# HSCB Annual Report 2017-18

## Contents

# Foreword from Independent Chair

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

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

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

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

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

Sally Halls

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# 1. About this report

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

This report sets out how Herefordshire Safeguarding Children Board has worked to meet its statutory objectives during 2017/2018, which are to co-ordinate local work to safeguard and promote the welfare of children and young people, and to ensure the effectiveness of that work. It is submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the chair of the Health and Well-being Board. The report provides an assessment of the performance and effectiveness of local services. It identifies areas for improvement, and the actions being taken to address them. It also gives detail on the priority areas addressed by the Board during this period, as well as the data and reporting provided by partner agencies regarding their performance in working together to safeguard children and young people in Herefordshire.

The report includes lessons learned from reviews undertaken during the year and how the LSCB has used the learning to improve practice.

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

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

DRAFT 2

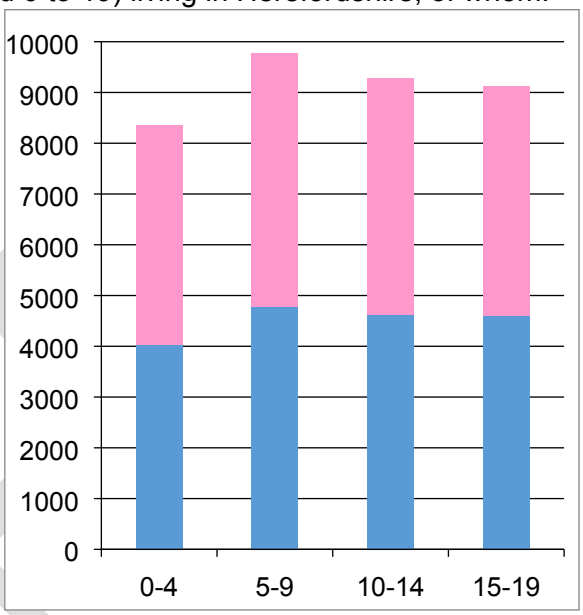
# 2. The local context: children in Herefordshire

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

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

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

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




And there are also

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


Illustrated is number of children assessed as in need, numbers of children with a child protection plan and numbers of children in the care of the Local Authority as at 31st March 2018.

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# 3. About HSCB

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

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

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

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

**ADD LINK**

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

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

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

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

DRAFT 2

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

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

Key elements include:

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

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

Priority 1: Neglect.

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

Priority 3: Safeguarding Vulnerable Children.

Priority 4: Early Help.

Priority 5: Strong Leadership, strong partnership.

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

DRAFT 2

# 5. Progress on HSCB priorities 2017-18.

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

## Priority 1: Childhood Neglect

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

**What the HSCB wanted to see achieved:**

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

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

The Board therefore needed to ensure that:

- Concerns about possible childhood neglect are identified early and interventions put in place to ensure children's needs are met and they are not at risk of, or experiencing, neglect.
- Where chronic cases of neglect are identified plans are put in place to protect children from further neglect.
- Consistent and timely response across agencies
- Innovative tools and approaches are put in place to support practitioners in assessing and understanding neglect and improving and better targeting work and interventions with families. With a clear focus of the impact of neglect on children and young people.

**What did we do?**

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

DRAFT 2

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

**What still needs to be done and understood:**

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

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

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

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

**What the HSCB wanted to see achieved:**

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

The Board therefore needed to ensure that:

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

DRAFT 2

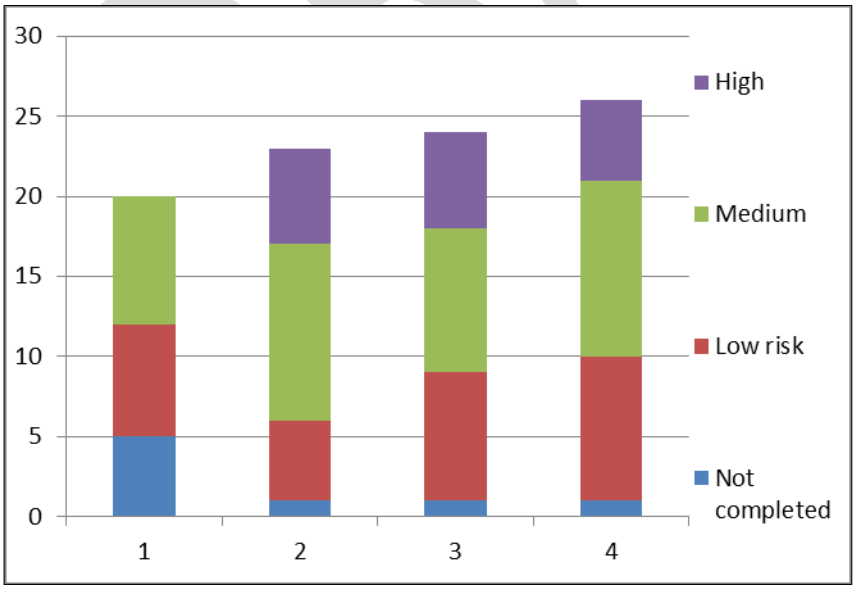
**What did we do?**

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

**What has been learned and achieved?**

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

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




**Assessments completed and level of risk**

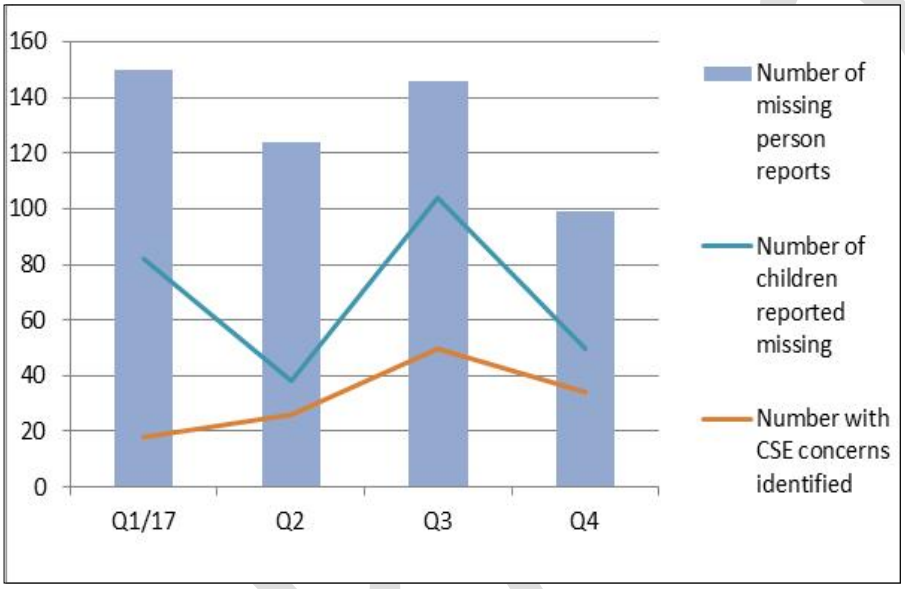
- Cases involved a higher proportion of children and young people living at home.
- Hereford City figures higher than other areas of Herefordshire.

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

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

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

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




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

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

**What difference have we made?**

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

**What still needs to be done and understood:**

- Consider the vulnerabilities of children missing education

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

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

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

## Priority 3: Safeguarding vulnerable children

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

**What the HSCB wanted to see achieved:**

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

**What did we do?:**

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

DRAFT 2

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

The Board also sought assurance that:

- The process and decision making at the initial stages of the child protection process (strategy meetings / section 47 investigations) comply with statutory guidance, and the decisions are consistent with the levels of need in Herefordshire.
- The child protection planning and review process (child protection conferences / core groups) are truly multi-agency and consistent with guidance and procedures.
- Child protection plans are effective in reducing/ eradicating the risk of significant harm to children.
- Children at risk of suffering significant harm are identified, safeguarded and wellbeing promoted

**What has been achieved and learnt:**

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

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

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

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

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

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

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

DRAFT 2

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

**What still need to be done and understood:**

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

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

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

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

## Priority 4: Early Help

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

**What the HSCB wanted to see achieved:**

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

The Board therefore needed to satisfy itself that:

- Early help services effectively identify needs and concerns relating to children and families, and that services address these needs through effective planning and interventions to enable families to function effectively and children's needs are met and they are supported to achieve their full potential.
- Effective decision making is taking place at the early stage of identification of needs, and appropriately directed to WISH, Early Triage (MAG) or referred to MASH so that children and their families receive effective help at the right time.

DRAFT 2

- Early Help Assessments are taking place within timescales and are effective in identifying needs of children and families and planning interventions (there is clear multi-agency engagement in this process).
- Lead professionals are identified in each case deemed level 2 or 3 on the continuum of need.

**What did we do?**

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

**What has been learned and achieved?**

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

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**What still needs to be done and understood:**

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

The Board will therefore undertake the following activities:

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

## Priority 5: Strong Leadership - Strong Partnership

**What we want to achieve:**

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

Agreed indicators of effectiveness included:

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

**What has been achieved and learnt:**

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

Details are given elsewhere in this report.

DRAFT 2

**What still needs to be done:**

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

DRAFT 2

# 6. Case reviews

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

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

The different types of review include:

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

**1) Serious case reviews**

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

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

**2) Practice Learning reviews**

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

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

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

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

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

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

3. Update the current HSCB Escalation Policy.

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

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

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

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

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

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

**What we have learned**

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

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

Feedback from attendees included:

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

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

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

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

### 3) Child Death Overview Panel (CDOP)

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

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

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

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

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

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

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

**Modifiable Factors**

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

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

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

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

**Rapid Response**

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

**What we have achieved**

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

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

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

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

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

DRAFT 2

# 7. Safeguarding Board statutory functions and other activities undertaken

LSCBs have a number of statutory functions. These are:

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

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

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

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

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

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

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

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

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

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

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

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

**Private fostering**

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

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

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

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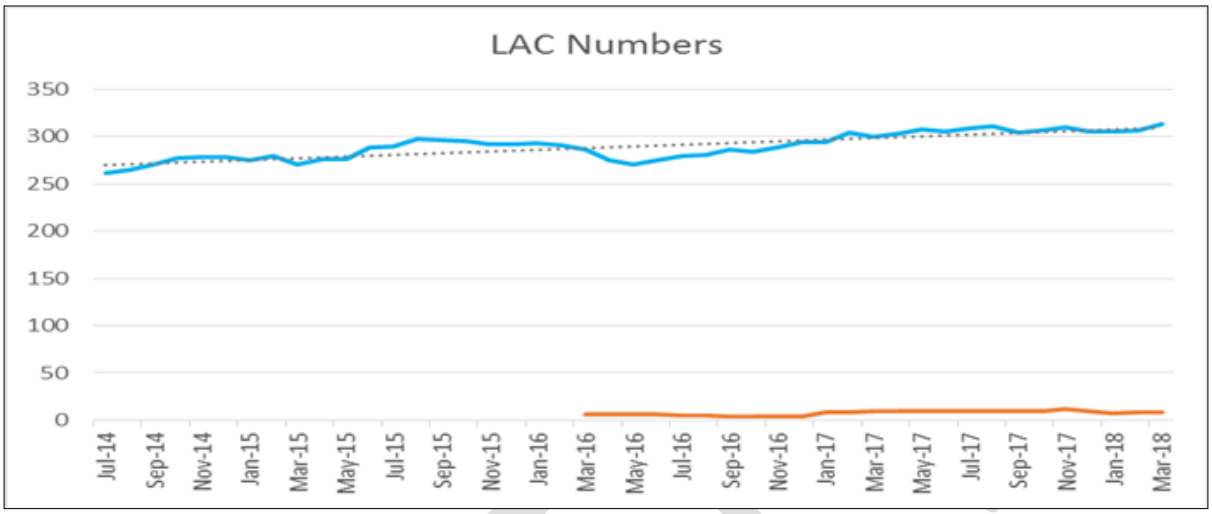
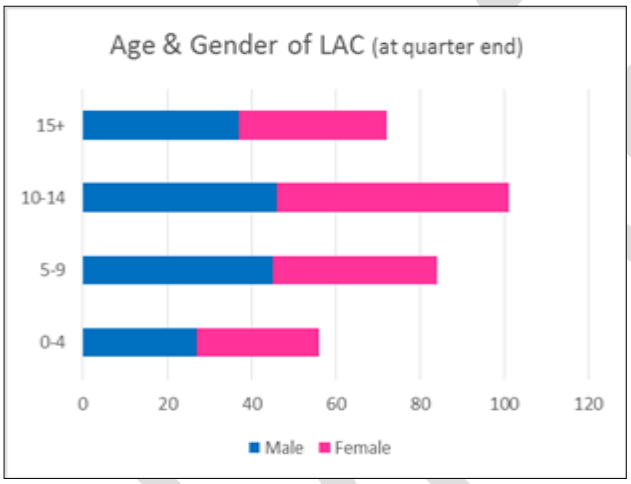
**Looked after children (LAC)**

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




**Safety of the children's workforce (LADO)**

**Currently going through LA governance**

**Unaccompanied Asylum Seeking Children**

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

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

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

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

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

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

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

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# Assessment of the effectiveness of safeguarding arrangements in Herefordshire

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

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

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

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

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

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

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

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

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

**Safeguarding is a demonstrable priority for all the statutory members.**

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

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**There is a strong learning and improvement framework in place.**

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

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

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

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

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

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

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

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

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

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

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

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

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

## Appendix 1: Budget and contributions

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

Awaiting final spend figures

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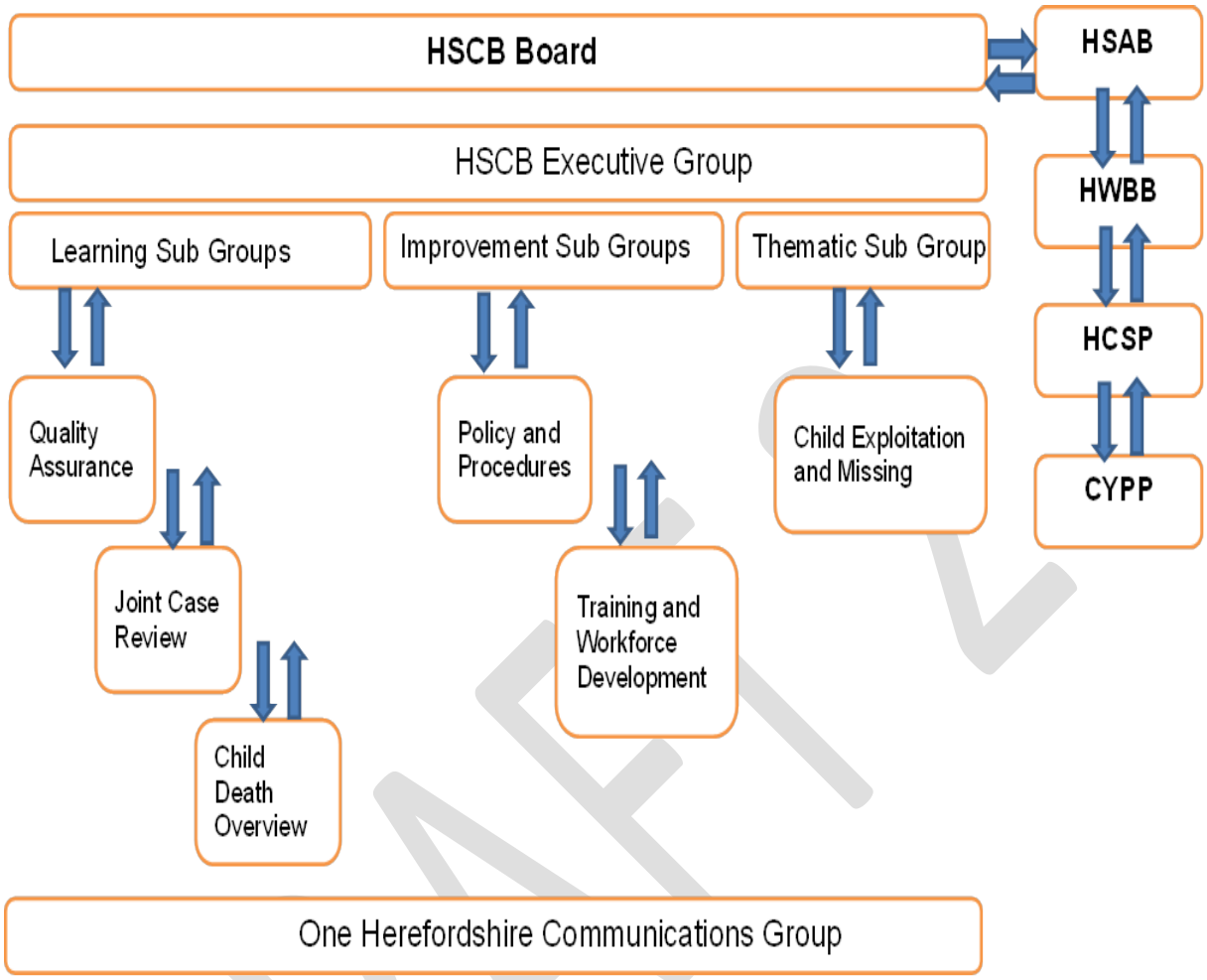
## Appendix 2: Structure and membership

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## Appendix 3: HSCB attendance

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

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## Appendix 4: HSCB subgroup activity

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

### Child Sexual Exploitation and Missing subgroup

Revised strategy and delivery plan focusing on:

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

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

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

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

SELFIE programme in primary and secondary schools

Police presentations in schools about texting and internet safety

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

HSCB CSE training offer

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

**What we have achieved:**

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

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**What next:**

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

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

## Policies and Practice subgroup

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

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

Introduction of policies including:

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

Redesign of key Herefordshire documents:

- Levels of need guidance
- Multi-agency referral form

Dissemination of information on:

- GDPR
- Early help strategy

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

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

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

**What next:**

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

DRAFT 2

## Quality Assurance subgroup

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

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

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

Production of thematic scorecards to support qualitative audit activity

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

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

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

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

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

**Audit highlighted 3 cases that were escalated to other services**

**Good multi-agency attendance at audits**

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**Better dissemination of audit findings**

**Improve communications with GPs to improve audit activity**

**Improve quality and analysis of performance information**

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

**Ensure appropriate representation from agencies at meetings**

## Workforce development subgroup

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

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

Initial feedback from those professionals has been positive

Delivery of Safeguarding Practitioner Forums to a multi-agency audience

Subjects this year have included:

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

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

Findings from reviews and audits are included in training

Hosted domestic violence conference which was attended by … delegates

DRAFT 2

**Practitioner forums have reached 90 practitioners over 31 agencies**

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

**Clear reporting back from professionals to Board about front line practice**

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

**Numbers attending HSCB multi-agency training courses 17/18**

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

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**Joint Case Review subgroup**

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

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

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

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

Agencies are referring cases in appropriately

There is healthy debate about thresholds

Action plans are routinely monitored

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

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

DRAFT 2

## Appendix 5: HSCB business Plan 2017-19

| Strategic Priority | Outcome | We will do this by; |
|---|---|---|
| 1. Neglect. | Early identification and response to childhood neglect, and it is prevented whenever possible.<br><br>Appropriate, consistent and timely responses across all agencies working together.<br><br>A clear focus on the impact of neglect on the child or young person. | 1.1. Implementing the childhood neglect strategy and action plan.<br>1.2. Delivering a launch event for the HSCB childhood neglect strategy and associated changes to business practice.<br>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.<br>1.4. Evaluating the effectiveness of that training.<br>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.<br>1.6. Ensuring the learning from previous SCR's and PLR's is properly embedded.<br>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.<br>2.2. Assessing the effectiveness of support services for victims of CSE in Herefordshire, and influencing commissioning of those services.<br>2.3. Ensuring a co-ordinated response with Community Safety Partnership to reducing sexual abuse of children.<br>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.<br>2.5. Gaining assurance on the arrangements for and frequency of missing children interviews.<br>2.6. Supporting ongoing local and national CSE awareness campaigns and improving knowledge and understanding of CSE toolkit within agencies in Herefordshire.<br>2.7. Reviewing the 'Children who abuse others' procedure and ensuring appropriate guidance is available to practitioners within Herefordshire.<br>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. |

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| Strategic Priority | Outcome | We will do this by; |
|---|---|---|
| 3. Safeguarding vulnerable children. | Vulnerable children are identified and safeguarded, and their wellbeing promoted. | 3.1. Maintaining up to date LSCB procedures that align with regional arrangements and statutory guidance to inform the journey of the child through the child protection process.<br>3.2. Developing the focus on 'hidden harm' and the increased risk to children with disabilities within multi-agency training.<br>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.<br>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.<br>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.<br>4.2. Assessing the impact of threshold decisions on those children who are not stepped up to higher levels of intervention.<br>4.3. Ensuring that the HSCB procedures support the early help strategy.<br>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.<br>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.<br>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.<br>4.7. Securing feedback from children, young people and their parents/carers about their experience of accessing and receiving early help (including Families First). |

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| Strategic Priority | Outcome | We will do this by; |
|---|---|---|
| 5. Strong leadership, strong partnership. | HSCB leads the safeguarding agenda, challenges the safeguarding work of partner organisations, and commits to an approach that learns lessons and embeds good practice.<br>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<br>5.2. continuing to strengthen the governance interface between HSCB and other key strategic forums<br>5.3. communicating and raising awareness about safeguarding to individuals, organisations and communities<br>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<br>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<br>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<br>5.7. engaging with practitioners to ensure they are supported to work effectively with children and their families. |

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**Appendix 6: Single Agency Assurance Reports.**

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



**Introduction**

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

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

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

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

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

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

**Background**

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

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

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

**Key Achievements (2017-18);**

**1) Partnerships and multi-agency working**

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

**2) Leadership and Accountability**

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

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

**3) Governance**

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

DRAFT 2

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

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

## 4) Enablers

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

### Key Objectives for 2018-19

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

### Conclusion

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

DRAFT 2

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

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

The Trust works collaboratively to support the business of the HSCB in a number of ways, aligning safeguarding children priorities to those of the HSCB business plans and contributing to the work of the board and subgroups.

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

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

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

WVT and CAMHS :

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

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

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

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

Young Ambassadors 2018

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

Caron Shelley
Named nurse safeguarding

DRAFT 2

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

**Achievements 2017/18**

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

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

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

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

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

**Priorities for 2018/19**

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

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

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

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

Alison Feher
Named nurse - safeguarding

DRAFT

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

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

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

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

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

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

Sue Thomas
Superintendent

National Probation Service

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

DRAFT 2

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

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

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

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

David Cookson
Deputy Head of Service

DRAFT 2

Warwickshire & West Mercia Community Rehabilitation Company PROBATION

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

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

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

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

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

George Branch
Assistant Chief Officer

DRAFT 2

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

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

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

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

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

DRAFT 2