive any data regarding missing children and young people in 2014-15 (Need to check if it was in HSCB dataset used during this period and if it was add " other than some data that was included in its overall performance dataset") and so the Board is unable to report in detail on missing children and young people. There are clear requirements for children who are placed in Herefordshire by other Local Authorities, who are missing and a target is to develop how Local Authorities work together to respond.

The team are currently working on a consistent way of recording children who go missing in Herefordshire and the intervention by the Local Authority as it is clear from the data set that it is not an accurate reflection of what is occurring operationally. A greater number of strategy meetings and risk management meetings have been convened. Joint work with the Performance Team and regional alliances will help develop the data set.

The CSE and missing sub group will progress this important area of work during 2015-16 so that the Board is able to understand, challenge and assure itself that children and young people who go missing have their needs assessed and receive support to reduce the risk they face.

HSCB participated in the National Working Group's Sexual Exploitation Awareness Day, with an information stand at Herefordshire Council Headquarters, posters and an awareness pack sent to all agencies and Herefordshire schools, a report in the local press and awareness raising advertisements on Twitter and Facebook. An Accommodation Provider's Forum, focusing on CSE, was also held, with over 60 providers in attendance. Feedback from those who attended included:

"*This event was very useful and informative, I was able to share the information given at the event with the management team– this will then be disseminated to other staff and foster parents."*

"I aim to deliver the powerpoint to all of our Registered Managers"

"The information linked to contacts in Hereford was very useful. I will use this to explore how we can develop our policy and procedure around the risk of exploitation ".

The refreshed CSE Strategy recognises the need for a co-ordinated approach to raising awareness of CSE across the whole community, including with children and young people.

Multi-agency training

Ensuring that the workforce and volunteers across the partnership are suitably knowledgeable and competent in undertaking safeguarding tasks is a significant contributory factor in children and young people receiving timely, high quality effective services that keep them safe and improve outcomes for them. Learning and development / training events are central to developing skills, ensuring up to date knowledge of policies, procedures and guidance, and incorporating lessons learnt from research and audits into practice.

During its Review of the effectiveness of the LSCB in April- May 2014, Ofsted found that;

"The LSCB has an established multi-agency training programme, which underpins safeguarding training provided within individual partner agencies. This has recently been revised and commissioned from an external provider following the departure of the LSCB training officer. Significant effort has been put into developing e-learning for partners. However, there has been low take-up or completion of e-learning. For example, e-learning on leadership for representatives engaging in the work of the LSCB has had poor take-up, with the exception of voluntary sector representatives, even though there are increasing numbers of new representatives on LSCB groups. Evaluation of the quality and impact of training on improving practice and the experience of children is significantly underdeveloped. This is primarily based on basic feedback from training participants through short questionnaires, which are not effectively used to ensure the quality, content or relevance of training or to enable the strategic development of multi-agency training. A number of awareness raising seminars have been delivered on behalf of the board, for example on learning from case reviews. These have been well received and enhanced awareness and understanding of safeguarding issues across partners."

Multi-agency training and staff development is led and overseen on behalf of the LSCB by the Training and Development subgroup, which has also implemented the responses to the key Ofsted findings:

- To ensure that multi-agency safeguarding training is sufficient, taken up by partners.
- Develop further the evaluation of the quality and impact of training on improving practice and the experience of children.

During 2014-2015, 45 Courses/events were delivered through the Board to 926 practitioners from a wide range of agencies during the year. A breakdown of attendance by each agency can be seen on page 37.

The HSCB also offers a number of e-learning packages, which have been completed by 320 professionals.

Training courses are free of charge to funding partner agencies; agencies that do not fund the board are charged £50pp for a day's course. Non-attendance by participants results in a charge to all partners.

Training courses / seminars delivered have focussed on a range of safeguarding themes including:

- Universal Introduction to Safeguarding
- Universal and Specialist Sexual Exploitation and Trafficking
- Targeted Multi-Agency Working Together to Safeguarding Children
- Specialist Safer Recruitment and Designated Member of Staff Training for Education
- Understanding Neglect
- Child sexual abuse and forensic child sexual medical examinations
- Serious Case Review briefings.

Sexual Exploitation and Trafficking continued to be a key area for Herefordshire Safeguarding Children Board in the 2014-2015 Business Plan. One element of the action plan was to continue to raise awareness across the children's workforce and as part of those activities the Board provided the following learning opportunities:

- The Board has offered a Sexual Exploitation and Trafficking module within all Targeted Working Together Training since June 2013. By the end of Q4 14/15 this had been delivered to 193 practitioners.

- 38 multi agency places were taken on the Specialist Sexual Exploitation and Trafficking training during 2014-2015. Feedback from the evaluations included:

"It was really helpful to discuss the legal context at the beginning and to then continually use the law in examples. I have developed my knowledge of the Sexual Offences Act 2003 and the grooming process"

"I am now confident that I can use the knowledge I have gained from attending the course and my past knowledge and skills to ensure children are safeguarded".

"I have gained an in-depth knowledge of the guidance on children who are sexually exploited and skills in identifying the warning signs for vulnerability"

"Well presented and gripping".

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

Developing evaluation processes / impact of training on practice and the experiences of children

As part of its 14-15 work plan the subgroup worked to develop and improve the evaluation data. Two examples of this work are:

1. Evaluation and impact of CSE Training

The **"**Child Sexual Exploitation and Trafficking Training Engagement and Impact Report" was received by the board in November 2014. Highlighted within this report;

Post course evaluations had been received from 35% of trainees and responses to our evaluation questions had been overwhelmingly positive:

Overall I was satisfied with the event	94.63%
The work of the tutor was good	96.67%
The objectives were met.	94.22%
As a result of your training do you feel more confident regarding safeguarding and decision making?	93.89%

A review of comments from course participants within their course evaluations illustrated that the course content had been sufficiently engaging to ensure wider dissemination of learning across the establishments they represent. Areas identified as key learning within those evaluations include:

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

Impact of CSE Training on case management/referrals

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

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

Further evaluation feedback received from a worker in the local authority's Early Help team following training who stated that they were:

- *"Able to use new knowledge to highlight dangers and refer to police and Social Services following CAFTAC when parent raised concerns re inappropriate texts from adult male to 12 year old daughter's mobile."*

Appropriate referrals were then received within the MASH in both of these cases.

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

Evaluation and impact of HSCB "Understanding Neglect" Training

Development of this new course first provided the board the opportunity not only to utilise feedback from participants to develop and amend the course content, but also to increase the rate of impact evaluations received by the board by directly targeting and following up all participants.

Initial findings are encouraging with all participants self-reporting greater knowledge, competence and confidence. Areas of key learning identified included;

- *Liam's recording: Very powerful way of realising the importance of the child's voice.*
- *Very good balance between Health and Children's Wellbeing input. Good role-modelling for multi-agency communication.*
- *Really interesting and helpful to discuss the serious case reviews and be aware of how the system can fail.*

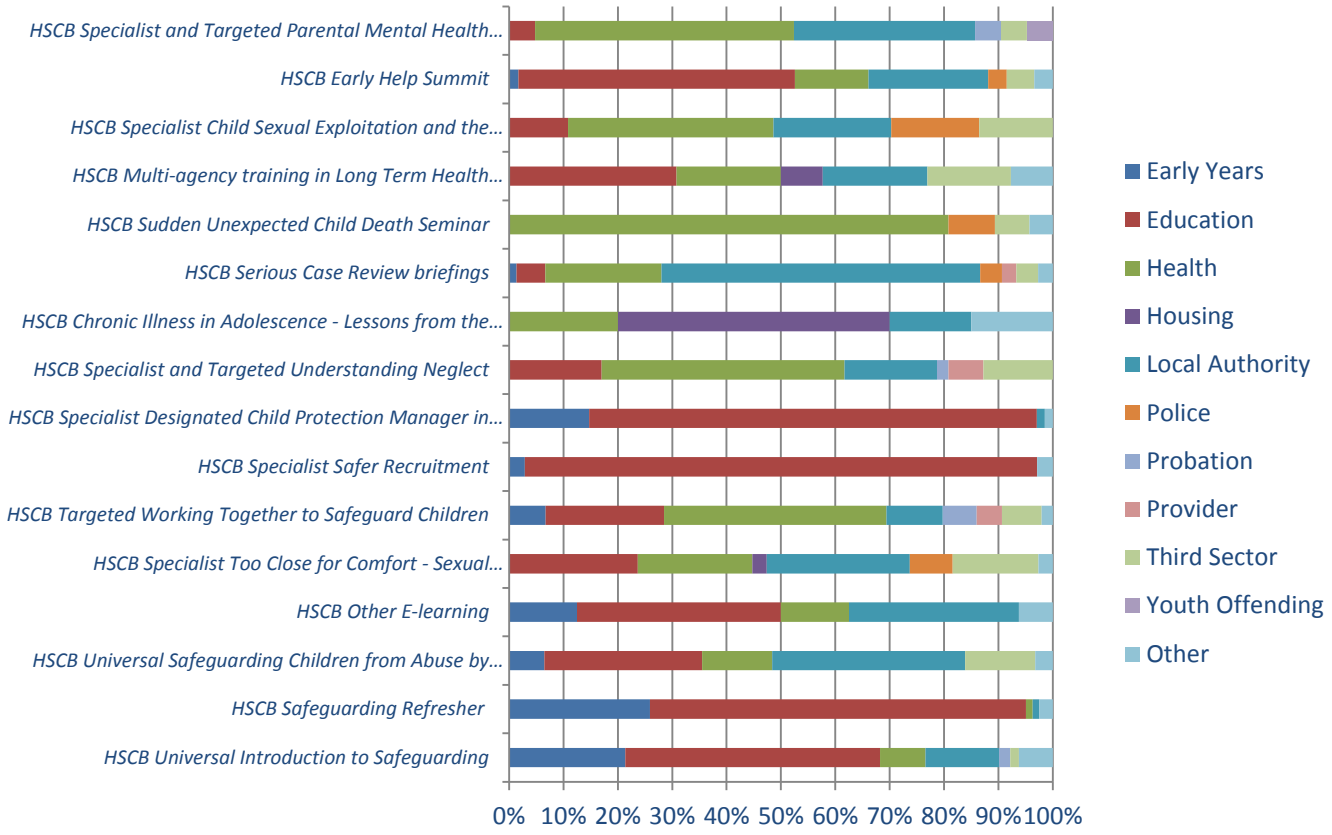
Impact evaluation comments 3 months post course include;

- *It has made me more aware of the issues and more confident in addressing the issues. For instance, one of the fathers of a family that I am working with would not allow me to visit the family home. After the training, I made a point of convincing him.*
- *In my consultancy work with social workers in complex cases it has reminded me to guide them in 'thinking the unthinkable'*

- *In a domestic abuse case where I am doing direct work with parents, it has reminded me to look beyond the obvious emotional abuse to the children of witnessing DV to other aspects of the parenting which have resulted in neglect of the children's needs.*
- *I feel that it will ultimately lead to a better level of care/protection as I am now aware to look out for many signs of neglect which I was unaware of before. Additionally, I am now better at explaining neglect to families that I work with (as they do not often think they are neglecting their children*.

It is envisaged that, through this on-going work, the subgroup will be able to provide HSCB detailed impact evaluation analysis later this year. It is proposed that the analysis will inform the board's training evaluation strategy.

HSCB Course Attendance by Agency



Course Name	Early Years	Education	Health	Housing	Local Authority	Police	Probation	Provider	Third Sector	Youth Offending	Other	Total Numbers Attending	Number of Courses
HSCB Universal Introduction to Safeguarding	41	90	16	0	26	0	4	0	3	0	12	192	n/a
HSCB Safeguarding Refresher	21	56	1	0	1	0	0	0	0	0	2	81	n/a
HSCB Universal Safeguarding Children from Abuse by Sexual Exploitation	2	9	4	0	11	0	0	0	4	0	1	31	n/a
HSCB Other E-learning	2	6	2	0	5	0	0	0	0	0	1	16	n/a
HSCB Specialist Too Close for Comfort - Sexual Exploitation and Trafficking	0	9	8	1	10	3	0	0	6	0	1	38	3
HSCB Targeted Working Together to Safeguard Children	13	42	79	0	20	0	12	9	14	0	4	193	16
HSCB Specialist Safer Recruitment	1	33	0	0	0	0	0	0	0	0	1	35	4
HSCB Specialist Designated Child Protection Manager in Education	10	56	0	0	1	0	0	0	0	0	1	68	6
HSCB Specialist and Targeted Understanding Neglect	0	8	21	0	8	0	1	3	6	0	0	47	3
HSCB Chronic Illness in Adolescence - Lessons from the Serious Case Reviews	0	0	4	10	3	0	0	0	0	0	3	20	2
HSCB Serious Case Review briefings	1	4	16	0	44	3	0	2	3	0	2	75	4
HSCB Sudden Unexpected Child Death Seminar	0	0	38	0	0	4	0	0	3	0	2	47	1
HSCB Multi-agency training in Long Term Health Conditions	0	8	5	2	5	0	0	0	4	0	2	26	2
HSCB Specialist Child Sexual Exploitation and the Herefordshire Paediatric Pathway for Child Sexual Abuse Examinations	0	4	14	0	8	6	0	0	5	0	0	37	2
HSCB Early Help Summit	1	30	8	0	13	2	0	0	3	0	2	59	1
HSCB Specialist and Targeted Parental Mental Health Workshop	0	1	10	0	7	0	1	0	1	1	0	21	1
	92	356	226	13	162	18	18	14	52	1	34	986	45

One of the challenges for the board during year was the loss of the Training and Workforce Development Officer post due to staff resignation. The post was not replaced in the Business Unit re-organisation. This has resulted in a reduction in dedicated hours available to commission, develop and deliver multi-agency training. External commissioning of training from external providers minimised the impact upon training deliver in the short term. However, developmental work identified within the 14-15 work plan has been limited by the loss of dedicated capacity to co-ordinate HSCB training.

Managing allegations against professionals

The Local Authority Designated Officer (LADO) is responsible for overseeing the management of allegations against individuals in a 'position of trust' in relation to children. This includes those whose employment brings them into direct contact with children, or those who may be working in a voluntary capacity.

The following tables give an overview of the work of the LADO unit and HSCB agencies who are managing allegations against professionals under current procedures. More detail is provided in the Annual Report.

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Table 1: Cases dealt with via LADO process – by sector

Sector	Number
Early Years	14
Education	39
Foster Care	20
Health	5
Herefordshire council	1
Independent Providers (Care homes)	55
Other	6
Police	3
Probation	0
Social Care	2
Voluntary Organisations and Leisure services	9
Youth Offending Team	0
Total	154

Table 2
Outcomes by sector

Agency	Substantiated	Unsubstantiated	Unfounded	Malicious	On-going Pending police investigation	Advice/Not met LADO Threshold	Advice/Employer/ Investigations	Total
Independent Providers (Care homes)	5	2	1	1	0	2	44	55
Early Years	0	2	0	0	0	0	12	14
Education	2	3	2	0	2	8	22	39
Health	1	2	0	0	1	1	0	5
Foster Care	1	0	3	1	2	2	11	20
Police	1	0	0	0	0	1	1	3
Social Care	0	0	1	0	0	0	1	2
Herefordshire Council	0	0	0	0	0	1	0	1
Other	0	1	0	0	0	0	5	6
Voluntary Orgs and Leisure services	1	0	0	0	0	3	5	9
Total	**11**	**10**	**7**	**2**	**5**	**18**	**101**	**154**

A brief analysis shows a high number of referrals from independent care home providers, usually around restraint issues, but also medication errors .All of these have involved employer investigations overseen by the LADO. In response to concerns identified in last year's report, a presentation on the LADO process was given to the independent Care Home providers as part of the Providers Forum.

Substantiated Concerns

In cases where concerns were substantiated, there were:

- 5 cases involving restraint/ violence/threats of violence.
- 3 cases were there concerns about the individual's behaviour towards their own child/ children and it was considered that there were indications of risks in the workplace
- 2 cases where individuals had taken illegal substances and this was seen as a risk in the workplace
- 2 cases involving sexual risk to children

Table 3. Action following findings of Substantiated concerns

	Warning/ Retraining	Dismissal/ No longer in regulated activity and DBS notified	Criminal Investigation/ Prosecution	NFA	Other
Physical harm 4	1	2			1 referral to Fostering panel
Emotional harm 0					
Sexual harm 2		2	2 Both convicted, 1 sentenced, 1 ongoing		Referrals to DBS completed
Neglect 1			1		Ongoing. Referral to DBS and report to Regulatory Authority
Professional Conduct 4	1 retraining	3 dismissal			

HSCB procedures on managing allegations against professionals have been updated, but following a DFE consultation period, new national procedures will need to be incorporated. In order to ensure procedures reflect the most efficient working practices, a series of meetings is being set up with agency colleagues in order to ensure there is clarity and clear communication on LADO issues.

Private Fostering

Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers or sisters. The plan is for private fostering to move into the SGO/Kinship team.

There were no reported privately fostered children within Herefordshire in 2014/15. The national picture remains low. A set of leaflets have been produced for young people, parents and carers and further will be undertaken by the Local Authority and Herefordshire Safeguarding Children Board to improve awareness of Private Fostering in the next year.

Conclusion

In order to assess whether the LSCB is fully discharging its responsibility to evaluate the effectiveness of the safeguarding system as a whole, and to evidence the impact it is having, it is helpful to consider the following questions:

- Are we doing the right things?
- Are we making sufficient progress?
- Are we managing risk safely and appropriately?
- Is the LSCB making sufficient progress?
- What impact is the Board having?

Are we doing the right things?

The Board selected its four priorities for the year in the light of evidence and information from a range of sources, including Ofsted and the Improvement Board. These are detailed elsewhere in the report, together with information about what activities were undertaken to make progress.

Are we making sufficient progress?

Review of performance and other qualitative information during the course of the year suggests that progress has been steady overall, and this was endorsed by the Ofsted inspection outcome. However, challenges remain in delivering a consistently high quality of service across agencies, but particularly in children's social care. Instability of the workforce is a key challenge for partners, and will remain a barrier to achieving and embedding lasting change. For this reason, safeguarding and promoting the welfare of children and young people who are abused and/or neglected, and supporting increased resilience in individuals, families and communities are two of the Board's priorities for the coming year.

In relation to tackling the sexual exploitation of children and young people, initial progress was rapid, but has levelled off. Renewed impetus is required, and this area remains a priority for 2015-16 and beyond.

Are we managing risk safely and appropriately?

Partners are each finding ways of managing services in a climate of increasing demand and expectations. At the highest level, chief executives are working together to find new ways of commissioning and delivering services. However, this does not always translate through all organisational levels, and there are stresses appearing across the system. The Board did not have a systematic system of addressing this, and will be developing a risk register to provide a framework for multi-agency ownership, mitigation and problem-solving during 2015-16.

Is the LSCB making sufficient progress?

Ofsted reviewed the LSCB at the same time as it inspected the council's children's services. As detailed above, it found the LSCB to be 'requiring improvement' and highlighted a number of areas for focus. These have been incorporated into the LSCB's business plan for 2015-16.

What impact is the Board having?

The Board has provided leadership in developing the multi-agency safeguarding hub (MASH) and Herefordshire's response to sexual exploitation. Through its quality assurance work, including case reviews, it has identified where services needed improving and has seen some positive results from this activity. To be even more effective, it needs to move faster, be more open to challenge between partners, and engage more positively with both practitioners and with the children and families who have need of safeguarding services.

Challenges for 2015-16

Through its work during the year, the LSCB has identified a series of challenges for itself, for partners, and for other strategic partnerships to be addressed in 2015/16. These are designed to maintain and increase the pace of improvement in the development and delivery of services to safeguard and promote the wellbeing of Herefordshire's children and young people.

Challenges to the Children and Young People's Partnership

The Children and Young People's Partnership will be held to account for delivering the new children and young people's plan, whilst embedding the participation of children and young people into all its activities.

This will mean, in particular:

- Promoting early help for families, developing the "Think Family" approach and culture across the Partnership;
- Improving the emotional and mental health and well-being of children, young people, and their parents and carers; and
- Meeting the needs of children and young people requiring safeguarding.

Challenges to the Health and Wellbeing Board, the Safeguarding Adults Board and the Community Safety Partnership

Co-operation between children's services and those for adults are essential in order to support the Children and Young People's Partnership to meet its objectives and deliver effective help to families at the right time.

These three strategic bodies have an important role in:

- promoting more integrated multi-agency working in responding to children and young people who live in the context of 'compromised parenting' (where there are adult issues of domestic violence, substance misuse, mental health problems and learning disability) and
- supporting young people to make the transition to adulthood successfully.

Challenges for the LSCB itself

The Board has set itself the challenge of becoming a truly effective agent for change that has a real impact for children and young people.
This means that it must focus relentlessly on achieving improvements in the Board's chosen priority areas. These were identified through evidence acquired from multi-agency case audits, the Ofsted inspection, the peer review diagnostic and performance analysis:

- To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people;
- To safeguard and promote the welfare of children and young people who are abused and/or neglected
- To support increased resilience in individuals, families and communities.

This will require to Board to develop further its use of performance information and other data about the quality and effectiveness of services, in order both to hold agencies effectively to account and to support Board members in becoming more challenging of each other. It will also mean that the Board must:

- maintain its focus on improving partnership working at both strategic and operational levels;
- ensure that its work is informed at all times by the voices of children and young people;
- engage systematically with practitioners and their managers;
- further develop and expand the role and influence of lay members;
- promote more systematic engagement of important partners such as
    - schools
    - faith and community groups
    - the ministry of defence locally
- consider how to respond effectively to issues of radicalisation, child trafficking, FGM and forced marriage;
- work effectively with other strategic partnerships and influence commissioning and local partnership safeguarding activity;
- find ways of embedding learning derived from its range of activities in order to improve outcomes for children and young people.

These challenges have been incorporated within the strategic plan for 2015 onwards, and incorporated into the Board's business plan for 2015-16. This is summarised in the table below.

Strategic Priorities	HSCB is a truly effective agent for change that has a real impact for children and young people.	To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people.	To support increased resilience in individuals, families and communities.	To safeguard and promote the welfare of children and young people who are abused and/or neglected.
What will success look like? **Key Outcome**	LSCB work is informed by the voice of the child and front line practitioners. Increased use of challenge results in improvements; for example, rate of repeat referrals.	Increased number of schools delivering safe and healthy relationship information to pupils.	Reduction in referral and re-referral rates to children's social care. Improved quality of referrals to children's social care.	Maintain rate of repeat child protection plans in line with statistical neighbours. (NB: to be reviewed in line with year end data.)
Measures	The LSCB works effectively with other strategic partnerships and influences commissioning and local partnership safeguarding activity.	Percentage increase in the number of welfare return interviews completed. Increase in the disruption and/or prosecution of perpetrators.	Percentage of professionals who report they are confident in responding to concerns in accordance with thresholds document.	Increased multi-agency attendance and contribution to child protection conferences. Child protection plans clearly set out what needs to change, how and by when.

References

Children in Herefordshire Integrated Needs Assessment; Hereford Public Health. June 2014

Understanding Herefordshire 2014, an integrated needs assessment, Version 1.1, May 2014

Review of child protection. Prof Eileen Munro. DfE, 2011

Appendices

LSCB finance and staffing

LSCB Membership and Attendance 2014-15

Appendix A: LSCB Finance and Staffing

The work of the HSCB is funded through contributions from partner agencies in line with an agreed funding formula.

Expenditure	2014/15
Independent Chair	£23,419
Business Unit Staff and Costs	£129,439
Additional Business Costs including overheads	£123,356
Training and development	£33,509
Meeting expenses	£3,347
Contributions from other organisations and Income from training	+ £102,094
Total expenditure	**£210,976**

Breakdown of Financial Contributions		2014/15
Council	£127,897	61.2%
NHS	£45,203	21.6%
West Mercia Police	£30,165	14.4%
YOS	£645	0.3%
Probation Services	£4,612	2.2%
CAFCASS	£550	0.3%
Total contributions	**£ 209,072**	

Appendix B: LSCB Membership and Attendance 2014-15

		Strategic Board	Steering Group	QA Sub Group	Joint Case Review	Child Death Overview Panel	MASH Governance	T&WD Sub Group	Policy and Procedure Subgroup	CSAR Strategic Sub Group	CSAR Operational Subgroup
HSCB (Chair and/or Lay Members)											
[2]gether NHS Foundation Trust											
Education Establishments											
Herefordshire Council (Elected Member)											
Herefordshire Council	Education										
	Children's social care										
	Sustainable Communities										
	Adult social care										
	Public Health										
Ministry of Defence											
Herefordshire CCG											
NHS England Area Team[3]											
West Mercia Police											
West Mercia Probation Trust											
Third Sector											
Wye Valley NHS Trust											
Youth Offending Service											
CAFCASS[17]											

Attendance Key

Attended more than 70% of meetings
Apologies sent, representative attended 30% or more meetings
Did not attend 30% or more meetings
Not a member of sub group

[3-17] The agencies are not expected to attend all Strategic Board meetings and attendance rating is calculated on their agreed attendance.