Version 1 (Draft)

Herefordshire Safeguarding Children Board

Annual Report

1 April 2016 – 31 March 2017

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1. Foreword from the Independent Chair

Sally Halls
Independent Chair
Herefordshire Safeguarding Children Board

2. About this report

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

The annual report is an account of the effectiveness of the LSCB and this report is published in relation to the financial year 2016-2017. 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 for improvement, 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 2017-2018.

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Date of Publication: XXXXXXXX

This report can be downloaded from the HSCB website at:

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3. Executive Summary

This report sets out how Herefordshire Safeguarding Children Board has worked to meet its statutory objectives during 2016/2017, which are to co-ordinate local work to safeguard and promote the welfare of children and young people, and to ensure the effectiveness of that work. The report also gives detail on the priority areas addressed by the Board during this period, as well as the data and reporting provided by partner agencies regarding their performance in working together to safeguard children and young people in Herefordshire. The report also sets out how effectively the Board identifies areas for improvement, including learning from case reviews and audits, and details the Board's planned priority areas for 2017-18.

Progress on Priorities 2016-18

Herefordshire Safeguarding Children Board's (HSCB) set the following priority areas for 2016/18.

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

Priority 1: Identification, prevention, and response to Child Sexual Exploitation/children who go missing.

During 2016/17 the Child Sexual Exploitation and Missing Children sub-group has reviewed the Board's strategy for tackling CSE in Herefordshire, and set a new work plan to build on the progress made during previous years. It has also reviewed the pathway for reporting CSE where someone working with a child has concerns, and the risk assessment and management processes to be used when such reports have been received.

On 27 April 2016, HSCB held a conference which focussed on the theme of Child Sexual Exploitation and covered a range of areas within this through a number of different workshops. This conference was attended by 110 multi-agency professionals and was very

well received. The Board has continued to support the role out of awareness training for local taxi drivers, and has reintroduced classroom based multi-agency CSE training.

CSE and Missing Children will continue to be a priority for the Board in 2017/19, and we will continue to work to ensure that;

- The various CSE pathway documents and guidance for professionals in relation to dealing with CSE and missing children are well understood by practitioners and embedded in practice.
- The importance of recognising and reporting concerns in relation to CSE is well understood by local hotels and other venues.
- The CSE Operational Group is effective in identifying and responding to information on emerging patterns of risk.
- It supports the new Herefordshire Community Safety Partnership priority of reducing sexual offending against children.

Priority 2: The child's journey through the child protection process ensures effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm.

During 2016 Board members attend Initial Child Protection Conferences and Review Child Protection Conferences as observers.

The Board Quality Assurance subgroup arranged and ran an audit of cases relating to children who were living in homes where domestic abuse was present. This replicated the approach of the Joint Area Team Inspection (JTAI) audits being carried out in relation to this theme by Ofsted, Her Majesty's Inspectorate of Constabulary and the Care Quality Commission.

During 2017/19 the Board will be working to ensure that;

- Learning from the Child Protection Conference observations is embedded through further Board member attendance at these meetings.
- Our Board procedures are in line with regional arrangements and statutory guidance so children receive the correct response.
- We use multi-agency performance data well to monitor the effectiveness of local safeguarding practice and the quality of child protection plans.
- We get feedback from children and young people who have experienced the child protection journey to understand the effectiveness of the local safeguarding system.
- Learning from our Serious Case Review and Practice Learning Reviews is used appropriately to improve the journey of the child through the child protection process.

Priority 3: Identification and response to childhood neglect.

During 2016/17 the Board completed the 'Family HJ' Serious Case Review, which is available to view on our website. This reinforced the importance of the identification and response to childhood neglect being a priority for the Board, and it made a number of recommendations. The Board has been working hard to meet those recommendations, for example it has

developed and agreed a comprehensive strategy to tackle childhood neglect in Herefordshire, which sets out the aims and objectives of the Board in relation to the prevention, identification and response to childhood neglect.

To support our understanding of the effectiveness of the response to childhood neglect in Herefordshire, the Board has held a focus group attended by professionals from a broad range of partner agencies. Feedback from this focus group has been used to help develop our plan to improve services to those who are at risk of, or being neglected.

Tackling childhood neglect is the main priority for the Board in 2017/19, and we intend to achieve this by;

- Developing a costed plan for introducing the Graded Care Profile 2 (GCP2) in Herefordshire
- Identifying the agreed number of multi-agency trainers and then delivering training in the use of GCP2.
- Ensuring that the forthcoming section 11 audits assesses the availability, quality and impact of single agency childhood neglect training within the partner agencies. This will be supported by the Board providing core training materials on neglect for use within partner agencies.
- The Board will promote the importance of this work, which will include a conference on childhood neglect for practitioners.
- The Board will be challenging agencies where practice relating to the capturing of the views of children who are at risk of or suffering from neglect needs improvement.
- The Board will be forming a specific task and finish group to examine how we can be assured of the effectiveness of the safeguarding of children with disabilities within Herefordshire, and how it can support improvements where necessary.

Priority 4: The early help services effectively identify needs and concerns relating to children and families, and services address these needs through the effective planning and interventions to enable families to function effectively and children's needs are met and they are supported to achieve their full potential.

During 2016/17 the Board has reviewed its Levels of Needs guidance used by practitioners to include a greater emphasis on early help. The Board also surveyed practitioners to help understand how well the Levels of Need were understood and being used in decision making.

The Board has continued to support and challenge the development of early help services within Herefordshire, receiving a report from Children's Wellbeing on the development of the early help response.

During the year the Board's Quality Assurance subgroup completed a multi-agency audit of early help cases, and the learning from that audit has been used to develop learning sessions for practitioners.

Early help will remain as a priority for the Board during 2017/19. As such, the Board will work to ensure that children and their families receive effective help at the right time which promotes their wellbeing by;

- Ensuring that Board procedures address the impact 'hidden harm' has on children and young people, and those procedures support the early help strategy.
- Assessing the impact of threshold decisions on those children who are not stepped up to higher levels of intervention.
- Evaluating the availability and effectiveness of early help support, particularly in relation to children living with neglect and domestic abuse, and children with disabilities.
- Ensuring the Board's training products promote understanding of the early help offer with practitioners.
- Securing feedback from children, young people and their parents/carers about the experience of accessing and receiving early help.

How the HSCB has carried out its statutory functions

a. Policies, procedures, practice guidance updates

The Herefordshire Safeguarding Children Board Policy and Procedures sub group has continued to grow through 2016/17 with strong representation from partner agencies.

The transformation project to introduce a collaborative West Midlands Local Safeguarding Children Board multi-agency policies and procedures resource has now been completed with the new web based facility having gone 'live' on 31 March 2017. This has seen the joint West Mercia arrangement for developing and hosting safeguarding procedures replaced by a wider West Midlands consortium of nine boards. The Herefordshire Safeguarding Board Policy and Procedures sub group has contributed to this work by reviewing a number of the procedures which are now shared regionally.

b. Training

During 2016/17 the Workforce Development sub group of the Board has developed evaluation procedures to ensure the quality of safeguarding training being delivered to practitioners. That process has been implemented across all training delivered to evaluate the impact of training on service delivery and outcomes for children.

We have been successful in increasing the numbers of practitioners attending the regular Practitioner Forums and increasing the variety of agencies accessing this forum. A Voice of the Practitioner report process is now in place and feeds back to the Board.

A training pool has been created to support delivery of specialist training which supports the Board priorities.

A Joint Workforce Development Strategy has been developed that includes a competency framework to be used to support the development of a skilled and competent workforce across Herefordshire. This includes the creation of a process to valid the training.

In 2017/18 the Board will be looking to improve how we share learning from audits and Serious Case Reviews amongst our practitioners, and we will be striving to further develop our training pool of staff in support of this.

The administration of the on-line training provision has returned to the Business Unit in order to make the Board more cost effective.

The Board now needs to develop the support from subject matter experts and sub groups to develop and deliver training events to meet requirements of key priorities and business plan objectives. These would then become part of the HSCB training programme.

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

A child under 16 (under 18 if disabled) who is cared for by someone who is not their parent or a 'close relative' is deemed to be privately fostered. Private fostering is an arrangement made between a parent and a carer for 28 days or more. The council has a legal duty to make sure that all private fostering arrangements are safe and appropriate for the child. HSCB receives an annual report about private fostering in Herefordshire. In 2016/17 the Local Authority were notified of four such private fostering arrangements.

d. Case reviews

During 2016/17 one Serious Case Review has been concluded, this having been initiated in 2015/16. Learning from that review continues to be rolled out to practitioners, and work continues to ensure all of the recommendations from the report are completed. A Practice Learning Review (PLR) was also completed during 2016/17. This is a new type of review for Herefordshire intended for cases that do not meet the criteria for a Serious Case Review, but where there is significant multi-agency learning to be gained.

e. The Child Death Overview Panel (CDOP)

A total of 11 deaths were recorded within the review period April 2016- March 2017, three of which are still awaiting completion of review.

The Child Death Overview Panel (CDOP) has continued to function as an effective sub group of the Board during 2016/17. Both the consideration of all referrals to the panel, and the annual return to the Department of Education have been timely, and referrals to the panel by local paediatricians continue to be of high quality. Where the completion of referral forms has been identified as being in need of improvement, training has been offered to those agencies. All recommendations from the 2015/16 CDOP report have been implemented.

f. Communication Sub Group

The Board shares a Joint Communications sub group with the Safeguarding Adult Board and Community Safety Partnership. The purpose of this sub group is to ensure that all the communications across the partnerships about safeguarding are as coordinated and effective as possible. The sub group is aware of the Boards priority areas and looks to ensure these are captured in communications. Importantly the group also share what each agency is doing on communications about particular topics so we can be more informed and coordinated about messages given to partners and the community. To develop this co-ordination further, the sub group is now working closely with the One Herefordshire Strategic Communication and Engagement Group, which is a forum led by the Herefordshire Clinical Commissioning Group.

g. Allegations concerning persons who work with children

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

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

During 2016/17, 140 allegations against professionals were managed by the LADO, compared to 117 in 2015/16. The average for the seven year period is 137, with 140 – 159 being the usual range for Herefordshire.

Working Together 2015 sets the expectation that 80% of cases should be resolved within one month of referral, 90% within three months and all but the most exceptional cases within twelve months (measured as number of days from referral to case closure). The data for 2016/17 shows that 73% of cases have been resolved within one month of referral,
and 90% of cases have been resolve within three months of referral. This represents a significant improvement on 2015/16 performance.

Effectiveness of agency safeguarding arrangements in Herefordshire

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

Section 11 audit

The HSCB conducted a full Section 11 audit in 2015/16, and the next such audit is due in 2017/18. As such there has been no full audit conducted this year, however a panel of members of the Herefordshire Safeguarding Children Board invited partners to present on how they had addressed areas for development identified within their own Section 11 audits, and the Board has also during this period been actively contributing to the development of a Regional Section 11 audit tool, to be used in the coming year.

Development of HSCB and its effectiveness 2016-17

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

The Board also works with other multi-agency partnerships across Herefordshire to both scrutinise and challenge their activities and to pursue joint objectives. Overall engagement by partners in the work of the HSCB has continued to be positive throughout 2016-17. The Board also continues to work closely with the Herefordshire Health and Wellbeing Board, Children and Young People's Partnership, Safeguarding Adult Board and Community Safety Partnership in recognition of the wide range of factors that can impact on the safety and wellbeing of children and young people.

Illustrations of HSCB challenge and impact

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

Challenge	Impact
Report of very low numbers of young people in 'staying put' placement at age 18+ in Herefordshire.	Reassurance report received from Director of Children's Services clarifying the number of young people using such arrangements and demonstrating appropriate provision and take-up within the county, so ensuring young people have the opportunity to choose to 'stay put' should they wish to do so.
A number of agencies were written to by the Chair challenging their lack of regular attendance at Board meetings.	Regular attendance now secured from those agencies. This ensures the Board makes decisions with full information available, so ensuring those decisions are likely to have the best possible impact on safeguarding children and young people.
Continued difficulty in obtaining Form B responses to child deaths in a timely fashion from several agencies.	The SUDIC pediatrician and the Chair of CDOP have written and spoken to professionals. The CDOP has considered the learning from this and have recommended the following:

	• Professionals are made aware of their role through the development of a pathway which is on the LSCB website. • A good practice guide and sample is posted on the web to assist with understanding. • The Director of Children Services, as the accountable officer has been alerted to take the appropriate action. • A communication item on the CDOP agenda to agree dissemination of learning, with responsibility for this to the HSCB Communications Sub Group. In securing more timely submission of information, opportunities to prevent SUDIC can be taken soonest, so improving the safeguarding of children.
Challenge to Addaction on lack of provision and suitable premises for young people, and safeguarding of children/young people in care of service users.	Children and young people who are living with parents with drug or alcohol issues, or have such issues of their own, are correctly identified as being more likely to need early help as a result, and where necessary those children and young people are given access to that help at the correct level and by the most appropriate agencies.
Improving the response to victims of 'peer on peer' abuse.	HSCB has taken the lead for reviewing the regional 'Children who abuse others' procedure, ensuring the new procedure is developed with input from all relevant agencies. This will ensure children and young people who are victims of abuse by their peers are better protected through a more robust response by professionals.
In relation to CSE/Missing Children, members of the executive questioned the availability of guidance for Risk Management meetings. The executive also explored whether the Risk Management meetings are subject to quality assurance.	Children's Social Care now have a Risk Management Practice Guidance, along with Risk Management Meeting Guidance and Agenda, which now sit within the suite of CSE procedures. This ensures children and young people who may be at risk of CSE are correctly identified and interventions that will most effectively protect them are agreed by partners, and implemented.

Conclusion and priorities for 2017/19

During 2016/17 the Board has been very active in directly promoting the effectiveness of child safeguarding arrangements in Herefordshire through the work of Board members and its sub groups. It has also however achieved notable success in contributing to the influencing of the work of other partnership forums in the county towards giving greater focus to safeguarding children in the county. Through engagement with the Herefordshire Community Safety Partnership that forum now has a priority for 2017 – 2020 of reducing sexual offending against children, whilst the Herefordshire Health and Wellbeing Board is now prioritising the dental health of children.

In reviewing progress against the 2016/18 priorities, the Board recognised that greater impetus is now required to improve our response to tackling childhood neglect, and as such this is our key priority for the coming 12 months.

The Board also recognised that our Child Sexual Exploitation strategy was in need of reviewing and refreshing, and that a renewed drive was needed to ensure we remain fully committed to tackling CSE and the risks created by children going missing.

In addition, the Board has had the opportunity to consider the extensive research that was commissioned from the Local Authority's Strategic Intelligence Team in relation to Child Sexual Exploitation and sexual offending against children and young people, and has as a result updated our priorities to reflect this. The priorities have also been simplified to ensure they are clear and easily understood.

As a result of the work of partners and challenges raised within the Board, the HSCB recognises that the collective response to 'peer on peer' abuse requires a greater focus and this will be provided through 2017/18.

The Board has also recognised that it needs to be better at making sure children and young people have a real influence and impact on what the Board does and how it works.

Reflecting on our progress and achievements in 2016/17 and considering a range of evidence and other information alongside the need to ensure continuous improvement, the HSCB has set five priorities for 2017 to 2019.

Priority 1.	***Priority 2.***	***Priority 3.***	***Priority 4.***	***Priority 5.***
Neglect	*Child Sexual Abuse/ Exploitation and children who go missing.*	*Safeguarding vulnerable children*	*Early Help*	*Strong leadership, strong partnership*

4. The Local Context

The latest (mid-2015) estimate of **Herefordshire's resident population is 188100**, which represents an increase of just 900 on the year before.

Herefordshire's population is scattered right across its 2,180 square kilometres, of which 95% of the land area is 'rural'. Just under a third (60,400 people) live in Hereford city and just over a fifth (40,500) in one of the five market towns, but over two-fifths (79,400) live in areas classified as 'rural village and dispersed'.

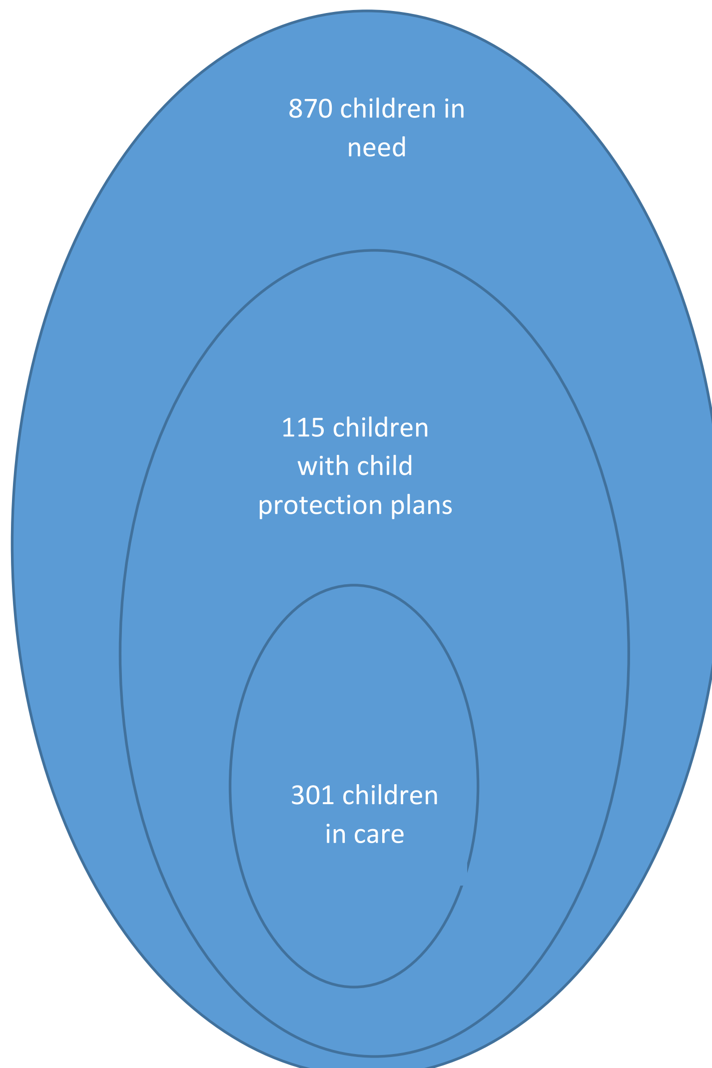
There are 39,900 (21%) children and young people (aged 0 to 19) living in Herefordshire, of whom:

- 9,900 (5%) are aged under five
- 21,900 (12%) are aged 5-15 years
- 8,100 (5%) are aged 16-19 years and

There are also

- 11,300 (6%) aged 20-25 years old.

Below is an illustration of the numbers of children assessed as in need, numbers of children with a child protection plan and numbers of children in the care of the Local Authority as at 31st March 2017.



5. Progress on our Priorities for 2016-18

Herefordshire Safeguarding Children Board (HSCB) set the following priority areas for 2016/18.

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

Priority 1: To improve the recognition and response to child sexual exploitation (CSE) and missing children and young people.

What we have done

The HSCB's CSE and Missing subgroup oversees and challenges the work of partners to recognise and respond effectively to this issue. The CSE Strategy and Delivery Plan was reviewed, updated and was signed off by the HSCB in January 2017. It has been informed by the existing and developing regional and local problem profiles and has drawn on evidence about effective practice from National and local research, policy and guidance. It has also been developed in line with the Shropshire CSE Strategy to ensure there is as much continuity for West Mercia wide agencies as possible, and shared responses can be developed whenever possible.

The CSE dataset has been regularly updated and is monitored by the CSE and Missing sub group and Board. Measures have been adapted to now incorporate data which reflects the prevalence and preventative measures taken to disrupt, and provide assurance to the HSCB. The dataset will be supplemented by targeted auditing to assess awareness of and responses to CSE risks and harm.

The CSE pre- checklist to help partners identify CSE concerns and refer has been updated and improved and a Risk Assessment Tool and Risk Management Practice Guidance has also been produced.

HSCB took part in the NWG #Thunderclap initiative during CSE Awareness Day in March 2017. The HSCB also arranged for an awareness raising screensaver to be rolled out throughout Herefordshire Council, and a communications pack was sent out to all Board Members to disseminate throughout their agencies.

CSE Conference

On 27 April 2016, HSCB held a conference which focussed on the theme of Child Sexual Exploitation and covered a range of areas within this through a number of different workshops. The conference was held at The Hereford Academy, and HSCB would like to convey their thanks to them for their hospitality and their part in making the event a success.

A total of 110 multi-agency professionals attended the conference which was well received. The Keynote speakers for the conference were Dr Peter Unwin, who spoke regarding perceptions of CSE in a rural county, and Lorin LaFave, who told her own personal story of how her son, Breck Bednar, was unwittingly groomed and lured to his death by someone he met online.

Lorin LaFave

The delegates had the opportunity to attend two workshops, which focused on areas relating to CSE including:

- Understanding Local Pathways
- Sexting
- Child Trafficking
- Understanding Consent
- Toxic Bedfellows

The aim of the conference was to increase practitioner's ability to identify CSE and improve their knowledge to help and work with children and their families.

What have we learned and what difference have we made

The impact of the conference was evident in a number of areas and course evaluation comments. Delegates said they found the workshops gave them a better understanding of each area of work which they could then include in their own practice and also commented on the powerful impact on them of the presentation from the key note speaker, Lorin LaFave. Her presentation was described as "heart-wrenching and informative" by delegates. Delegates were asked to rate whether their knowledge of CSE had improved after attending the conference with 1= not at all and 5= greatly improved. 53% marked the conference 5, and a further 32% marking the conference 4. Practitioners also highlighted the value of the learning from the workshops they attended.

As well as the CSE conference, the HSCB Business Unit joined colleagues from a range of agencies for an 'Engaging Communities' event in High Town, Hereford in July 2016.

The aim of the day for the Safeguarding Children Board Business Unit staff was to raise awareness of Child Sexual Exploitation and Private Fostering. The stand attracted the attention of a range of members of the public who were given verbal advice and signs and indicators leaflets.

The Mayor of Hereford Councillor Jim Kenyon is pictured above visiting the Herefordshire Safeguarding Boards stand at the event, alongside Bill Joyce, who was Interim Manager of the Safeguarding Boards Business Unit.

HSCB's work with licensing continued throughout 2016/17. The HSCB arranged for Safeguarding questions to be added to the "Conditions Test", which is a compulsory test that every taxi driver has to pass before they are granted their licence.

HSCB also commissioned an awareness raising sticker, which is displayed within every licensed Herefordshire taxi.

CSE awareness training for taxi drivers regularly took place, the sessions were well attended and included the two major taxi firms within Herefordshire.

Over 160 taxi drivers have now been trained, and all have been issued with a sticker for the back of their identity badge, which provides them with the number to call for the MASH Team, if they have any safeguarding concerns regarding a young passenger, and the Adult Referral Team (ART) if they have safeguarding concerns regarding an adult.

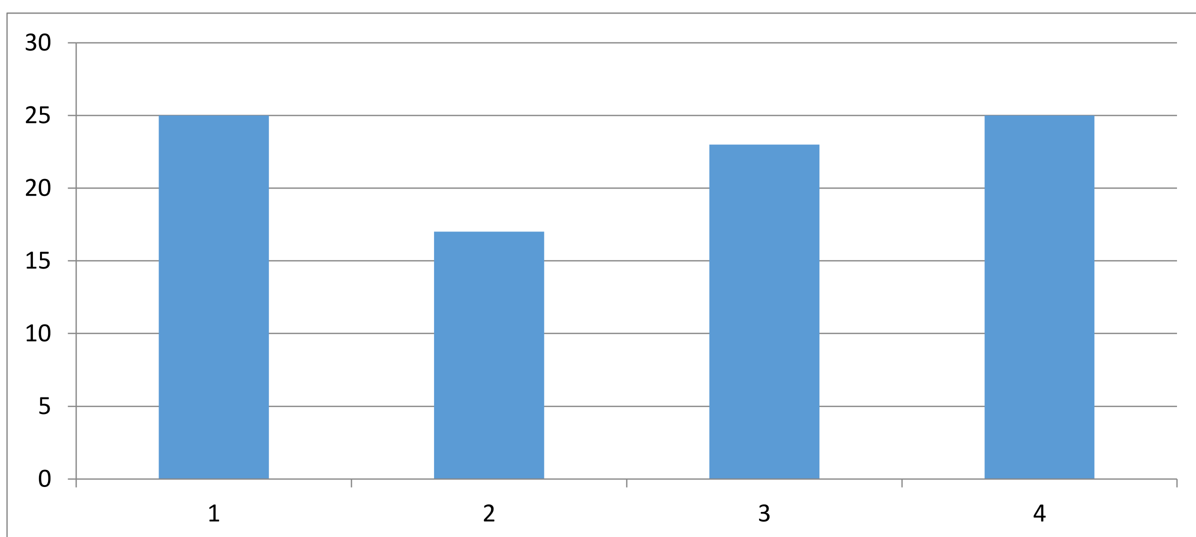
Discussions are in place for the next tranche of training, which will include hoteliers and licensed premises. The training was delivered by Young Solutions, who were commissioned by West Mercia Police. The HSCB Business Unit's input into arranging and promoting the training has been put forward as an effective process and good practice within Young Solutions.

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

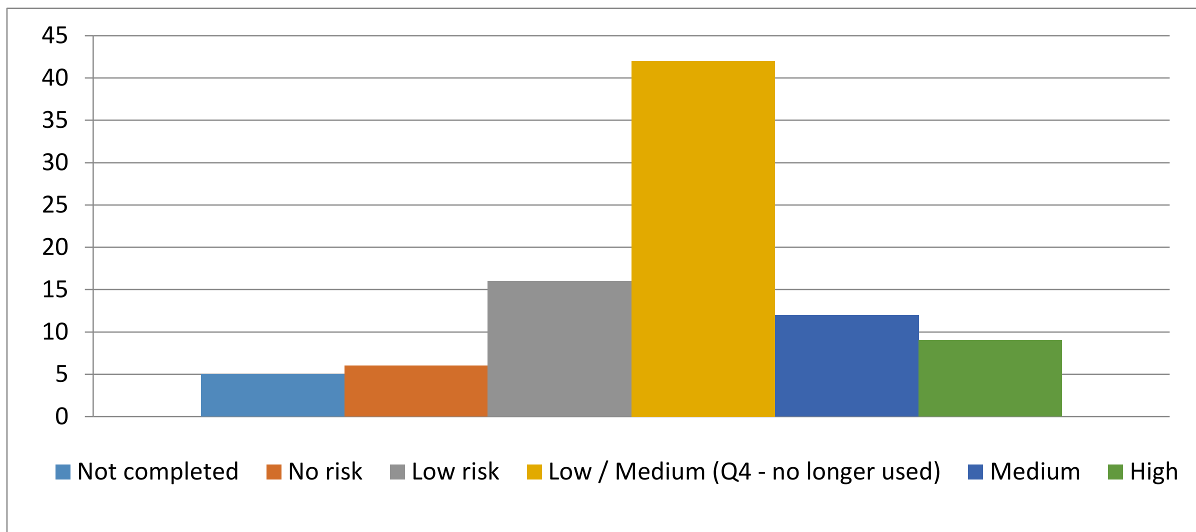
- Percentage increase in the number of welfare return interviews completed
- Increase in the disruption and/or prosecution of perpetrators

In 2016/17 **90** risk assessment tools were completed by staff in the MASH on referrals concerning possible CSE and of these **58** were deemed low or medium risk and **9** were assessed as high risk.

CSE assessments undertaken per quarter

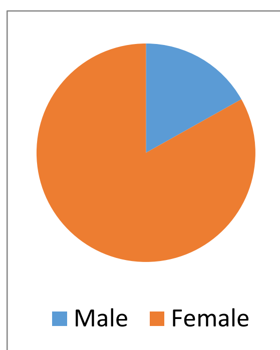


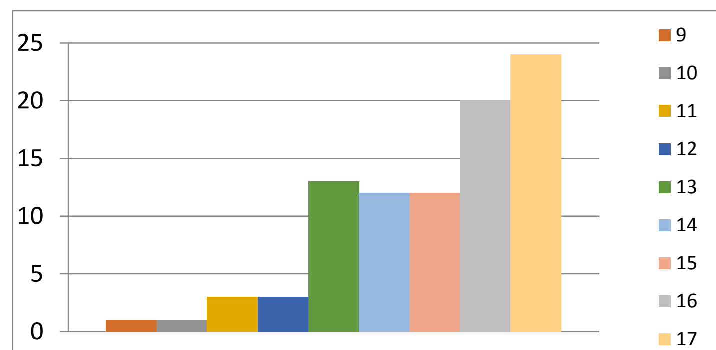
Outcome of CSE assessments



The CSE assessment tool was amended during Q3 to remove the dual low/medium banding. This was to encourage practitioners to consider the available evidence more carefully and reach a more definitive assessment.

The charts below show the profile of those that have had CSE assessments carried out





There is a continued decrease in the number of 16 / 17 year olds being identified at being of risk of CSE.

Whilst children reported missing from home and school has remained relatively consistent, there was a decrease in reports from placement providers of children missing from care, with 96 reported missing between April and June and only 52 reported between July and September and this downward trend continued. This may be attributable to the targeted work of the police care home team in working with care homes in regarding to the missing person protocol.

What we will do next

During 2017/18 the CSE & Missing sub group of the HSCB will be supporting the Herefordshire Community Safety Partnership in achieving its new priority for 2017 – 2020 of reducing sexual offending against children in the county.

Through 2016/17 the CSE & Missing sub-group has supported the operational group in reviewing and updating the various pathway documents and guidance for professionals in relation to dealing with CSE and missing children. In the coming year the sub group will be working to ensure that these documents are well understood by practitioners and embedded in practice.

Priority 2: The child's journey through the child protection process ensures effective planning and intervention to improve the care, safety and wellbeing of children and reduce/eradicate actual or the risk of significant harm.

What we have done

a. **Children living with domestic abuse**

In October 2016 the Quality Assurance sub group conducted an audit to assess the quality and effectiveness of services provided locally for children living in a household where domestic abuse is present. The audit framework used by the Joint Targeted Area Inspection (JTAI) process, which are inspections conducted by HM Inspector of Constabulary (HMIC), Care Quality Commission (CQC) and Ofsted, was used to ensure a thorough review of the cases, and achieve the best possible learning from the process.

Six such cases involving children were selected at random. A review of the case notes for these children's cases was completed to ensure that a full range of circumstances was included within the audit, and the response of all the agencies involved with the child and their family could be considered. All of the children either were or had been within the child protection process within the previous six months, and this audit therefore gave a very clear picture of how effective the work of the agencies had been in using the child protection process to safeguard children living within a domestic abuse environment.

The audit evidenced some high quality direct work which had clearly led to improved outcomes for children and their families. Within the cases examined there was evidence of the child's voice being evident, and good communication across agencies.

There were many instances of well attended statutory child protection meetings. Strategy discussions and resulting responses and actions were timely in all but one case where a strategy meeting had been recommended with no evidence that it had taken place.

There were often more than one male included in the family make up. However, assessments and plans for the children were often concentrated on the mother, even when the male in the family had parental responsibility. During the audit males were seen as 'shadowy' figures in the background, and work needs to be done with perpetrators in relation to addressing their behaviour.

Compromised parenting was a common factor within the cases examined. In five out of the six randomly identified cases there was information that either both or one of the parents had issues with substance (drugs) misuse, and half of the families were noted to have adult mental health engagement.

Whilst there were many instances of proactive work, there were examples of information sharing being seen as potentially problematic, with delays in communication in two cases. In one case information sharing between nursery and school was cited as difficult too.

Vennture, a charitable organisation based in Hereford, was seen as a good support for children and families. In one case the intensive involvement of Vennture was seen as helpful, especially the positive impact they had in engaging and working with the mother and then encouraging mother to work with other agencies.

The audit highlighted how HSCB and the Community Safety Partnership Domestic Violence and Abuse Delivery Group need to ensure that there is clarity across agencies in relation to how Multi-Agency Risk Assessment Conferences (MARAC) are used when a child already has a child protection plan or child in need plan to avoid any confusion in ownership and management of risk. The audit also highlighted the need for Addaction, the drug and alcohol support service, to be seen as a service central to protecting the child, rather than having a peripheral role. Finally, the audit highlighted that professionals tend to focus on the mother and her ability to keep the child safe, and there needs to be greater focus on the perpetrator in the context of assessing the risk presented to the child.

During 2017/18 the HSCB will be monitoring how each agency responds to the recommendations on how services to children within the child protection process as a result of domestic abuse can be improved, in order to improve the safety of children living with domestic violence

In addition to the audit work, in September 2016 the Board received a report from the Domestic Violence and Abuse Delivery Group of the Community Safety Partnership. This report updated the Board on the prevalence of domestic violence and abuse in Herefordshire with a specific emphasis on children who witness and experience domestic violence and abuse.

Data in relation to the number of children in Herefordshire that have been recorded as being exposed to domestic abuse, and numbers of children and young people involved with the Children's Independent Domestic Violence Advisor are available in Appendices 3 and 4.

b. Child Protection Review Conferences

Between April 2016 and November 2016 nine members of the Herefordshire Safeguarding Children Board attended various Child Protection Review Conferences and recorded their observations.

The feedback was captured within a number of specific areas, for example the quality of the multi-agency work, how well the child's views and experience were captured and then taken into account, and the quality of the conference process and resulting child protection plan. It

was helpful to all concerned to have the Board members in a position to record exactly what they saw of the child protection system being used in practice and then feedback to practitioners. Examples of comments recorded by Board members on observation sheets are;

- “The social worker had completed a comprehensive report which was circulated prior to the meeting. The report had been shared with the mother nine days before conference.”
- “The baby was well catered for, playing happily with toys, under the supervision of his grandmother. This kept the child firmly in focus throughout the conference.”
- “Child’s father attended and was very much involved in the discussions.”
- “Young person attended and made her views well known.”
- “Mother and son were very well supported during the meeting. The Chair made sure, at every stage, that they had the opportunity to contribute and that they understood what was being said.”
- “The paternal grandmother is a significant figure with regular care of the baby, but was not present. Again, it is not clear whether she had been invited.”
- “Reports were analytical to a point. However, language used in some reports, particularly the social workers, was technical and therefore questionable how much was understood really. Professional language code not helpful to families.”
- “The Chair was very clear with the child, asked him at every stage if he understood and wished to add anything. The Chair supported the child to read out part of a statement that he had written which outlined how individuals from agencies had supported him and helped him to feel better about the situation with his Mother and with life in general. The agency workers had also support the child to look forward and to plan a future for himself.”
- “In considering the risk and ongoing management of this matter, there was no recognition of or discussion about any possible course of action should the father of the child recommence their relationship with the mother, the ending of this relationship having been a significant factor in the assessment of reduced risk to the child.”
- “There was no attempt to outline the implications for parenting of continued dependence on methadone, including issues re safe storage.”
- “This baby was made the subject of a child protection plan since birth. From discussion at the conference, the correct agencies appear to have been involved, the CP plan was clearly understood by the parents, and a number of risks identified and addressed.”

Since the visits and feedback there have been a number of changes made which will improve the child’s and family members’ experience of child protection conferences and also improve the effectiveness of planning and sharing of information within the meeting. Examples of this are;

- New accommodation has been found which gives a more pleasant environment for all involved, with waiting areas, a children’s play area, and baby changing facilities.
- Changes are being made to the social worker report template to help ensure the best possible planning of conferences takes place in partnership with families.

- The format of the reports submitted by partners to the conference, and the information attendees are provided in the invite letters, have been updated to make expectations and process clear to all.
- Practitioners' knowledge of how they can most effectively contribute to child protection conferences is being enhanced through multi-agency training and practitioner forums.
- Further visits will be conducted in 2017/18 with the intention of looking specifically at whether progress has been made within the identified areas for development.

During the year the Board also received assurance on the effectiveness of the Independent Review Officer (IRO) service in Herefordshire, which has a key role in relation to the improvement of care planning for children. The work of the IRO's in Herefordshire, and the direction of travel for the service is positive, for example, the majority of all reviews for 'Looked After' children were held within statutory timescales, the IRO team has moved to a full set of permanent staff so providing continuity for children in care, the IRO's routinely advocate on behalf of children and young people and ensure they are aware of their rights and entitlements, that they have opportunities to participate in and contribute to the review of their care plan, and that their voices are heard and inform their planning. The significant reduction in the number of children on a child protection plan during 2016/17 through the appropriate application of the threshold guidance has supported IRO's in focusing on those children who most need their support, so improving the service those children and young people receive, and the outcomes for them.

c. Developments within Children's Wellbeing Services

During 2016/17 the conduct of both Child Protection Conferences and Strategy Discussions were further enhanced by Children's Wellbeing Services as a result of review and audit work. Full details of these improvements can be found in section (i) of Appendix 6.

d. Multi-Agency Safeguarding Hub

In January 2016 the Board requested a report on the practices and processes of the Herefordshire Multi Agency Safeguarding Hub (MASH) at that time. This was prompted by concerns that the MASH was not functioning as effectively as it could, and the volumes of child protection activity did not reflect our population size and statistical neighbours. This report was received and considered in April 2016, and was the result of a comprehensive review by the Assistant Director Safeguarding and Family Support in Herefordshire, which examined all aspects of the MASH function, including the application of the Threshold Guidance at point of referral, the quality referrals, information sharing and the resulting strategy discussions.

The report highlighted that the Herefordshire MASH was very fortunate to have a group of skilled, knowledgeable and experienced professionals who were committed to working together. Further, decisions were made quickly, meeting statutory expectations. However, a number of areas for development were also highlighted by the report. The Board were informed that the role of the MASH was unclear, and this was not helped by the need for an update of the MASH Standard Operating Procedures, and the need to be clear on the

distinction between a 'contact' and a 'referral'. The transmission of a concern had become confused with a request for service, and this was having an impact on the effectiveness of the MASH. Further, there was no shared IT system within the MASH, which contributed to slow information sharing. The Threshold Guidance was not being used consistently as the basis for decision making, and strategy meetings were focusing more on historical information and the behaviour of the parents, rather than the evidence for the impact of these upon the child. A number of recommendations were made within the report, which were accepted by the Board.

As a result of this work there have been a number changes made through 2016/17 to improve the functioning of the MASH, and so ensure that children and young people who are referred receive the appropriate service to meet their needs. The MASH Governance Board was reconstituted to oversee the delivery of the recommendations and required improvements. This board now has a smaller membership and continues to meet regularly. The MASH now clearly distinguishes between referrals and contacts, so focusing professions' efforts on the core role of the MASH, that being to enhance the management of the children and young people considered to be at Level 4 (most at risk). Discussions continue to take place with those responsible for delivering the early help strategy to make sure that those children who do not meet that level of need do receive the appropriate support. This is an area which the Board will be monitoring in 2017/18 in line with the early help priority. A forthcoming peer review in September 2017 will also help with the Board's understanding of the effectiveness of these arrangements.

The Board has continued to emphasise the importance of the Threshold Guidance document within its multi-agency training, so supporting the improvement in the quality of referrals to the MASH. Funding has been identified to pay for a MASH specific IT programme to support the work of the team and software options are currently being explored.

The challenge remains in 2017/18 for the MASH Governance Board to continue to improve strategy meeting practice, however it is recognised that this will need the support of all Board members in ensuring their organisations contribute appropriately to the referral, gaining of consent, information sharing and strategy meeting processes as required, and the Board will continue to monitor that contribution.

What we have learned and what difference we have made

It was recognised by the Board that the standard Domestic Abuse Stalking and Harassment (DASH) risk assessment in use in Herefordshire was not always suited to situations where the victim of the domestic abuse was under 18 years of age. This is an issue that has also been highlighted within a Serious Case Review in another Safeguarding Board area. To ensure every opportunity was being taken to improve the safety of young people subject to domestic abuse, the Board worked with the Domestic Violence and Abuse delivery group of the Herefordshire Community Safety Partnership to introduce a bespoke DASH risk assessment form which is better suited to using with younger victims.

Throughout 2016/17 the Board has also received regular updates in relation to partners' arrangements and readiness to receive unaccompanied asylum seekers. The Board ensured

that both accommodation and services were in place to receive the anticipated numbers of these children and young people, recognising that their experiences would require access to particular types of specialist support.

What we will do next

The results of the audit of children living with domestic abuse will be reported on in early 2017/18 and the HSCB will monitoring how each agency responds to the recommendations on how services to children within the child protection process as a result of domestic abuse can be improved.

In addition, in 2017/19 the Board will be working to ensure that;

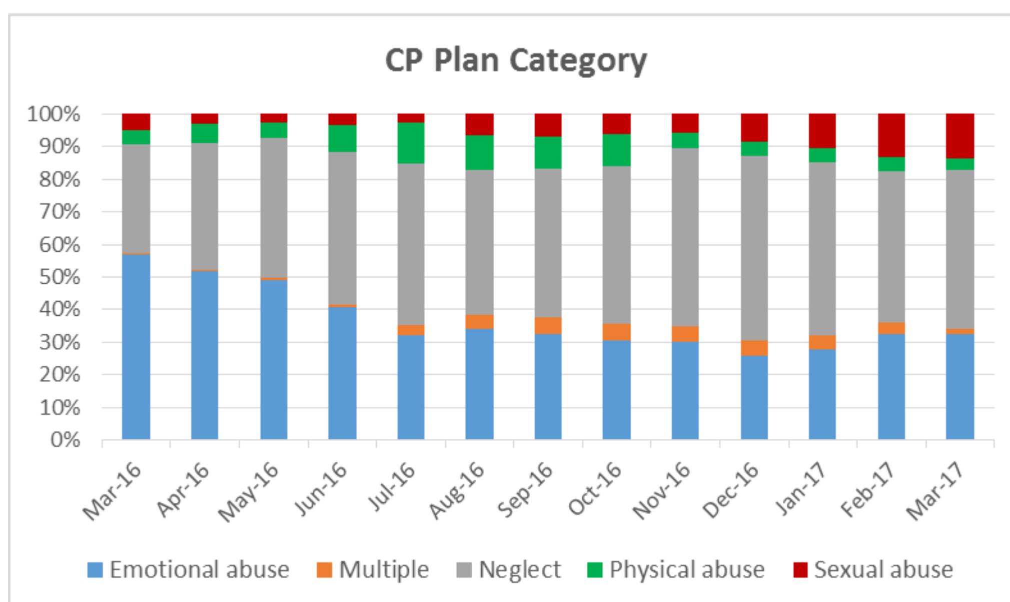
- Learning from the Child Protection Conference observations is embedded through further Board member attendance.
- Our Board procedures are in line with regional arrangements and statutory guidance so children receive the correct response.
- We use multi-agency performance data well to monitor the effectiveness of local safeguarding practice and the quality of child protection plans.
- We get feedback from children and young people who have experienced the child protection journey to understand the effectiveness of the local safeguarding system.
- Learning from our Serious Case Review and Practice Learning Reviews is used appropriately to improve the journey of the child through the child protection process.
- We will continue to monitor national events and decisions in relation to young unaccompanied asylum seekers and ensure services are in place to meet their needs when required.

Priority 3: Identification and response to childhood neglect.

Tackling childhood neglect remains a key challenge for the Board. As can be seen from the figures below, Herefordshire reflects the national pattern where neglect is the most common reason for children being made subject of a child protection plan.

1. Number of children subject to CP Plan by category as at the last day of each quarter 2016/17.

Category	Q1	Q2	Q3	Q4
Emotional abuse	41%	32%	26%	32%
Multiple	1%	5%	5%	2%
Neglect	47%	46%	56%	49%
Physical abuse	8%	10%	5%	3%
Sexual abuse	3%	7%	8%	14%



What we have done

The ‘family HJ’ Serious Case Review which was commissioned by the Board in October 2015 delivered a final report in December 2016. The circumstances of the incident covered within the Serious Case Review reinforced the importance of the identification and response to childhood neglect being a priority for the HSCB, and made a number of recommendations to the Board on how the response to childhood neglect could be improved. The first of these recommendations was that the HSCB should ensure that there is an effective multi-agency childhood neglect strategy in place. As a result the Board has developed a childhood neglect strategy, and this is now available to view on the website.

The neglect strategy sets out the strategic aims and core objectives of the Herefordshire Safeguarding Children Board in relation to the prevention, identification and response to childhood neglect, and how the broader partnerships support and contribute to those. This strategy also sets out the key principles under which work around neglect should be undertaken and identifies key priority areas of work in order to improve our collective response to neglect. The strategy forms part of Herefordshire's approach to Early Help, which is led by the Children and Young People's Partnership, and complements other key strategies within the partnerships, including Herefordshire's Health and Wellbeing Strategy, the Community Safety Partnership Strategic Plan, and the Herefordshire Levels of Need Threshold Guidance.

The strategy also sets a number of objectives for the HSCB to achieve, and these objectives cover such things as improving the early recognition of neglect through the use of effective early assessment tools, providing training for practitioners in identifying neglect, and what then to do about it, monitoring the effectiveness of that training, carrying out audits of neglect cases to check that the response is improving, and ensuring that the views and opinions of the children and young people who may be subject to or at risk of neglect are properly taken into account.

In order to ensure that these objectives are achieved the Board has invited the members of the Policy and Procedures sub group to focus their efforts entirely on delivering the necessary changes. In addition, throughout 2017 – 2018 there will be an update on the progress of the work of this group at every Board meeting in recognition of the importance of momentum being maintained.

A further recommendation from the Serious Case Review was that the HSCB should request that Early Help and other safeguarding processes consider and reinforce the whole family approach. This is in recognition that neglect very rarely happens in isolation, and is often caused or exacerbated by other problems and challenges already existing within the family. As a result of this recommendation Herefordshire's Early Help Strategy, which reinforces the 'whole family' approach, has been endorsed by the HSCB, the Health and Wellbeing Board and the Children and Young People's Partnership. This will be supported by delivery of whole family approach training to practitioners.

To support our understanding of the effectiveness of the response to childhood neglect in Herefordshire, in February 2017 HSCB Quality Assurance Group held a focus group attended by professionals from a broad range of partner agencies. The session comprised of ten questions which were put to the members, who then discussed these based on their experiences of actually working with children, young people and their families within the current partnership structures. The questions asked of the groups are set out below;

- How well do we understand the nature and scale of neglect in Herefordshire?
- How far are children, young people, parents and carers able to seek and receive help?
- How well are the public supported to report concerns about child neglect?

- How well do staff in universal and targeted services recognise and work together to help children at risk of, or currently experiencing, neglect?
- How well do staff in specialist services recognise and work together to help children at risk of, or currently experiencing, neglect?
- How effective are local systems and mechanisms to assess a range of intelligence about concerns for a child and support informed decisions about when, how and who should intervene?
- How well are practitioners equipped to recognise and intervene in cases of neglect, supported by local guidance and evidence based assessment tools; able to access reflective supervision?
- How far do services commission/provide accessible, high quality, evidence based targeted support for children/young people and parents/carers with additional needs?
- How is the neglect strategy and toolkit embedded in agencies that don't predominantly work with children?
- How effective is the strategic leadership of the local response to neglect?

A number of themes emerged from this exercise, and the key ones are summarised below.

- There is a need to ensure that the definition of neglect and how thresholds relate to neglect is well understood across agencies, and reassurance is needed that these are applied consistently.
- A suitable toolkit to support the assessment of neglect cases is needed.
- The understanding of the resolution of professional disagreement policy needs to be strengthened across agencies, and work is needed to strengthen practitioners' confidence in the policy.
- There are differing views between practitioners in relation to the willingness to share family information without appropriate consent.
- Concerns were expressed in relation to the provision of commissioned service for tiers 1 and 2 (emotional support). Additionally, there is a need for greater understanding amongst practitioners in relation to CAMHS and their need to focus specialist services on those at greater risk of harm, rather than providing a universal service.

What we have learned and what difference we have made

In relation to learning for the HSCB, the Serious Case Review and feedback from practitioners has highlighted the need to focus on the response to childhood neglect, embed the neglect strategy and a common toolkit for identifying and assessing levels of neglect, and providing multi-agency training which addresses the identified themes.

This has led to a series of roadshows being held for practitioners to raise the awareness of childhood neglect, how to recognise it and when and how to report it.

Specific learning came from the 'Family HJ' serious case review in relation to children with disabilities. The Board has learned that there is a need to improve the knowledge of disability amongst practitioners, including how current procedures and good practice relate to situations involving children with disabilities, to review the appropriateness of the current 'Levels of Need' guidance to assessing children with disabilities, and to ensure that disagreements about cases can quickly be resolved using the 'resolution of professional disagreements' procedure.

What we will do next

Tackling childhood neglect in Herefordshire is the key priority for the Board in the coming year. As such the Board will be working hard to achieve the objectives set out in the strategy, and an implementation group has been formed to drive this activity. Specifically this group will be;

- Developing a costed plan for introducing the Graded Care Profile 2 (GCP2) in Herefordshire
- Identifying the agreed number of multi-agency trainers and then delivering training in the use of GCP2.
- Ensuring that the forthcoming section 11 audits assesses the availability, quality and impact of single agency childhood neglect training within the partner agencies. This will be supported by the Board providing core training materials on neglect for use within partner agencies.
- The Board will promote the importance of this work, which will include a conference on childhood neglect for practitioners.
- The Board will be challenging agencies where practice relating to the capturing of the views of children who are at risk of or suffering from neglect needs improvement.
- The Board will be forming a specific task and finish group to examine how the Board can be assured of the effectiveness of the response to children with disabilities within Herefordshire, and how it can support improvements where necessary.

The Graded Care Profile (GCP) will form an important part of the development of our response to childhood neglect. During 2016/17 the HSCB multi-agency training on childhood neglect was reviewed to include a section on the use of this tool, however a more comprehensive approach to implementation of the most up to date GCP assessment tool across partner agencies will be one of the Board's key aims during 2017/18.

The HSCB, via the Quality Assurance sub group will also be collecting data against the agreed scorecard, which is closely linked with Herefordshire's 'Families First' dataset, in order to measure the effectiveness of the changes.

Priority 4: The early help services effectively identify needs and concerns relating to children and families, and services address these needs through effective planning and interventions to enable families to function effectively and children's needs are met and they are supported to achieve their full potential.

This priority area continued the Board's support for the Herefordshire Children and Young Person's Plan, which has established early help as a key priority.

Early help arrangements are important for the children and families of Herefordshire. There are children and young people at risk of harm but who have not yet reached the "significant harm" threshold for whom a preventative service would reduce the likelihood of that risk of harm escalating. These children and young people might be identified by local authorities, youth offending teams, probation trusts, police, adult social care, schools, primary, mental and acute health services, children's centres and local safeguarding children's board partners including the voluntary sector.

What we have done

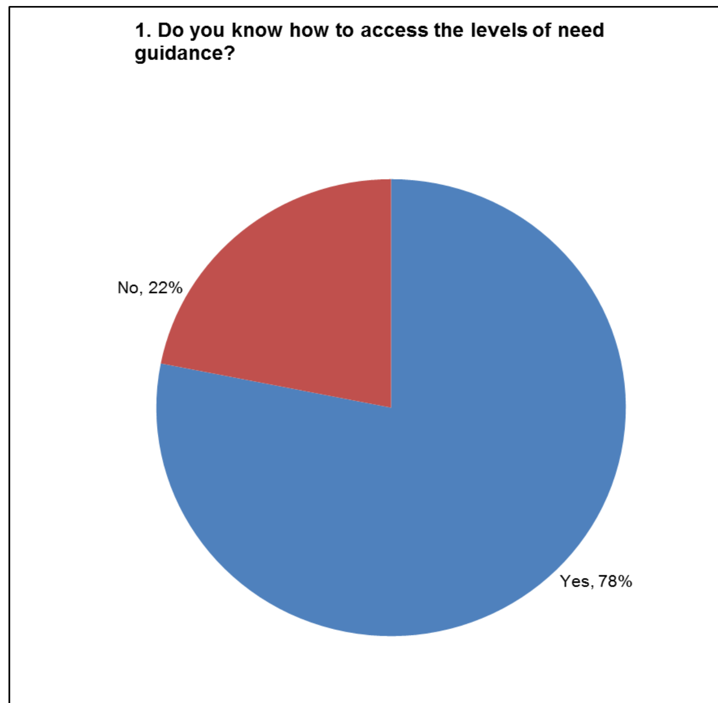
a) Thresholds for intervention

Following the development of the 'Levels of Need' during 2105/16, a guide to support professional judgement when considering help that children and families need and when to refer concerns, the HSCB Policy and Procedure Group has reviewed and revised the Levels of Need Threshold guidance and the Multi-Agency Referral Form during 2016/17. A task and finish group was held to address this work at the end of October with good and enthusiastic representation from across the partnership. The conclusion of the group was that a revision was required rather than a major re-write to ensure HSCB levels of need were compliant with Working Together 2015 and gave greater clarity to practitioners to inform their decision making on a child's level of need. It was recognised for example that the 'Levels of Need' document needed to include a greater emphasis on early help, to include links to service provision, to give greater clarity to the needs of children whose health and development are impacted by compromised parenting, and clarification of criteria for eligibility for Children with Disabilities social work service.

To help us understand how well the Levels of Need document is understood and being used within Herefordshire, the Board's Quality Assurance sub group ran a survey audit for practitioners which asked a number of questions of staff. 246 responses were received from ten different partner agencies, and examples of the questions and responses can be seen below.

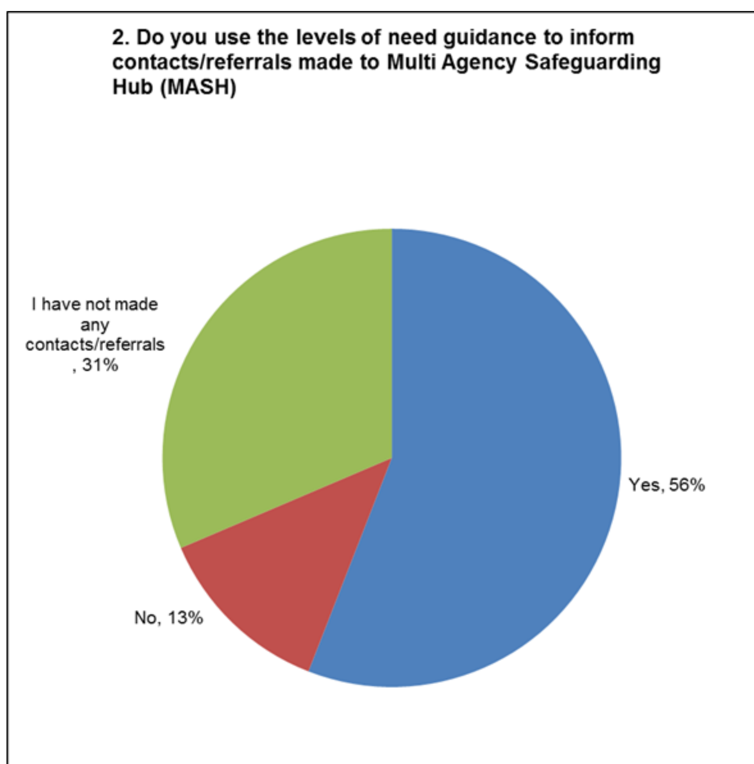
1. Do you know how to access the levels of need guidance?

	Number of respondents	Per cent of respondents
Yes	189	78%
No	53	22%
Total respondents	242	100%
Not answered	4	



2. Do you use the levels of need guidance to inform contacts/referrals made to Multi Agency Safeguarding Hub (MASH) where you have concerns for the welfare or safety of a child?

	Number of respondents	Per cent of respondents
Yes	137	56%
No	31	13%
I have not made any contacts/referrals	77	31%
Total respondents	245	100%
Not answered	1	



As can be seen from the charts, 78% of respondents reported that they knew how to access the document, and reassuringly the majority of those that had needed to make a contact or referral had used the Levels of Need to inform that submission.

Practitioners were also asked whether they had received feedback on their referral, or whether they had ever used the Levels of Need guidance to challenge decision making on the outcome of a referral or contact they had made.

The focus on improving the awareness and understanding of the Levels of Need amongst practitioners, together with the ongoing drive to ensure that they are correctly applied in assessment and decision making has contributed significantly to the reduction in the number of children and young people in Herefordshire on a child protection plan. The data monitored by the Board tells us that in January 2016 there were 277 children on a plan, however this had reduced to 117 by 31 March 2017. This means that children and young people are now being supported and safeguarded at the appropriate level, and practitioners are able to provide sufficient focus on those that are most in need of help, so improving the outcomes for those children and young people.

b) **Early Help**

HSCB adopted an Early Help Strategy in the spring of 2016 and its implementation is being led by the Head of Educational Development. The Head of Additional Needs now manages an integrated 0-25 SEND Service which will give children and their families a more consistent and coherent service. The Head of Learning and Achievement has overseen the review of over half of Herefordshire's schools' safeguarding policies to ensure that they are fit for purpose and understood by staff.

The HSCB has continued to support and challenge the development of Early Help services within Herefordshire. The Board received a report from Children's Wellbeing on the development of the Early Help response, and was reassured that the effectiveness of this response continues to develop. Specifically, strategic and operational groups with clear terms of reference have been formed and are reporting to the Children and Young Person's Partnership. Specifically, these groups are examining carefully how need is identified, who it is that assesses, what they do with the information, how it is shared, the permission to share and what happens as a result. We know there are many universal services such as schools and health visitors supporting children and families with significant need along with local authority family support and commissioned services like Vennture and Homestart. These operational groups are now working to ensure all of these arrangements are coordinated effectively, and some examples of work undertaken and progress being made are as follows;

- An overall early help strategy has been developed and was approved by Herefordshire Council in October 2016. Operationally the Council continues with the multi- agency group (MAG meetings) and the oversite and management of common assessment framework (CAF) procedures.
- The CAF assessment and support plan has been married up to the families first eligibility criteria and the Herefordshire outcomes framework (Families First) so the maximum number of families are identified, engaged and are being supported to work towards achieving sustainable change.
- Audit arrangements with HSCB Quality Assurance sub group have been trialled, and an audit tool has been developed to support this activity.
- Extensive engagement work with professionals, parents and community representatives has been undertaken to explore the early years and early help delivery. This is an important strand of the approach at it provides opportunities for communities to develop support arrangements that will in the long term reduce the likelihood of circumstances and risks of poor outcomes escalating.

From 26 to 30 September 2016, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection in Herefordshire to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014. The inspection was led by one of Her Majesty's Inspectors (HMI) from Ofsted. The team members were an Ofsted Inspector and a Children's Services Inspector from the CQC.

Version 1 (Draft)

Inspectors spoke with children and young people who have special educational needs and/or disabilities, parents and carers, representatives of the local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors also met with leaders from the local area for health, social care and education. Inspectors reviewed performance data and evidence about the local offer and joint commissioning.

As with all such inspections, there was a considerable amount of feedback from Ofsted, and the overall positive nature of this feedback has been highlighted by the resulting contact received by Herefordshire from other areas wishing to learn from the local practice.

A summary of some of the key findings is provided below;

- Leaders have a clear understanding of the strengths and weaknesses of the different partners who contribute to the implementation of the reforms. This, combined with a strong sense of purpose and aspiration to improve outcomes for children and young people who have special educational needs and/or disabilities means that partners are taking increasingly effective action to ensure that the reforms are implemented well.

- The service provided by the tier 3 child and adolescent mental health services (CAMHS) is of a very high quality.

- The children and young people who spoke with inspectors indicated that they are happy, safe and well supported. Their independence is being developed well and they have high aspirations for themselves.

- The local area has clear procedures in place to check that children and young people who have special educational needs and/or disabilities are safe.

- Health visitors deliver the healthy child programme well. A two-year integrated review enables appropriate intervention and support for children and their families where progress is less than expected.

- Leaders acknowledge that some schools' identification of the needs of older children is not precise enough. Herefordshire has a higher proportion of children and young people identified by schools as requiring special educational needs support than the English average.

- Systems are in place to ensure that the needs of vulnerable groups are met. For example, the dedicated nurses work creatively to engage children looked after by the local authority in their health care assessments. This has resulted in almost all young people looked after attending their health assessment in the last year.

- The views of parents are not used consistently in assessing the needs of children and young people. Parents do not feel fully consulted and parents' groups have not been suitably involved in strategic planning.

c) Single Agency Assurance Reporting

The Board has continued to monitor the effectiveness of agencies individual contributions to safeguarding, including the early help support they provide, through regular assurance reporting. An example of the assurance reporting process and challenge resulting from the Board was in relation to the Addaction report considered in October 2016. Addaction are the commissioned provider for drug and alcohol services in Herefordshire, and had recently been awarded the contract for this work. Addaction recognised the need to make a number of fundamental changes in the way services were being delivered, and highlighted these within the assurance report to Board. The Board in turn challenged Addaction in relation to the lack of provision for young people, the lack of premises in which to deliver a service to young people, and the safeguarding of young people in the care of adults known to the treatment services. Following these challenges, Addaction were later able to update the Board that their young people's service had been brought up to full strength and that services were being delivered in appropriate accommodation in line with best practice. Finally, Addaction were able to reassure the Board that processes were in place to establish the parental status of the service user, and then if a parent, explore their capacity to fulfil their responsibilities to the child(ren). This is supported by a very good working relationship with the Multi-Agency Safeguarding Hub.

In challenging Addaction in this manner, the Board has been able to ensure that children and young people who are living with parents with drug or alcohol issues, or have such issues of their own, are correctly identified as being more likely to need early help as a result, and where necessary that those children and young people are given access to that help at the correct level and by the most appropriate agencies. It also gave the Board the opportunity to review its own hidden harm policy to ensure it supported and complemented the work of partner agencies.

During 2017/18 the Board will continue to seek assurance that Public Health as service commissioner receives suitable assurances from Addaction that children living with people who abuse substances are identified and safeguarded.

What we have learned and what difference we have made

From the Levels of Needs survey we now better understand the use of the Levels of Need by practitioners when they make a referral. We also now know that we need to raise the awareness of the Levels of Need document for practitioners within certain areas, for example within the Police.

During 2016 the HSCB Quality Assurance sub group conducted a multi-agency audit of six randomly selected early help cases which involved examining in detail how the cases had been dealt with by partner agencies.

This audit highlighted outstanding practice in some of the cases, for example excellent and sustained engagement from schools, good engagement with the family, stability in the membership of the team working with the family, and being able to provide the right service to families at the right time. It also highlighted some areas for development, for example better inclusion of fathers in the Common Assessment Framework process when appropriate, and use of a chronology in certain circumstances.

Through the multi-agency audit team examining these cases in detail, further opportunities were identified to help two of the children, and this help has now made a significant difference to them.

One of the families included within the audit was from the Traveller community. The audit highlighted that the expectations set for the family within their Common Assessment Framework discussions had not taken into account the conditions under which they were living. As a result of this finding, multi-agency awareness sessions were provided in order to raise the understanding of practitioners in Herefordshire of the Traveller community, with the intention of improving outcomes for children and young people from this community

What we will do next

As a result of the Levels of Need audit the Board via the Workforce Development sub group has ensured that sufficient emphasis is placed on their use within the various training courses provided. Board representatives have also been asked to reflect on how they can support increasing the knowledge and use of this document within their own agencies. The Board will also complete its review of the Levels of Need, and then promote awareness of those changes across the partnership.

The Board will be supporting the work of the Children and Young Person's Partnership in ensuring that the workforce is sufficiently prepared for the shift in emphasis towards early help by ensuring that HSCB training products promote understanding of the early help offer.

The HSCB Quality Assurance sub group will also be developing a set of assurance questions for use in assessing the effectiveness of the changes to early help arrangements and will be carrying out an audit of early help cases during 2017/18.

6. How the HSCB has carried out its statutory functions

LSCBs have a statutory responsibility to:

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

LSCB's also have a number of statutory functions to fulfil, and this section of the report provides details of work against those functions and the wider areas of safeguarding additional to the priority areas for 2017/19.

a. Policies, procedures, practice guidance updates

By far the most significant achievement for the HSCB Policies and Procedures sub group for 2016/17 is the successful implementation of the West Midlands Regional Safeguarding Procedures Project. The West Midlands Regional Safeguarding Children Procedures website was launched on the 01 April 2017.

Herefordshire Safeguarding Children Board has joined eight other safeguarding boards across the region to develop the regional procedures, procure a host platform for the procedures and collaboratively launch the project. The initiative has provided policy consistency across boards in the region, economies of scale (significantly reducing the cost of providing multi-agency procedures), and accessed regional expertise on policy development.

The HSCB Policies and Procedure sub group oversaw the development of the project from the Herefordshire perspective, providing Board governance and the sub group ratified several procedures to be adopted by the region.

The functionality of the web site allows professionals to access procedures on three levels. Level 1 procedures are those that are overarching child protection procedures, Level 2 procedures are those agreed at a regional level, and Level 3 procedures are area specific, including referral guidance, local levels of need, and named contacts.

The Regional Safeguarding Procedures Group (RSPG) continues to meet regularly with HSCB representation. RSPG has a rolling programme in place to refresh and update the West Midlands procedures.

Notable local Herefordshire policy developments during 2016/17 include the development and publication of the parental Substance Misuse, Hidden Harm and the Impact on Children and Young People, and the Suicide Prevention Pathway. Also on behalf of the region, the HSCB Policies and Procedures sub group has developed the regional policy and guidance on Sexually Active Children and Young People (including under age sexual activity).

b. Training

Multi-agency training

The Multi-Agency Workforce Strategy has been developed which determines the workforce development plans for all who work with and support children and young people at risk to ensure that they are skilled and competent. It includes learning from serious case reviews and changes to legislation. The updated workforce strategy also includes a validation process and competency framework.

Provider services / training providers are invited to apply to have their training programmes validated as meeting the requirements of the strategy and new competency framework. This new strategy and validation process has been developed to support the HSCB to fulfil its statutory functions under regulation 5:
"monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children". (WTSC 2015 page 67)

The new evaluation process has been established and used with learning events delivered on behalf of the HSCB. This will enable the sub group to measure if the learning events have made an impact on the knowledge and skills of the workforce to enable families to function effectively and ensure children's needs are met and they are supported to achieve their full potential.

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

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

Improving numbers attending the Joint Safeguarding Practitioner Forums is encouraging with the last 2 forums being booked to capacity. We have had 330 bookings and 236 practitioners attended over the 7 sessions this year who have represented 48 agencies. This forum programme included dissemination of learning from serious case reviews, informing practitioners about the work of the Board, Care Act and Making Safeguarding Personal. From each Practitioner Forum a Voice of the Practitioner report is developed and presented to HSCB Executive Group.

The specialist conference "Silent Victim" was held this year at The Kindle Centre on Oct 19th and was attended by 122 practitioners drawn from over 30 agencies based in Herefordshire. Evaluations from the event were positive, particularly for two presenters who were talking

from their own personal experience and the session highlighting the barriers faced by people from the minority communities.

The Training Pool was launched in June with over 30 people showing an interest in joining and supporting the group. A full programme of development activities was developed to support the trainers but unfortunately due to a very low uptake these were cancelled. A new approach to the Training Pool has now been agreed and for the coming year; subject matter expert will work with the HSCB training resource to develop the specialist training and agree the delivery programme. This will make best use of resources and provide opportunities to extend the training offer to meet the requirement of the new competency framework.

Numbers attending HSCB multi-agency training courses 2016-17

Course	Numbers
Targeted Working Together to Safeguard Children, 1 day	157
Targeted Working Together to Safeguard Children half day refresher	38
Targeted Course Understanding Neglect	40
Child Sexual Exploitation, half day	32
Child Protection Conferences	17
Domestic Abuse 3 day course	43
HSCB/HSAB Practitioner Forums	236
Serious Case Review Learning Event	48

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

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

The team responsible for managing private fostering arrangements have continued to work hard to increase the awareness of what constitutes private fostering and the need to notify such arrangements. This has included the production and circulation of leaflets, training to practitioners, regular communication with their colleagues in health, schools and other agencies, the use of social media and a quick guide on private fostering has been developed and is now available to staff. In July 2016 the HSCB Business Unit supported this by providing information about private fostering at a public event in High Town, Hereford.

In 2016/17 there were four private fostering arrangements notified to the Local Authority. Although this is a slight increase on last year’s figure, the number does still appear low, and demonstrates the need for awareness raising to continue in this area.

d. Children in care

Although the local authority has the lead responsibility for children in care, the HSCB take an active interest in the numbers of children in care in Herefordshire, how this compares with a statistic neighbours, and most importantly the quality of service that children and young people receive whilst in the care of the local authority.

Month	LAC Numbers
Apr-16	276
May-16	271
Jun-16	275
Jul-16	279
Aug-16	281
Sep-16	286
Oct-16	284
Nov-16	289
Dec-16	294
Jan-17	295
Feb-17	305
Mar-17	302

Figure 1

During 2016/17 there has been a steady increase in the number of looked after children (LAC) in Herefordshire (Figure 1). We know from regional in-year benchmarking and other additional analysis, that our number of looked after children per population is approximately 7% higher than other West Midlands authorities, 60% higher than our statistical neighbours and double that of those with similar levels of deprivation. The average number of new looked after children admitted to care each month has been reduced (from an average of 10.2 during 2015/16 to 8.8 during 2016/17), but there has also been a decrease in the rate at which children cease LAC resulting in an overall rise. Focus during 2017/18 will be on ensuring that where it is in the children's best interests there is a focus upon rehabilitation to home or moving into Special Guardianship Orders to reduce the number of looked after children whilst maintaining the threshold for admission to care.

The Board received an annual report on Corporate Parenting from the Head of Looked After Children, which detailed the ongoing areas of safeguarding in relation to looked after children, and activity to ensure children are being kept safe. Looked after children who enjoy stability in placements are more likely to do well at school, and are less likely to misuse alcohol and drugs, or fall victim to exploitation. The Board were therefore encouraged to hear that only 3.5% of looked after children had been in 3 or more placements in the last 12 months. This is well below the regional (10.9%) and national (10%) average.
During the 12 month period October 2015 to October 2016 there were a total of 106 missing episodes recorded which related to Herefordshire looked after children. Of these, 67 return

from missing interviews were completed for Herefordshire's looked after children. All children are now offered a return interview. The direct work service has been responsible for completing all return from missing interviews and analysis from these interviews is shared with the operational child sexual exploitation and missing group.

The HSCB's CSE and Missing sub group has continued to monitor and support this work, including the development of recording practices for children placed out of Herefordshire who go missing. Further, the work of the Board on producing a high quality risk assessment tool and practitioner guidance, and the forthcoming introduction of standard agendas and guidance for Risk Management Meetings contributes to better outcomes for looked after children who do go missing and/or are at risk of CSE as the understanding of the specific risks they face, and the planning to reduce those risks is robust.

The Board was also updated as to the number of looked after children who are engaged with the Youth Offending Service. It has been agreed that the Youth Offending Service will complete a more detailed analysis of offending within this small group so that an understanding of how a child's care status and offending behaviour are linked. The Board will take a particular interest in this work as the 'Children living with Domestic Abuse' audit also showed a strong correlation between the perpetrators and their being previously involved with the Youth Offending Service.
The Children in Care Council has once again been very active in making sure that children and young people's voices are heard in relation to the services they receive, and the work of this group has taken a number of forms.

A young person in Local Authority care was given the opportunity to chair their own Looked After Child Review meetings. This came about after the point was made by one young person that they did not feel listened to, especially not in LAC Reviews. The feedback from this initiative has been very positive;

"My Social Worker asked me if I wanted to chair my own Looked After Child Review. I did not know what this meant. My social worker is really supportive so she helped me to understand what I would need to do and what I did not need to do if I did not want to. The bit my social worker did which was the best was; she gave me a list to remind me what I wanted to talk about."

So then I chaired my own Looked After Child Review and it made me really happy! I felt in control of my life, I felt really powerful – you should all definitely give it a go! Be in charge of your life."

As a result of this the Children in Care Council are arranged to hold 'U Chair' training to help children and young people in Herefordshire to understand their rights and get involved.

Finally, the hard work and commitment of all those involved with these children and young people is very clear from the feedback they have received;

We want the world to know that we are….listened to!!!!

You listen to us and make sure what we say makes a difference……

"Thank you to Foster Carers for getting back to us, thank you for giving us information and making changes."

"Thank you Michelle Baxter for letting us know the information we gave you will be part of your finance policy and you will give us more information soon. But thank you for also letting us know that there will be changes to the support 16+ give."

"Thank you to Gill for coming to introduce herself and asking what we think."

"Thank you for letting us have a say in who we employ – sometimes we find it hard when we really like someone who you don't think is good enough. But we understand that you want the best for Herefordshire."

"Thank you Hilary Jones for funding our new laptops – we finally have them and they are great. We have already drawn loads of picture on them."

"We met some Cllrs at bowling and they listened to how we are interested in politics and how we would like for them to come to some of our meetings."

During 2016/17 the Corporate Parenting Strategy has been reviewed and the Board has taken part in the consultation process. In 2017/18 the Board will be conducting a case file audit of safeguarding arrangements for looked after children in Herefordshire, and using the findings of that to further enhance the safeguarding of this vulnerable group of children and young people.

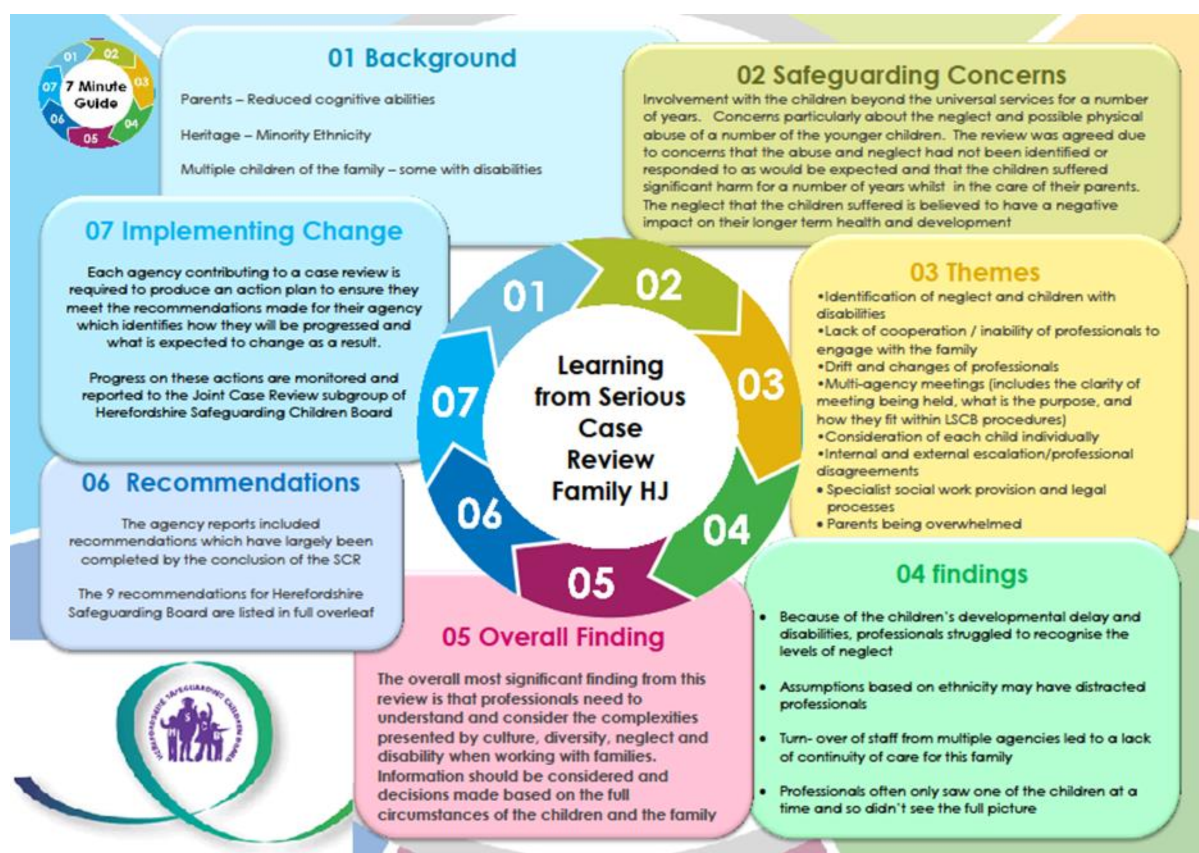
e. Case reviews

The Joint Case Review sub group provides oversight to the commissioning and ongoing management of Serious Case Reviews, and other types of multi-agency reviews. LSCB's are required to undertake reviews of serious cases to determine and communicate lessons to be learned in order to improve practice. It makes recommendations to the HSCB Independent

Chair on whether referred cases meet the criteria for a Serious Case Review or other type of review.

The HSCB published one Serious Case Review in 2016 (Family HJ), involving a minority ethnicity family with multiple children, some with significant disabilities. The review was agreed due to concerns that abuse and neglect had not been identified or responded to as would be expected and that the children suffered significant harm for a number of years whilst in the care of their parents. A number of recommendations were made focusing on culturally competent practice, dealing with more complex parenting circumstances and risk management. The most significant finding from this review was that professionals need to understand and consider the complexities presented by culture, diversity, neglect and disability when working with families. Information should be considered and decisions made based on the full circumstances of the children and the family. An action plan was developed and its progress is monitored regularly at the JCR sub group and reported to the Board.

Learning from the review has been delivered at multi-agency learning events and a practitioner forum in order to share the key lessons with practitioners. Further sessions will be held at the Designated Safeguarding Leads meetings. The HSCB also produced a “7 Minute Learning” guide, disseminated at the learning sessions and available on our website, which quickly identifies the key findings of the review. This type of learning guide is new to Herefordshire and was developed for use with this Serious Case Review, however as a tool to help promote learning it has received very positive feedback and the Board are keen to use it whenever appropriate in the future.



A Practice Learning Review (PLR) was also carried out in 2016/17. This is a new type of review for Herefordshire intended for cases that do not meet the criteria for a Serious Case Review, but where there is significant multi-agency learning to be gained.

This case considered a ‘peer on peer’ sexual assault, which was initially recorded as consensual. However, this was followed by a further allegation and conviction of a serious sexual assault of a much younger child whilst the young person was granted bail. The overriding theme from the PLR was that there was too much focus on the young person as a child with limited assessment of the risk that he posed as a sexual offender to other children. There were significant gaps in assessments and limited information sharing. Where information was shared, there was an assumption of action that was not clearly followed up to confirm it.

Discussions at the PLR evidenced that learning points had already been noted by participant agencies and that changes were being made to practice. An action plan was compiled and its progress is being regularly monitored by the JCR sub group.

The recommendations from this PLR included:

1. In cases where a child poses a risk to others, Children’s Social Care to consider a process to assess Parent’s/Guardian’s ability to monitor and protect, as well as assess the risk a child presents, and any new information should trigger a re-assessment

Action: The child and family single assessment was introduced in the autumn 2016 and training provided to all social workers to complement its implementation.

2. Consideration needs to be given to how Police and Social Care can liaise to discuss the setting of bail conditions and the ongoing management of the individual to protect the public from further offending.

Action: Inter-agency communication in the MASH has developed since December 2016 and effective practice is embedded re discussions about the appropriate setting of bail conditions.

3. Examine the current process for monitoring and oversight of complex cases to ensure information sharing is co-ordinated and appropriate.

Action: The complex abuse procedure has been recently reviewed in light of a separate, current complex investigation and this is operating effectively.

4. Explore the possibility of providing a specialist resource for such cases.

Action: The Youth Offending Service has developed an in-house resource for direct work in youth justice cases.

JCR sub group has also considered the learning/themes from national serious case reviews and, as a consequence, HSCB held a case study session as part of a “Learning from Case Reviews” Practitioner Forum on Gloucestershire’s SCR “Lucy”.

A further 2 PLR's have recently been commissioned by the JCR sub group. These will commence shortly and be reported on in the 2017-18 Annual Report.

The first of these was put forward to the JCR as there were concerns around the likelihood of severe neglect of a child's developmental needs, which ended in the child being permanently removed from the parents care.

The second was put forward regarding concern that a child with disabilities experienced avoidable neglect and harm over a period of time that was unnecessarily long whilst remaining in the care of parents who were unable to meet the needs of the child.

Although neither of these cases met the threshold for a Serious Case Review, it was felt that there were learnings for agencies on how to effectively work together.
During 2016/17 HSCB worked with Herefordshire Safeguarding Adult Board to review the effectiveness of the Joint Case Review sub group which was considering both child and adult referrals. This review highlighted the separating of the chairing responsibilities in respect of the business agenda for children and adult JCR held advantages, the demand on a single chair and the need for a clear definition between the adult and child processes and decision making were apparent.

It was also recognised that it would be beneficial for the chair of the adult section of the meeting to be a current Safeguarding Adult Board member with a strong knowledge of adult safeguarding.

As a result of this review the HSCB once again has a separate Case Review sub group, albeit running consecutively with the Adult's Board equivalent.

f. The Child Death Overview Panel (CDOP)

Chapter 5 of Working Together to Safeguard Children sets out the responsibilities of the Local Safeguarding Children Board "for ensuring that a review of each death of a child normally resident in the LSCB area is undertaken by a CDOP". The CDOP has a fixed core membership drawn from organisations represented on HSCB.
A total of 11 deaths occurred within the review period April 2016- March 2017, three of which are still awaiting completion of review.
There were 14 deaths signed off at the CDOP meetings within this review period, and these are the focus of the Annual Return to the Department of Education for Herefordshire. Of these 14 deaths, 9 of the reviews were completed in under 6 months, 3 in 6-7 months, with 2 taking between 8-9 months.
The issue of delayed submission of some of the statutory form B's needed from agencies to enable the CDOP to complete the review has improved this year, however this continues to be monitored by the Business Unit and the Child Death Review meetings which take place in between the formal quarterly meetings.
Of the 14 deaths, 3 were reported as having modifiable factors.

CDOP considered the learning and actions arising from these, which have included:

- If women have had recent tests prior to review, these should be accessed and seen by maternity and obstetric staff. A review of medical notes at any assessment to gain information related to patient. A 10 point plan for triage has been put in practice.
Learning has been disseminated across Obstetric Services through a safety brief and all Risk and Governance meetings, Perinatal and Morbidity and Mortality Meetings.
- Research into similar accidental deaths investigated within the regional CDOP's and by Police. Advice and guidance shared and discussed at CDOP.
- Recommendations for patients to refer to PAUSE. Pause works with women who have experienced, or are at risk of, repeat removals of children from their care. Through an intense programme of support, it aims to break this cycle and give women the opportunity to reflect, tackle destructive patterns of behaviour, and to develop new skills and responses that can help them create a more positive future.

There were no serious case review referrals made from CDOP during the year.
The Child Death Overview Panel provides an Annual Report to HSCB which contains more detailed information.

g. Communication

The Board shares a Joint Communications sub group with the Safeguarding Adult Board and Community Safety Partnership. The purpose of this sub group is to ensure that all safeguarding communications across the partnerships are as coordinated and effective as possible. The sub group is aware of the Board's priority areas and looks to ensure these are captured in communications. Importantly the group also share what each agency is doing on communications about particular topics so we can be more informed and coordinated about messages given to partners and the community. To develop this co-ordination further, the sub group is now working closely with the One Herefordshire Strategic Communication and Engagement Group which is a forum led by the Herefordshire Clinical Commissioning Group.

During the year we have contacted parish magazines and requested that they include the following information within their publications. Whilst we cannot insist that they comply with this request we have had confirmation from most that it has been included.

Herefordshire Safeguarding Boards

Everyone has a responsibility for safeguarding children, young people and adults at risk of harm. We can help you make sure you know what to do if you think that is happening.
It might be difficult to accept, but anyone can be hurt, put at risk of harm or abused, regardless of their age, gender, religion or ethnicity by either someone they know or a stranger.

If you are concerned about an adult ring 01432 260715 (weekdays 9-5) OR
0330 123 9309 (at any other time)

If you are concerned about a child ring 01432 260800

If someone is injured or in immediate danger dial 999
If there is no emergency but you think a crime may have been committed ring West Mercia Police on 0300 333 3000 or 101
Abuse of any description is wrong and by reporting it you can help to bring it to an end
If, as a member of the public or an organisation, you want more information about the work that the Safeguarding Boards do to keep children and adults that live and work in Herefordshire safe than please contact us on 01432 260100

h. Allegations concerning persons who work with children

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

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

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

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

For 2016/17, 140 allegations against professionals were managed by the LADO, compared to 117 in 2015/16. The average number for the seven year period is 137, with 140 - 159 being the usual range for Herefordshire. The increase in referrals meeting the criteria this year compared to a decline over the previous 3 years may not be statistically significant, but could partially be attributed to an increased awareness of LADO procedures in 2016/17 following the rollout of LADO awareness sessions and the promotion of LADO procedures through the LADO Quick Guide.

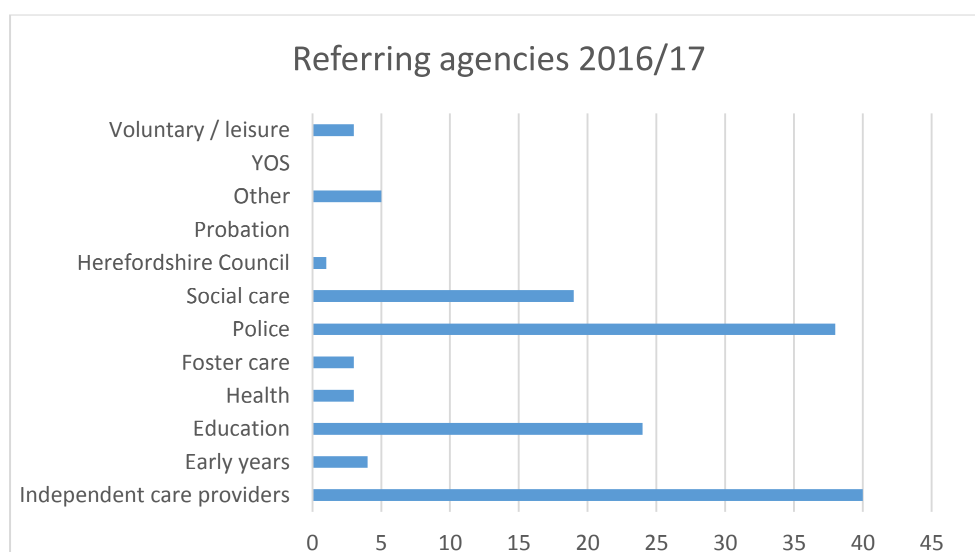
Working Together 2015 sets the expectation that 80% of cases should be resolved within one month of referral, 90% within three months and all but the most exceptional cases within twelve months (measured as number of days from referral to case closure). It was recognised that in 2015/16 performance in relation to the timely progression and resolution of LADO referrals needed to improve, with only 25% of cases resolved within one month, 58% within three months and 42% of cases remaining open for more than three months during that year.

The data for 2016/17 shows that there has been significant improvement in performance:

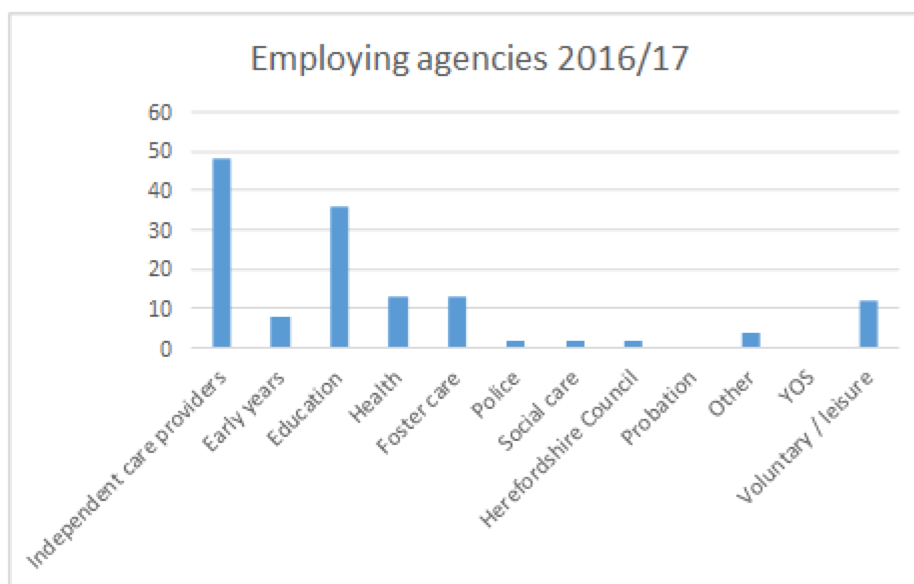
73% of cases have been resolved within one month of referral
90% of cases have been resolve within three months of referral

As at 31st March 2016, 10 cases remained open awaiting the outcome of criminal proceedings or complex employee disciplinary proceedings.

The graph below shows referring agencies to the LADO for 2016/17



The graph below shows the employing agency 2016/17



Education, Police, Childrens Social Care and Independent Care Providers continue make most LADO referrals. There has been an increase in LADO referrals from the police this year. This is a positive indication that the changes in police operational deployment have not had the potential negative impact on referrals that was referred to in last year's report.

Referrals from independent care providers have increased from last year. This increase is not due to inappropriate referrals. The outcome data shows that this sector has the highest proportion of substantiated allegations of any employment sector. LADO awareness training with this sector and the introduction of quarterly Residential Care Manager's forums have led to improved levels of communication and liaison with the LADO.

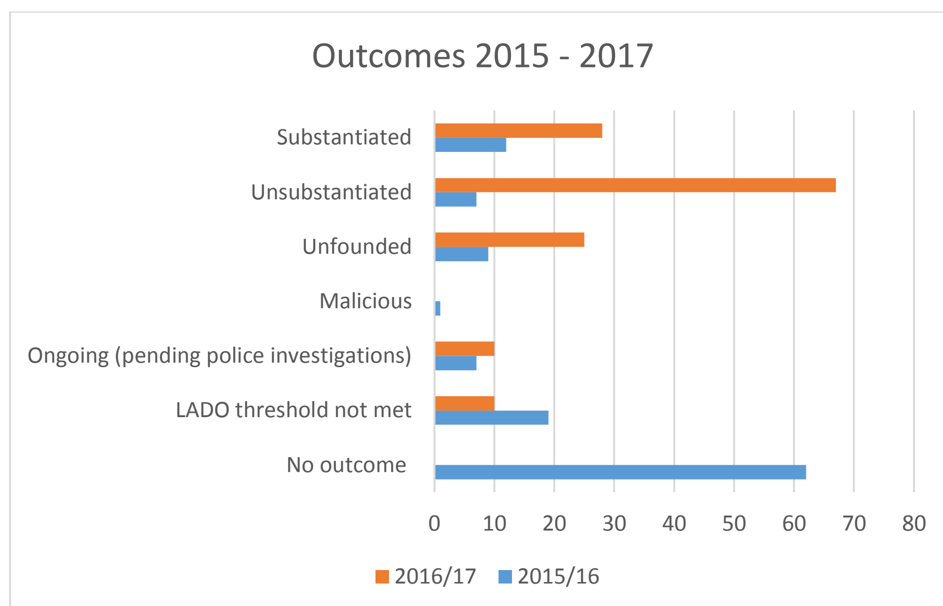
Childrens Social Care have not significantly changed in the number of referrals they have made over the past two years. The level of contact indicates a good understanding of procedures and a willingness to contact the LADO for discussion. Referral rates are still comparatively low however and continued awareness raising is required.

Youth offending services (YOS) were highlighted in last year's report for not having made any referrals or having an employee who is the subject of a referral. However, following the LADO delivering a session on LADO procedures to YOS staff, a referral was made, and there are also reported to have been referrals made to Worcestershire LADO from this service in recent years, due to the YOS cross-county working arrangements.

Referrals from Fostering have reduced by two thirds from 2015/16 to 2016/17. This has been explored with the service and is not due to a lack of LADO awareness among staff, evidenced by the referrals that have been made which demonstrate a good understanding of the procedures. This referral and consultation rate will continue to be monitored.

Health referrals have reduced this year and remain proportionately low given the size of the workforce. The Board will continue to monitor referral rates from this sector.

The graph below shows comparative outcomes of referrals 2015/2017



When the data is compared it highlights a disproportionate increase in the number of unsubstantiated allegations against professionals working for independent care providers. This is due to all allegations now having a recorded outcome. The percentage of cases that resulted in a substantiated allegation has not changed when the increase in referral numbers 2015/16-2017 is factored in.

Review of LADO activity 2016/17

The LADO annual report 2015/16 proposed priorities and plans for the year as follows:

- Further develop internal recording processes and practice in relation to advice and consultation; recording of categories of harm and referral outcomes; and progression and timeliness of individual cases.

Internal recording processes now capture data on advice and consultation, overall referral rates including referrals that did meet the LADO criteria, outcomes and categories of harm.

- Improve the timeliness of referrals being progressed and resolved, in line with Working Together guidelines, through a more robust chasing of investigation outcomes with employers and a monitoring tracker.

The timeliness of referral outcomes is now in line with Working Together guidelines.

- LADO awareness raising through briefings to key teams in social care and partner agencies, including the independent care sector and the police, and other agencies where referral rates indicate that this is required.

Awareness of LADO procedures has been raised this year through a new LADO Quick Guide which provides key information on the LADO criteria and referral process, new LADO training material has been incorporated into the HSCB Initial Multi-Agency Safeguarding Course, and the LADO has delivered extensive training and awareness sessions across the partnership.

Priorities for 2017/18 include:

- Make further improvements to the electronic recording system.
- Develop an information and advice leaflet for professionals who have allegations made against them.
- Continue to raise awareness of the role of the LADO and the importance of referring concerns.
- Develop a risk assessment template to help with decision making when a professional has had an allegation made against them.
- Revise LADO procedures to include a clear criteria for when an allegations management meeting should be held.

Board members will be supporting these priorities by continuing to promote knowledge of the LADO role and processes within their organisations, and the need for timely progression of individual cases.

7. Effectiveness of agency safeguarding arrangements in Herefordshire

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

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

Quality Assurance 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 quarterly;
- Produce thematic scorecards for each of the Board's priorities to inform and complement audit activity;
- Multi-agency case audits based on board priorities or emerging trends and themes as identified by the group;

- 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;
- Co-ordination and analysis of the statutory 'section 11' audit of single agency contributions to safeguarding children.

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

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

In the coming year the group will work within the five board priorities, but with the ability to look at other themes and issues if deemed appropriate, an example of which was the recent paper on youth homelessness. There will be a quarterly balanced scorecard for each thematic audit.

Section 11 audit

The HSCB conducted a full Section 11 audit with partners in 2015/16, and the next audit is due in 2017/18. As such there has been no full audit conducted this year, however a panel of members of the Herefordshire Safeguarding Children Board invited partners to present on how they had addressed areas for development identified within their own Section 11 audits.

The Board has during this period also been actively working with our local boards across the West Midlands Region to develop a standardised regional Section 11 audit tool, which will be trialled in Herefordshire in October 2017.

Single Agency Assurance Reporting

Throughout the year the Board receive assurance reports from the various agencies that have safeguarding responsibilities within Herefordshire. This helps the Board to assure itself of the effectiveness of single agency arrangements, and also provides partners on the Board with an opportunity to identify emerging themes, and where appropriate challenge the work of that agency. Some of the highlights from these reports are set out below.

In July 2016 **West Mercia Police** increased both the number of specialist Child Abuse Investigators and the coverage they provide. Detectives trained in specialist child abuse investigation moved to seven day working, and with availability from 0800hrs to 2300hrs. This means that children and young people who report serious cases of abuse receive a response from an appropriately qualified investigator, so ensuring the child gets the best possible response at the earliest point.

Where children are involved in the life of an offender, The **National Probation Service (NPS)** make sure that any necessary actions required to keep the child safe are included in the offender's risk management plan. Child safeguarding issues are addressed directly with offenders in supervision sessions, and child safeguarding is also reinforced by programme facilitators where the offender is participating in domestic violence or sex offender group

work programmes. These measures place the child firmly at the centre of the planning done by the NPS to manage offenders' behaviour.

The Warwickshire and West Mercia Community Rehabilitation Company (WWM CRC) has undergone significant changes since the Transforming Rehabilitation Programme in June 2015. During these changes however, the WWM CRC has been able to retain its commitment to safeguarding children. All of its staff are appropriately trained in safeguarding children. The WWM CRC also actively audit cases to identify where safeguarding can be improved, this for example has highlighted that where a children's services check is returned that has different information to that in the previously completed risk assessment, a review should be completed by the offender manager. This ensures that the child involved is kept at the centre of the risk assessment process, and professionals are regularly considering their safety, so problems or concerns can be tackled sooner. Earlier intervention gives the best possible opportunity to prevent children and young people coming to significant harm.

Within the Health sector, all of the organisations involved have very strong safeguarding training programmes for their staff, which are closely monitored. This means that children and young people who have contact with health services in Herefordshire and are in need of safeguarding have the best possible chance of having their needs recognised and responded to in the correct manner. Within the Child and Adolescent Mental Health Service, safeguarding supervision is included as an agenda item for all team meetings and for individual operational/professional supervision. This is particularly reassuring as the work of the Board's CSE and Missing sub group has highlighted how vulnerable to exploitation children and young people with mental health problems are.

In June 2014 the **Wye Valley NHS Trust** (WVT) received a rating of 'inadequate' following a Care Quality Commission (CQC) inspection. Since this time significant improvements have been made, and in July 2016 a follow up inspection rated "Are Services Safe?" as 'good', so reflecting the hard work of all involved. The inspectors found that staff across the trust had an understanding of their roles and responsibilities and the types of concerns that may indicate that a child safeguarding referral was required. They understood the referral process and knew how to make referrals. The work of the Young Ambassador group was acknowledged as excellent , noting their input into service re-design and the current project of involvement in the making a film on transitional care for national distribution. The inspectors found that staff listened to and respected their opinions and that they saw the services provided "through the eyes of the children and young people". It is reassuring that within Herefordshire young people are getting the opportunity to influence so directly the development of services that are there for them.

Within Education, the tracking of children missing from education has been increasingly successful, meaning less children are at risk of being out of contact with agencies who can recognise when support or safeguarding is needed.

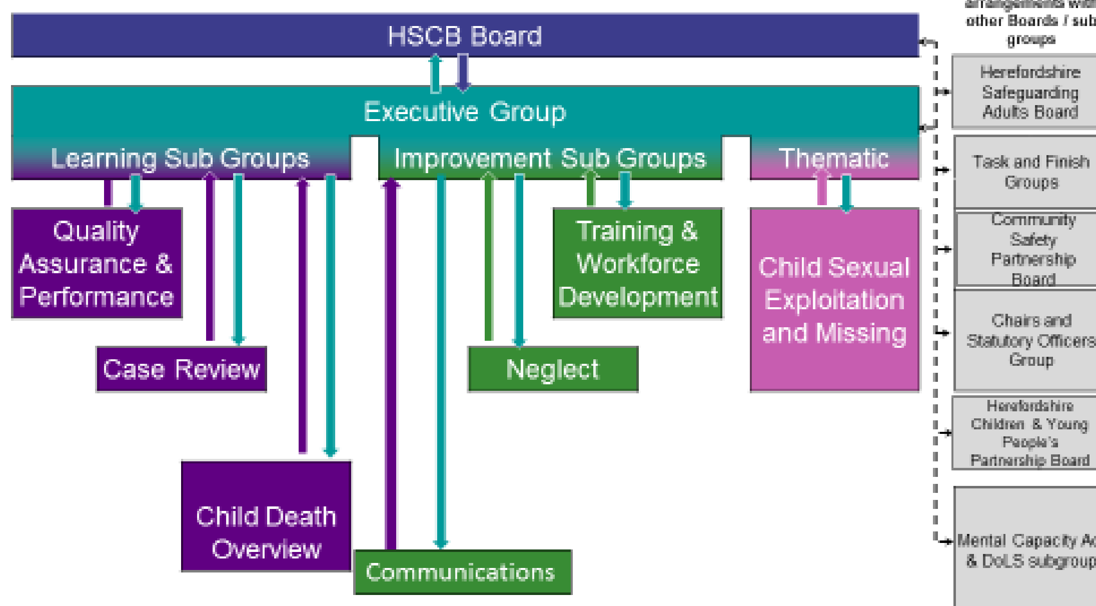
8. Development of HSCB and its effectiveness 2016-17

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

The Board also works with other multi-agency partnerships across Herefordshire to both scrutinise and challenge their activities and to pursue joint objectives. The forum that was established in 2015 to bring together the Chairs of the two safeguarding boards (adults and children), the Health and Well Being Board, the Children and Young Peoples Partnership and the Community Safety Partnership, has continued to develop and as the Safeguarding Chairs and Statutory Officer's Group now meets quarterly to discuss cross cutting matters for the various partnership boards and importantly make joint decisions on such matters as ownership and responsibility for emerging safeguarding concerns within Herefordshire. A recent example of this is the use of this forum to discuss and decide where responsibility for addressing the risks of human trafficking and forced marriage should sit (Community Safety Partnership delivery groups), with safeguarding boards continuing to assure themselves of the effectiveness of that response.

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

HSCB Structure and Governance Chart
April 2017



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

Overall engagement by partners in the work of the HSCB has continued to be positive throughout 2016-17. Member reviews with the Independent Chair have ensured that agency representatives understand their role and responsibilities as Board members. There have been occasions through this period when sub groups have not been quorate, however these have been reported to the HSCB Executive when they have occurred, and addressed within that group. There have been particular challenges within the Joint Communications sub group, primarily due to changes in partners' communications team arrangements and the wide demands on this relatively small group of practitioners. To address this, the HSCB has worked with the Safeguarding Adult Board and the One Herefordshire Strategic Communication and Engagement Group, which is a separate communications group within the county but with similar attendance and partnership coverage to align the work of the two sub groups to reduce the impact on partnership resources, whilst strengthening joint working and expanding the opportunity to share safeguarding information.

Towards the end of 2015/16 the Board also reviewed the effectiveness of its Executive Group arrangements, and as a result of this streamlined this group to consist primarily of the sub group chairs, with partners being invited to attend to address specific topic. The Board has continued to use this arrangement throughout 2016/17 and this has helped the Board to conduct its business more efficiently, and is now making best use of partners' valuable time.

HSCB has continued to benefit from a joint Business Unit arrangement, which is now in its second year. As well as supporting the HSCB, this unit also supports the Safeguarding Adults Board and the Community Safety Partnership. This is jointly funded by partners, and details of the budget, contributions and expenditure are included in **appendix 2.**

The Unit consists of:

- Business Unit Manager
- Learning and Development Officers X 3
- Business Support Coordinator X 3

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

The Business Unit is also supported by a commissioned training resource, but in order to make best use of the funding available, has now reduced that support by returning the administration of the on line training provision to the Business Support Coordinators.

Although one of our lay members decided to step down from the Board during the year, the Board has continued to receive excellent support from the remaining lay member, who regularly attends the meetings, has been involved in our work to develop a more effective approach to ensuring the Board's work is informed by children's views, and has also taken part in the reviews of the Section 11 audits and how agencies have developed the safeguarding arrangements as a result of those.

Illustrations of HSCB challenge and impact

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

Challenge	Impact
Report of very low numbers of young people in 'staying put' placement at age 18+ in Herefordshire.	Reassurance report received from Director of Children's Services clarifying the number of young people using such arrangements and demonstrating appropriate provision and take-up within the county, so ensuring young people have the opportunity to choose to 'stay put' should they wish to do so.
A number of agencies were written to by the Chair challenging their lack of regular attendance at Board meetings.	Regular attendance now secured from those agencies. This ensures the Board makes decisions with full information available, so ensuring those decisions are likely to have the best possible impact on safeguarding children and young people.
Continued difficulty in obtaining Form B responses to child deaths in a timely fashion from several agencies.	The SUDIC pediatrician and the Chair of CDOP have written and spoken to professionals. The CDOP has considered the learning from this and have recommended the following: • Professionals are made aware of their role through the development of a pathway which is on the LSCB website. • A good practice guide and sample is posted on the web to assist with understanding. • The Director of Children Services, as the accountable officer has been alerted to take the appropriate action. • A communication item on the CDOP agenda to agree dissemination of learning, with responsibility for this to the HSCB Communications Sub Group. In securing more timely submission of information, opportunities to prevent SUDIC can be taken soonest, so improving the safeguarding of children.
Challenge to Addaction on lack of provision and suitable premises for young people, and safeguarding of children/young people in care of service users.	Children and young people who are living with parents with drug or alcohol issues, or have such issues of their own, are correctly identified as being more likely to need early help as a result, and where necessary those

	children and young people are given access to that help at the correct level and by the most appropriate agencies.
Improving the response to victims of 'peer on peer' abuse.	HSCB has taken the lead for reviewing the regional 'Children who abuse others' procedure, ensuring the new procedure is developed with input from all relevant agencies. This will ensure children and young people who are victims of abuse by their peers are better protected through a more robust response by professionals.
In relation to CSE/Missing Children, members of the executive questioned the availability of guidance for Risk Management meetings. The executive also explored whether the Risk Management meetings are subject to quality assurance.	Children's Social Care now have a Risk Management Practice Guidance, along with Risk Management Meeting Guidance and Agenda, which now sit within the suite of CSE procedures. This ensures children and young people who may be at risk of CSE are correctly identified and interventions that will most effectively protect them are agreed by partners, and implemented.

9. Conclusion and future priorities

As a result of the work undertaken by the Board during 2016/17 we now have a much stronger understanding of the profile of CSE in Herefordshire. We have up to date tools and pathways to deal with reports of CSE, and have improved the quality of awareness and training to multi-agency partners on how to recognise and address the threat of CSE. In the coming year the Board will be focusing on assuring itself of the effectiveness of risk management planning in relation to individual children and young people at risk of CSE, and the support services available to victims of CSE. This will be achieved in a number of ways, including the delivery of the revised strategy and action plan, with audit activity to check that this has the impact intended on services. The Board also recognises that there is a relatively high rate of recording of sexual crimes against children in Herefordshire, and we need to understand why that is and how such offending can be better prevented. The Board will be supporting the Herefordshire Community Safety Partnership in achieving this.

Board members have made an active contribution to further developing the quality of child protection conferences in Herefordshire, and work will continue to ensure those developments are well embedded. Audit work has shown that within the child protection system there is high quality direct work taking place which clearly leads to improved outcomes for children and their families, including the child's voice being clearly evident, and the demonstration of good communication across agencies. There is strong evidence of statutory child protection meetings being well attended and resulting responses and actions

being timely. That said, the Board remains cognisant of the need to ensure continued focus on the quality of supervision of practitioners and continuity of staff within agencies as a vital part of effective safeguarding procedures.

Tackling childhood neglect will remain a key priority for the Board during the coming year. Although progress has been made during 2016/17, it is clear that real and sustainable change across the partnership in how neglect is identified and responded to must be achieved. As such the Board will be investing considerable resources in introducing new ways of working, and providing practitioners with the skills to take full advantage of those.

The Board has continued to work towards ensuring that the Levels of Need supports the development of early help within Herefordshire. The coming year will see the further development of those services, and it is important that the Board supports that work and the work of the Children and Young Person's Partnership in ensuring that the workforce is sufficiently prepared for the shift of emphasis towards early help.

Reflecting on the achievements of the Board through 2016-2017, and using a range of sources of information which have included inspections, self-assessments, learning from reviews and consultation with our partners in Herefordshire highlighting areas where development is required, the Board has set five priorities for 2017 – 2019. These are;

Priority 1: Neglect.

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

Priority 3: Safeguarding Vulnerable Children.

Priority 4: Early Help.

Priority 5: Strong Leadership, strong partnership.

Priority five has been added as the Board recognises that as recent legislative changes create opportunities for a review of safeguarding structures, must continue to deliver strong leadership and retain strong partnership working to ensure the best possible arrangements remain in place to safeguard children and young people.

These priorities also reflect those of the Health and Wellbeing Board (Priority 3 addresses the importance of keeping children safe), and the Children and Young People's Partnership. Priority 4 of the Children and Young People's Plan is "Children and young people in need of safeguarding", and includes expectations in relation to effective early intervention, identifying children at risk of sexual exploitation, a reduction in the number of children subject of a child protection plan and looked after, and support for children with enduring needs particularly in relation to transition in to adult life. Early help is also a key priority within the Children and Young People's Plan. In addition Priority 2 supports the Herefordshire Community Safety Partnership priority of 'Reducing sexual crimes against children'.

The full Children and Young Peoples Plan can be found here.

Version 1 (Draft)

It is the intention of the Board during the coming year to concentrate on these and other areas where we can make a real difference to the safety and development of children and young people in Herefordshire by promoting and ensuring efficient and effective practice.

The actions against each of the priorities in the plan below have been identified following a recent review of our progress during the past twelve months, and are designed to deliver the improvements as set out above. Further, all contribute to achieving our vision, and fulfilling our statutory responsibilities of the board to coordinate and ensure the effectiveness of safeguarding arrangements in Herefordshire.

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

		understanding of CSE toolkit within agencies in Herefordshire. 2.7. Reviewing the 'Children who abuse others' procedure and ensuring appropriate guidance is available to practitioners within Herefordshire. 2.8. Checking the effectiveness of the response to previous CSE audit findings, the quality and availability of post abuse support to victims of CSE and the quality of intelligence relating to CSE, and the effectiveness of its sharing and use.
3. Safeguarding vulnerable children.	Vulnerable children are identified and safeguarded, and their wellbeing promoted.	3.1. Maintaining up to date LSCB procedures that align with regional arrangements and statutory guidance to inform the journey of the child through the child protection process. 3.2. Developing the focus on 'hidden harm' and the increased risk to children with disabilities within multi-agency training. 3.3. Using multi-agency performance data to ensure the effectiveness of local safeguarding practice, specifically the application of LSCB thresholds, and the quality of child protection plans. 3.4. Ensuring learning from SCR's and PLR's is appropriately used to improve the journey of the child through the child protection process. 3.5. Securing feedback from children and young people who are subject to a child protection plan or who are looked after, to understand the effectiveness of the local safeguarding system.
4. Early Help	Children and their families receive effective help at the right time which promotes their wellbeing.	4.1. Ensuring LSCB procedures address the impact 'hidden harm' has on children and young people, for example children living with substance misuse and domestic abuse within the family. 4.2. Assessing the impact of threshold decisions on those children who are not stepped up to higher levels of intervention. 4.3. Ensuring that the HSCB procedures support the early help strategy. 4.4. Evaluating the availability and effectiveness of early help support, particularly in relation to children living with neglect and domestic abuse, and children with disabilities. 4.5. Working with the Children and Young Person's Partnership to ensure LSCB training products promote understanding of the early help offer with practitioners, to include overhaul of working together

		training sessions, and use of evaluation process to monitor effectiveness. 4.6. Assessing the quality, effectiveness and availability of early help support and interventions in relation to those families where childhood neglect is a risk or present. 4.7. Securing feedback from children, young people and their parents/carers about their experience of accessing and receiving early help (including Families First).
5. Strong leadership, strong partnership.	HSCB leads the safeguarding agenda, challenges the safeguarding work of partner organisations, and commits to an approach that learns lessons and embeds good practice. The partnership has effective plans in place for maintaining the effectiveness of safeguarding in the future.	5.1. working with partners to deliver successfully against the Business Plan and associated work plans set for HSCB and its subgroups / working groups 5.2. continuing to strengthen the governance interface between HSCB and other key strategic forums 5.3. communicating and raising awareness about safeguarding to individuals, organisations and communities 5.4. maintaining HSCB's Learning & Improvement Framework, facilitating, promoting and embedding learning from evidenced based practice, including SCRs and local learning reviews, and assessing impact of learning activity 5.5. scrutinising and challenging the individual and collective performance of partner organisations in safeguarding and improving outcomes for children, particularly those who are most vulnerable 5.6. engaging with children, young people and families to capture their views and experiences, influence the partnership's work and evaluate the impact of partner activity on their outcomes 5.7. engaging with practitioners to ensure they are supported to work effectively with children and their families.

The HSCB will continue to seek assurance from partners of improving services and positive outcomes for children through audits, review and reporting.

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

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

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

Safeguarding area
Looked after children
Female genital mutilation (FGM)
Prevention of radicalization and extremism
Health Services assurance reporting
Public Protection assurance reporting
Education assurance reporting
Child Death Reviews
Serious Case Reviews and other case reviews that the Board have identified should take place
Private Fostering
Adult Factors that impact upon the safety and wellbeing of children

Appendix 1

Attendance of agencies at HSCB Board meetings 2016-17*

Agency/ person	Board meeting 25/4/16	Board meeting 25/7/16	Board meeting 17/10/16	Board meeting 25/1/17
Independent Chair	✓	✓		✓
Lay Member 1	✓	✓	✓	✓
Lay Member 2	✓	✓		
HC Children's Wellbeing	✓	✓	✓	✓
HC Adult Safeguarding			✓	
2Gether NHS Trust	✓	✓	✓	✓
Wye Valley Trust (WVT)	✓	✓	✓	✓
Clinical commissioning Group (CCG)	✓	✓	✓	✓
National Probation Service	✓		✓	✓
Youth Offending Service / Youth Justice Service	✓	✓	✓	✓
Community Rehabilitation Company (CRC)			✓	✓
West Mercia Police	✓	✓	✓	✓
CAFCASS	✓			
Lead Member Children's Well Being	✓	✓		
Education representative	✓	✓	✓	✓
Voluntary and community representative	✓	✓		

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

Appendix 2

Partnership Boards budget*

AGREED BUDGET FOR 2016/17	
Children's Wellbeing	130,017
Adults Wellbeing	103,000
Other Council Dept	7,365
CCG	80,190
Police	53,510
Probation	6,136
CAFCASS	550
YOS	1,144
TOTAL GROSS BUDGET	**374,547**

FINAL 2016-17 EXPENDITURE STATEMENT		
Category	**Spend**	**Notes and comments**
Salary Costs	**242,116**	
Agency staff costs	**37,195**	Costs of Serious Case Review chair included within this.
Transport costs	**673**	
Independent chair costs	**36,960**	
Serious Case Review costs	**1,111**	
Training expenses	**27,675**	
Office expenses	**58,474**	Includes end of year recharges for council back office services of £32,000
Training income	**-3,455**	
Additional income	**-33,700**	Funding from CCG for MCA training and tools + PCC income
TOTAL	**367,048**	

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

Appendix 3

Children exposed to domestic abuse MARAC data

Measure	Source									Change	Comment
Number of unique children - quarterly totals	West Mercia Womens Aid	Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	46%	
		284	376	243	273	314	271	149	218		
Number of children exposed to DA crimes and incidents	West Mercia Police	Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	-8%	Smaller is better
		287	270	298	330	327	385	367	339		
Number of children exposed to DA three or more times	West Mercia Police	Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	7%	Smaller is better
		35	24	26	32	29	51	29	31		
Number of children in the household in MARAC (**'Safe Lives'**) data in last three months	West Mercia Police	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	-34%	Smaller is better
		104	88	94	86	102	73	96	63		
Number of children exposed to DA as recorded by: **Children's Social Care**	Herefordshire Council Chidren's Social Service	Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	25%	
		93	50	79	32	89	71	20	25		

Appendix 4

Numbers of children and young people involved with Children's Independent Domestic Violence Adviser 2016-17

17. IDVA SERVICE USER CHILDREN DATA	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Total
No. of service user children recorded at the end of previous period	13	19	19	23	21	21	26	29	41	32	27	29	300
No. of new service user children recorded during the month	15	19	14	20	16	15	22	22	13	14	9	20	199
No. of service user children closed during the month	9	19	10	22	14	10	19	10	22	19	7	6	167
TOTAL NO. OF CHILDREN ASSOCIATED WITH SERVICE USERS EACH MONTH	**28**	**38**	**33**	**43**	**37**	**36**	**48**	**51**	**54**	**46**	**36**	**49**	**499**
TOTAL NO. OF UNIQUE SERVICE USER CHILDREN RECORDED DURING THE YEAR	**28**	**19**	**14**	**20**	**16**	**15**	**22**	**22**	**13**	**14**	**9**	**20**	**212**

19. IDVA SERVICE USER CHILDREN AGE	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Total
<1	3	1	0	2	0	1	0	2	2	1	0	0	12
1 - 4	6	8	5	7	7	6	4	8	4	6	5	8	74
5 - 9	9	3	7	10	3	2	13	7	2	5	2	7	70
10 - 14	7	3	1	1	4	3	3	1	4	1	2	4	34
15 - 18	3	4	1	0	2	3	2	3	1	1	0	1	21
Unknown	0	0	0	0	0	0	0	1	0	0	0	0	1
TOTAL	**28**	**19**	**14**	**20**	**16**	**15**	**22**	**22**	**13**	**14**	**9**	**20**	**212**

Appendix 5

Single agency assurance reporting

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

a. **West Mercia Police.**

In January 2016, the alliance launched 'Pathfinder' in Worcestershire as a new investigative model. This brought together CID, PVP and IOM (Integrated Offender Management) into a single investigative team with the most appropriate resources deployed to respond and investigate incidents and crimes. This is+ based on the threat, harm and risk inherent in that incident, rather than based primarily on category heading.

In line with our vision to protect the most vulnerable from harm, the revised investigative model has sought to enhance the quality of service to victims, witnesses and suspects.

The single team contains officers and staff with necessary specialism's (such as child abuse investigators, ABE interviewers, suspect interviewers etc) to respond effectively to incidents at the earliest opportunity. Detective officers are (when appropriate to do so) adopting the role of first responders to incidents, promoting a 'right first time' approach.

The investigative model now allows for detective resilience for addressing child protection investigations from 0800hrs to 2300hrs seven days a week. The investigators have access to first and second line management to ensure appropriate support, resilience and management scrutiny or the most complex of cases and appropriate engagement for interagency planning. Additional resources have been invested in Learning & Development to increase the number of specialist and appropriately qualified child abuse investigators within the model. This is further supported by the delivery of a programme of vulnerability training for all front line officers and staff. This will ensure those responding have the ability to recognise risk to our most vulnerable children and adults, and deal appropriately.

The new investigative model was extended to Warwickshire in June and Herefordshire in July 2016. It is acknowledged that a period of stability is required to embed the investigative model. The implementation across Telford and Shropshire is paused in order to take into account a review and learning from the existing areas. A key element of the revised investigative model is the transfer of ownership of resources from central to 'local' ownership.

An additional investment of 54 posts within investigation and Harm Assessment Unit teams are to be made permanent. A proportion of these resources are to be allocated to dedicated

CSE and on-line CSE teams. This is in recognition of the changing nature of demand and the need to safeguard children and young people against new and emerging threats.

The ‘recognising and responding to vulnerability’ change programme has been delivered to Warwickshire staff in late 2016 and rollout for West Mercia is planned later in 2017 following the independent evaluation by Worcester University. Supervisors will receive additional inputs early 2018.

The continued development of the Strategic Vulnerability team will allow for environmental scanning and dissemination of learning from SCRs and DHRs, driving activity in response to HMIC. The Major Crime Statutory Review Unit (MCSRU) has been aligned under the Superintendent Strategic Vulnerability role to further enhance the learning organisation culture.

Embedding these structural changes has impacted upon multi-agency working. There is an increased pool of experienced individuals within West Mercia Police available to engage at the appropriate level with partner agencies. HAU staff engage in MASH, developing DA and CSE / missing triage.

In relation to child safeguarding the main point of connectivity between the new investigative model and our partners are within the various MASH functions and within the child protection processes as set out in working together. In respect of MASH, consultation is being addressed via the various strategic governance groups within the LA areas, and in respect of child protection processes the Police are committed to continuing to fulfil their statutory responsibility to ensure attendance and appropriate contribution by a representative with the appropriate experience and knowledge of the case.

HMIC have published their PEEL report for both West Mercia Police and Warwickshire Police on 01.03.16. The learning identified will be used to further develop and enhance the policing response to vulnerability.

b. The National Probation Service (NPS)

Hereford NPS continues to be committed to child safeguarding.

Child safeguarding checks are carried out via MASH at the beginning of each order.

Wherever children are involved in the life of an offender any necessary identified action regarding child safeguarding is included in the offender’s risk management plan. Actions may include Home Visits or regular liaison with other agencies such as children’s services or police.

MAPPA action points regarding additional child safeguarding are often identified during the course of a MAPPA 2/3 panel and the Probation OM will complete these where tasked to do so. Action points may include MARF completion or the need for some form of disclosure to protect children.

NPS staff are aware of identified CSE processes and refer in any identified cases via MASH. Identified CSE issues are also fully addressed in the NPS risk assessment and risk management processes.

NPS offender managers address child safeguarding issues directly with offenders in supervision sessions. Such topics may include the impact of DV on children or the child's perspective where that child has been sexually abused. Child safeguarding/protection is also reinforced by programme facilitators where the offender is participating in DV or sex offender group work programmes.

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

On 1st June 2015 under the Transforming Rehabilitation (TR) Programme, the 35 Probation Trusts were reorganised in to a National Probation Service (NPS) and 21 Community Rehabilitation Companies (CRCs). The TR reforms created a two-stream probation system, which comprises the public sector NPS, responsible for high-risk offenders, and 21 private CRCs, responsible for low- and medium risk offenders.

The split has resulted in organisational bifurcation and significant change in the status of workers across the new delivery structures. This has created challenges to safeguarding as it has added a further level of complexity onto the probation system, with additional handover points between the NPS and CRCs.

Unlike our counterparts in the NPS, staff working in the CRC as private sector employees no longer retain the historical status as officers of the court. The NPS is responsible for making initial decisions about the risk posed by offenders, allocation of cases to NPS or CRC and for providing information and advice to the courts with respect to all offenders including the preparation of reports and initial checks with children agencies.

The CRC is not involved in preparing reports for court and many of the new cases are assigned to offender managers who have no previous knowledge of the offender. CRCs are contracted to deliver probation services for the majority of those given community orders or suspended sentence orders by the courts and those who require supervision upon release from custody.

Good communication between the NPS and the CRC is crucial in ensuring the smooth allocation of cases, full transfer of information and to make sure that proper breach and escalation procedures are followed.

Version 1 (Draft)

WWMCRC Changes

The WWMCRC has undergone significant changes since the introduction of TR in June 2014. WWMCRC has developed the Support, Transforming, Education and Progress (STEP) Centres in Worcester and Telford. A 'One Roof' partnership model to offer wider services from a single location. A 'contact Centre' developed in Shrewsbury to see offenders who are unable to travel in to Telford due to employment or transport difficulties. All staff from Shrewsbury and Telford office, which we previously shared with the NPS, transferred to the STEP centre in Telford. The Hereford, Nuneaton and Leamington offices remain shared offices with staff from NPS.

The projected workloads calculated prior to TR had not come to fruition and this had an adverse impact upon WWMCRC income. This created great uncertainty within the business. Workloads were lower than anticipated and consequently a restructure of the business took place during June – September 2016 that led to reductions in staffing

Information sharing between the NPS and CRC has improved with monthly interface meetings arranged to address any challenges. There is evidence of problem solving and solution focus with the NPS over appropriate proposals for reports, case supervision and safeguarding of children.

All staff are appropriately trained in domestic violence and the safeguarding of children.

Phase 1 of the new information technology system was delivered and a new case management system – ENIGMA will be introduced in 2017/18.

Like all other CRCs WWMCRC are subject to monitoring against the contractual targets set by the National Offender Management Service (NOMS). At the end of March 2017 WWMCRC was performing well against the contractual requirements and those measures applied by NOMS to provide assurance.

As part of TR changes to reduce the stubborn high re-offending rates the Offender Rehabilitation Act 2014 introduced statutory post-release supervision for short sentence prisoners (less than 12 months' custody) at resettlement prisons. Through the Gate resettlement, services were introduced in May 2015 as part of the contract for CRCs. WWMCRC has a strong commitment to addressing high reoffending rates and deployed considerable resources in to the Through the Gate team lead by a senior manager at Featherstone and Hewell resettlement prisons.

Quality Assurance.

WWM CRC has implemented a quality development plan to assure the NOMS contract management team that the CRC is regularly undertaking quality assurance on a monthly basis.

The quality development plan captures team, Local Delivery Unit (LDU) and area wide quality development actions and objectives. The quality development plan incorporates a response to findings of internal audits, NOMS operational assurance reviews, inspection reports and serious further offence reviews.
The majority of quality development objectives are derived from our internal audit programme and NOMS operational assurance reviews. Audit findings are circulated monthly with ratings for each team and LDU, which are then reviewed at LDU manager meetings. Practice and quality issues are addressed with individuals by senior probation officers in supervision. Team issues/themes are recorded and monitored against progress on the quality development template.
We have undertaken audits on enforcement and on cases that should have been seen at 5 days, 6 weeks and 3 monthly periods. Failure to see offenders or take effective enforcement action meant that responsible officers are not able to identify properly the risk of harm posed to others at the start or during the sentence or licence. This meant that offender managers could not prioritise protection of the public or potential victims.

We have undertaken an audit of our recording practice with regards to recorded professional judgements entries and offender assessment (OASys) reviews in response to significant events and/change of circumstances. (The offender manager decides whether the seriousness of the change requires an OASys or professional judgement needs to be completed. More information can be input into OASys than a professional judgement). Most cases had safeguarding issues recorded however; the audit highlighted some common themes:

1. Offender managers need to be evidencing that following a significant event or change in circumstance the case is reviewed.

2. The lack of consideration given to risk of harm and re-offending. From the audits the following examples have been raised with staff:

- If the initial sentence plan assesses that, the offender's accommodation is linked to both harm and re-offending and information is received that they have moved. The case needs to be reviewed and risked assessed by completing the OASys document or providing a recorded professional judgement. Domestic violence and checks with children services are required to be completed.

- When domestic abuse perpetrator starts a new relationship, the offender manager needs to be reviewing the case using either completing a full offender assessment document or a professional judgement to evidence what actions is being taken to manage the case.

- If a domestic abuse or children's services check is returned that has different information than that in a previously completed OASys, offender managers need to be completing a review (either OASys or professional judgement) to evidence that it has been risk assessed and are managing the risk based on the new information

- Many of the critiques from audits is that offender managers record information but do not assess or analyse the information.

We have commenced an audit of our sentence plans. The audit is a peer audit with the aim to support the offender manager's awareness and understanding of sentence planning quality standards.

A sample of cases previously audited found the assessment of the risk of harm posed to others, and subsequent planning was not carried out well enough in a number of cases inspected. Assessments were not always up to date and had missing or incorrect information. Significant information was not always recognised as such and there was a lack of awareness of domestic abuse and child safeguarding issues. This problem was exacerbated where screenings or assessments from court did not include all relevant information.

Poor practice example:

In one case, the offender manager did not consider the risk of harm the offender posed to others. Instead, the offender manager took at face value that the offender embedded the learning from the Building Better Relationships programme (an accredited programme to address domestic violence) and Alcohol treatment from a counsellor and would not reoffend. There was no consideration to the fact that he had re-established contact with his partner. He had overnight contact with his daughter in his home who was potentially at risk from him. There was no contact with children's social services to assess or plan how to protect the daughter, despite her already being known to them as a child in need.

The risk management plan lacked any detail. It did not specify how children or the victims would be kept safe. There was a restraining order in place but no detail how this would be monitored or enforced. Overall, the quality of risk management in this case was poor.

Good practice example:

CR (the offender) committed an offence of breach of a non-molestation order against his ex-partner. He has a long history of substance misuse related offending covering a range of offences. CR was assessed as posing a medium risk of harm to others, mainly his ex-partner and her child (should the child witness any domestic abuse).

This risk had been appropriately managed with regular liaison with children services, substance misuse services and police domestic violence unit.

Overall
There has been improved communication and information sharing between the NPS and CRC. Prompt allocation of cases and good quality assurance processes has enabled offender managers to manage and have oversight of cases where children are at risk.

d. West Mercia Youth Offending Service

In 2016/17 the service was transferred to the Office of the Police and Crime Commissioner and underwent a restructure which was completed in November 2016. Also during the first 6 months of 2016/17 the service implemented a new case management system in order to support the concurrent implementation of a new assessment and planning framework. The new assessment framework includes and single integrated plan for the risk areas of re-offending, risk to others and safeguarding.

The work started in 2015/16 to improve the quality of assessments and plans continued into the first quarter of 2016/17, and monthly auditing demonstrated continuous improvement. The implementation of the new assessment and planning framework has necessitated developing a new quality assurance process for this area of work, and a baseline of current quality has been established. Further work is planned in order to fully embed the new assessment and planning framework in practice.

The service continued to undertake critical learning reviews during 2016/17 when young people under the supervision of the Youth Justice Service committed defined serious further offences or where they have died, attempted suicide or been a victim of serious offence, however in 2016/17 there were no Herefordshire cases requiring review. The findings of the reviews are reported to the LSCB through the annual assurance report.

e. Herefordshire Clinical Commissioning Group

Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013, they are membership organisations that bring together general practices to commission services for their registered populations and for unregistered patients who live in their area. CCGs are responsible for commissioning most hospital and community healthcare services as well as primary care services

In July 2015 NHS England published a document Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework which sets out the responsibilities of each part of the NHS system. Herefordshire CCG conforms to all the requirements set out in this document.

All staff receive yearly safeguarding training and those who have patient contact receive regular safeguarding supervision.

As a commissioning organisation the CCG ensures that all its commissioned services have robust safeguarding processes and policies in place. We frequently assure ourselves that these processes are robustly adhered to by holding regular Contract Quality Review Forums with all our major contractors and also conducting quality assurance visits to provider's clinical areas.

The CCG has good working relationships with partner agencies and supports Herefordshire Safeguarding Boards both financially and by a commitment to the functioning of the Boards, including the chairing of several sub groups.

The CCG regularly reviews its safeguarding duties by reporting performance and safeguarding developments to the CCG's Quality and Patient Safety Committee (a sub group of the Governing Body) and the Governing Body.

The CCG Governing Body receive an annual NHS system wide safeguarding report which analyses safeguarding across all NHS services, and provides assurance that the NHS is delivering services which protect the residents of Herefordshire.

f. 2Gether NHS Foundation TRUST

Safeguarding Children Activity

In Herefordshire 2g is commissioned to provide a range of mental health services including Child and Adolescent Mental Health Services (CAMHS -Tier 1-3), Adult Mental Health services, Older Adult and Community Learning Disability services.

All services have responsibilities for safeguarding children within a 'Think family' framework.

Staff in Herefordshire are actively encouraged to contact the 2g Trust Safeguarding team for consultation around all safeguarding issues. The team have been contacted on 28 occasions during the year 2016 -2017. Staff also contact the Local Authority directly for advice and are encouraged to do – this is emphasised in local training. If abuse or neglect is being experienced (or suspected) staff will directly contact the Local Authority via the Multi-Agency Safeguarding Hub (MASH).

The CAMHS team, including staff who work with children with disabilities, receive group Reflective Safeguarding Supervision on a monthly basis. All staff working with children attend a minimum of 3 sessions a year. This has been provided by the Named Doctor and Named Nurse for safeguarding. Safeguarding Supervision is also included as an agenda item for all team meetings and for individual operational/professional supervision (in line with 2g Supervision Policy).

Staff follow the West Midlands Safeguarding Policies and Procedures and access the relevant documents from the HSCB website. Any updates to policies and procedures are published on the 2g website to inform all staff, by the 2g Communications team. The 2g Safeguarding Children Policy includes links to the website.

Herefordshire Local Authority hold and monitor the Safeguarding data for the County. One challenge is that the local authority is unable to provide 2g with data E.g. how many referrals come from 2g, as all health agencies are classed as one under the banner of 'Health'. It is also unable to reflect on the number of contacts for advice, for the same reason.

Any issues around practice are identified when participating in Multi-Agency Audits under the Quality Assurance sub group of the Safeguarding Board and 2g single agency audits. These actions will be monitored through our internal monthly safeguarding subcommittee which reports to our governance committee. Herefordshire Clinical Commissioning Group (HCCG) is invited to attend this subcommittee for additional assurance.

2g is fully engaged in partnership working. The DDoN attended the Strategic Meetings including being an active member of both Safeguarding Boards.

The 2g safeguarding team participate in all subgroups of the Adult and Children Safeguarding Boards, where requested. These include:

HSAB Executive as a sub group chair, Joint Case Review, Performance, Audit and Quality, Training and Workforce development, MCA & DoLS, Policy and Procedure for adults and Child Sexual exploitation.

The 2g Safeguarding Lead has recently taken over chairing the Policy and Procedure sub group for Adults and deputises for the Quality Assurance for Children and Adults.

Frontline staff have participated in multi-agency audits for Quality Assurance when requested to. 2g also actively participates in 'practice runs' e.g. for the Joint Targeted Area Inspection (JTAI) to establish any gaps in practice.

Frontline staff and Team Managers have participated in Serious Case Reviews, Safeguarding Adult Reviews and other learning processes (including Domestic Homicide Reviews). The 2g Safeguarding Lead has chaired Practice Learning Review meetings and written independent reports for Learning Reviews for adults.

The 2g Trust Training Lead attends the Training and Workforce development sub group. The Safeguarding Team have offered to be part of the training pool and have presented at Practitioner Forums.

Operational Managers in 2g attend MAPPA, Prevent, and MARAC steering groups.

Updates from all Safeguarding meetings are relayed to Safeguarding champions who attend the 2g Trust monthly Safeguarding subcommittee meeting. This is held at Trust Headquarters

in Gloucester and quarterly in Herefordshire. A representative from Herefordshire Adult Mental Health and CAMHS attend monthly. Highlights from this meeting, along with a monthly topical Newsletter are sent out to all attendees, who disseminate to all team managers in the area.

Information is also taken to safeguarding supervision sessions, and adult teams for updates, including that relating to training requirements and available opportunities. This includes all alerts and information disseminated via the Local Safeguarding Boards.

Training

Over the last year, the training requirements for staff have been reviewed. This is largely owing to the requirements set out in 'Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document.'3

Level one safeguarding Adults and Children training is provided in a 1 hour session to all staff at Corporate Induction. All staff receive this – there is a 100% compliance rate.

Level Two Safeguarding Adults and Children (Universal) training is delivered by Hoople and attended by the 2g Safeguarding Practitioner when possible. This is delivered as a 'Think Family' training day and as of March 31st 2017; compliance was at a rate of 79%.

3 Royal College of Paediatrics and Child Health (2014) Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document. RCPCH

Level 3 Safeguarding Children (Targeted Working together to safeguard children) is delivered by Hoople as a Multi-agency training day. As of 31st March 2017, the compliance rate was captured as 73% across teams in Herefordshire.

The monthly internal safeguarding subcommittee monitors all areas of training compliance and has put in place plans to increase training and in addition plans to train all adult mental health workers to level 3 children safeguarding. This is a major task and involved large numbers of staff within the trust. This will also be monitored via the HCCG Clinical Quality and Performance Forum (CQRF)

Policies

The Safeguarding Adult and Safeguarding Children policies in 2g reflect requirements for safeguarding from National and Local Legislation and guidance. Direction is given with links to the West Midlands Policy & procedures.

The policies include guidance for working with Domestic Abuse and Sexual Violence (including MARAC), Female Genital Mutilation (FGM), Prevent and MAPPA, rather than stand-alone policies and procedures for these specific issues.

Safeguarding is central to all work within the Trust and so is included in all areas of the policy framework e.g. Assessment and Care Management, Recruitment of staff, Serious Incident investigations, Supervision Policy, Children Visiting Psychiatric Hospitals, Under 18s admission into Adult wards.

Both the Adult and Children Safeguarding Policies have been reviewed (May 2017) to reflect the changes in training requirements for Safeguarding Children and Prevent.

2gether NHS Foundation Trust Safeguarding Objectives and actions 2015/16

1 Shared learning from local Serious Case Reviews and other learning processes (Serious Incident Learning Processes (SILP), Herefordshire Evaluation Learning Process (HELP), SCIE, Root Cause Analysis (RCA) and Domestic Homicide Reviews (DHRs) to improve safeguarding for adults and children practice. Monitored at the 2g safeguarding subcommittee and is on-going.

2 Increased provision of formal group safeguarding supervision and safeguarding awareness/educative sessions to teams working with Children and Adults. Safeguarding Supervision for CAMHS is held monthly.

3 Promotion of a 'Think Family' approach to adult teams, alongside 'safeguarding adults' in view of the Care Act 2014 provisions and 'Making Safeguarding Personal'. Safeguarding Practitioner sits within mental health teams to promote all aspects of safeguarding practice.

4 Ensuring all staff receive the appropriate level of training according to their role, noting developments associated with The Care act 2014 and the Intercollegiate guidance 2014 for safeguarding children. Training needs have been reviewed and compliance rates have increased.

5 Improving partnership working with stakeholder agencies, prioritising on issues relating to: Domestic Abuse, Parental Mental Health, Substance Misuse, Child Sexual Exploitation, Female Genital Mutilation and PREVENT. This is evidenced in attendance at sub groups, participation in audits, inclusion in the Think Family training day (level 2) and discussions with staff/informal supervision.

6 Providing assurance to the Trust Board that safeguarding is a priority function of the Trust and is being delivered to expected standard – quarterly reporting to and challenge at the 2g Quality Clinical risk Governance committee.

g. Wye Valley NHS Trust (WVT)

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

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

The Trust works collaboratively to support the business of the HSCB in a number of ways, aligning safeguarding children priorities to those of the HSCB business plans and contributing to the work of the board and subgroups; for example during 2016-17 WVT supported the work of the board in the development of policy, chairing of the Policy and Practice sub group and the development and delivery of multi- agency training on behalf of the board.

In the previous HSCB annual report we highlighted that WVT had been in special measures since June 2014 following a Care Quality Commission (CQC) inspection rating of inadequate. Since this time a quality improvement programme has been in place and significant improvements have been made. A re –inspection of hospital services took in July 2016, (community services were not part of the inspection as the previous inspection had not identified any significant concerns). Following this inspection the Trust was taken out of special measures. The summary of findings report can be accessed at http://www.cqc.org.uk/sites/default/files/new_reports/AAAF7512.pdf

The inspectors found that there was a significant improvement in children and young people's services. The rating for "Are Services Safe? " had improved from inadequate to good. The inspectors found that staff across the trust had an understanding of their roles and responsibilities and the types of concerns that may indicate that a child safeguarding referral was required. They understood the referral process and knew how to make referrals. The work of the Young Ambassador group was acknowledged as excellent , noting their input into service re-design and the current project of involvement in the making a film on transitional care for national distribution. The inspectors found that staff listened to and respected their opinions and that they saw the services provided "through the eyes of the children and young people".

The Trust continues to work towards further improving services with actions to improve compliance with mandatory children's safeguarding children training; contribution to the

Herefordshire CCG group which is tasked to improve CAMHS services to children and young people requiring acute admission to Hereford hospital and to secure a new safeguarding children advisor post based in the hospital.

h. Education and Schools

Schools remain critically important partners in our collective responsibilities towards safeguarding children. The increased diversity of school organisation - Local Authority maintained, academy, free school, coupled with increasing financial autonomy, presents a challenge to centralised safeguarding approaches. This has been exemplified, from April 2017, by the change in funding arrangements for the MASH education posts and the safeguarding services provided to schools by the learning and achievement service.

Since the inception of the MASH, the education officer funding had been top-sliced from schools with consent from Schools Forum. This established funding arrangement has changed at the insistence of the Department for Education. Consequently, Herefordshire introduced a service level agreement with schools to fund these services from April 2017. This has been a difficult process, with a sizeable minority of schools questioning the new arrangements (despite failing to raise objections during consultation) and requiring personal intervention to convince them of the revised arrangements. A small number of schools still refuse to pay, July 2017. Despite these difficulties, Herefordshire schools continue to fund 1.5 education officers in the Multi-Agency Safeguarding Hub. The education officers form an integral part of the MASH in the gathering and dissemination of information to and from education partners. In addition, the MASH education officers offer advice, support and training to schools to assist with the development of best practice and statutory compliance. They represent schools on the HSCB CSE operational group and workforce development group. In addition, they represent Herefordshire at meetings of the Midlands Association of Safeguarding in Education to further enhance best practice across the region

The academic year 2016/17 has seen further changes in schools as we continue to shape our work in response to new and challenging circumstances. This has included: the ongoing participation of professionals in Workshops to Raise Awareness of Prevent; the implementation of the CSE pre-checklist and toolkit; the completion of the audit process of policy and practice with regard to Keeping Children Safe in Education (KCSiE). Responses to the audit have been encouraging, with all but three educational establishments completing the audit. The audit tool has been redrafted to reflect KCSiE 2016 and, subject to additional input from Herefordshire School Improvement Partnership, will be ready for issue to schools during autumn term 2017. Importantly, the revised audit will be issued to all private education settings as the Local Authority must be satisfied with the safeguarding arrangements of these institutions too.

The HSCB has been monitors the following key indicators in education:

Children Missing from Education (CME)

The tracking down of children referred as 'missing from education' has been increasingly successful over the past 4 years, with fewer children remaining as 'missing' from one quarter to the next. There has been a steady improvement in the tracking and location of CME year on year.

CME data during the period 01/09/2015 to 31/08/2016
68 New Referrals received
Breakdown
Autumn 2015: 37
Spring 2016: 14
Summer 2016: 17
Total New cases: 68
B/fwd. from 2014/15: 5
Closed 2015/16: 71
Carried/fwd. to 2016/17: 2

This performance is reflective of the dedication and tenacity of the CME officer, coupled with the heightened awareness of partner agencies of the critical importance of this work towards keeping children safe.

Elective Home Education (EHE)

2016-17 saw a further increase, from 118 to 170, in the numbers of children known to the local authority who are educated at home. There were 85 children educated at home 2011-12. It is likely that the proportion of parents registering children as Electively Home Educated with the local authority is increasing, in addition to a growth in this parental choice. The EHE officer continues to offer guidance and to make robust monitoring visits about outcomes for children. The number of parents who choose to meet with our EHE service in order to receive advice and to discuss the suitability of their arrangements is a measure of the confidence that home educators have in our EHE officer. The feedback from parents who receive advice and guidance from the EHE officer remains overwhelmingly positive. It will be important to consider the current arrangements as the post holder is currently employed on 0.5 contract, but has seen a doubling of caseload over a five year period.

Reporting by schools of bullying and racist incidents

Year	Bullying	Racist Incidents
2014/15	**79**	**39**
2015/16	**48**	**48**
2016/17	**25**	**11**

Reported incidents of bullying and racist incidents have reduced significantly, compared to the previous year. Whilst there has been an improvement in recent years of the number of schools complying with the request to submit a return, this has decreased 2015/16. In addition, further work is required on the number of schools providing nil returns, i.e. no reported incidents. There appear to be too many nil returns relative to the expected incidence of bullying. However, it is encouraging that there appears to be a significant reduction in racist incidents in schools, despite a national spike in hate-crime, post-Brexit.

i. Herefordshire Council: Children's Wellbeing Services

During this year, the Children's Wellbeing Directorate built on the improvements of the previous year by reviewing key elements of its safeguarding practice to ensure that was as effective as possible. An extensive review of our MASH led to HSCB agreeing revisions to the its purpose, emphasising its role in managing requests for a social work service and ensuring that children at risk received a prompt response. A MASH Governance Board was established and this has overseen the revision of guidance and the move from Bath St to Nelson House, planned for the spring of 2017.

Following an audit of child protection casework and conferences, the guidance to professionals attending child protection meetings was revised to ensure a focus on the evidence of harm and HSCB granted the Conference Chairs the power to veto decisions that are not supported by evidence. This approach also informed a review of child protection strategy meetings. The consequence of this work, considered in the round, has been a sustained reduction in the number of children subject to child protection plans in the county. This reduction has meant that professionals have more time to respond in depth to those children who are subject to a plan while other families are supported through the children in need process.

The Fieldwork Service reviewed its team structure during the year and introduced a specialist model which will support best practice and allow social workers to develop expertise. Child Protection and Court teams will take responsibility for the children at greatest risk while the Assessment Teams will dedicate time to support children in need and their families after assessment. The service has been renamed the Children in Need Service.

We welcomed a permanent Head of Looked After Children and Adoption who has initiated a major review of the county's corporate parenting strategy as well as negotiating our membership of a Regional Adoption Agency which will conclude during 2017.

HSCB adopted an Early Help Strategy in the spring of 2016 and its implementation is being led by the Head of Educational Development who chairs a multidisciplinary group. The Head of Additional Needs now manages an integrated 0-25 SEND Service which will give children and their families a more consistent and coherent service. The Head of Learning and Achievement has overseen the review of over half of Herefordshire's schools' safeguarding policies to ensure that they are fit for purpose and understood by staff.

Directorate staff convene regular commissioning network meetings with local service providers. These meetings have been utilised to develop a broader understanding of safeguarding across the county through specific presentations and discussion.

The Local Authority Designated Officer continues to advise employers on the management of concerns about staff behaviour towards children and also offers training and support to organisations in the county.

Our Quality Assurance Framework has been to incorporate advice from Ofsted about the scope and focus case file audits. The revised model has been introduced and is being evaluated. There is a clearer focus on the experience of the child and the improvement of their situation.

There has been a significant increase in the percentage of permanent Social Workers in the establishment. We have reduced our use of agency staff from 60 at the beginning of 2016 to 16 at the end. Currently we have 80% of our posts occupied by permanent staff, 11% by agency staff and 9% vacant. We continue to recruit to our establishment to reduce the number of vacancies further. The introduction of a revised senior social work role and a change to our management structure improve our career pathways for staff and should improve staff retention in the coming years.

j. Hereford & Worcester Fire and Rescue Service

Hereford IGNITE Scheme

Members of the Hereford & Worcester Fire and Rescue Service Community Risk team including Service Volunteers have undertaken a project at Brookfield School, Hereford entitled IGNITE.

The week long scheme delivered to Year 10 pupils focused on a number of elements including team work, leadership and effective communication. Throughout the week the young people were given a number of challenging tasks to complete which involved them working together in order for them to achieve the set tasks whilst demonstrating the new skills they had developed. As well as receiving input into a number of operational elements they also took part in a number of workshops involving fire and water safety, arson awareness, first aid and road safety during which they were able to observe an RTC

reconstruction. The students, all of whom are currently passengers in vehicles and many of whom will be looking to drive in the future took a great deal from the experience.

The week concluded with the students tackling a simulated car fire bringing together all the skills and knowledge they gained and all the students were presented with a certificate by the Service formally recording and recognising their achievements.

The school were also very pleased with how the pupils developed and worked together, with the Deputy Head teacher adding “I just wanted to catch up with you to say a big thank you for the course that you and your team presented for our students. I just wanted to re-emphasise how successful we as a school felt that the course was. All the students gained a tremendous amount from the activities and being together, learning those skills of teamwork, communication, leadership and responsibility in a fun and exciting way”

Based upon the success of the project it is envisaged that further schemes may be rolled out in the future.