HERTFORDSHIRE
safeguardingchildren
BOARD

Annual Report
April 2012 – March 2013

www.hertssafeguarding.org.uk

Essential Information

Annual Report compiled in August 2013 on behalf of Hertfordshire Safeguarding Children Board by:
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Approved by the Strategic Board in October 2013.

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Contents

The publication of an annual report summarising the work of the Hertfordshire Safeguarding Children Board (HSCB) and assessing the state of safeguarding across the partnership is a requirement of the statutory framework within which Safeguarding Boards work.

Independent Chair's Summary of Safeguarding Children in Hertfordshire

This 2012-13 report is my third annual report since becoming Chair of HSCB and the first produced under the new guidelines which were brought in by Working Together 2013.

The year has been one of considerable change for local partners with the reorganisation of NHS Hertfordshire into two Clinical Commissioning Groups, the development of the Health and Wellbeing Board as the strategic driver for services, and the election of the first Police and Crime Commissioner. In Hertfordshire these changes had less immediate impact on safeguarding than was foreseen at the time of writing the last Annual Report when I expressed my concerns about a potential lack of continuity. The Board was fortunate that a number of the lead PCT directors have taken up roles in the NHS Local Area structures and the existing named and designated NHS professionals transferred across into the CCG structures, so the potential disruption in partnership working was avoided. Continuity has also resulted from the election of the previous Chair of the Police Authority as the new Police and Crime Commissioner. Even though the change programmes were distracting, partners continued to show a strong visible commitment at Board level and this ensured the on-going prioritisation of safeguarding in all agencies. The County Council, as lead partner for the Board, remains very committed to the partnership approach to safeguarding and this is evident in both the work of HSCB and the Children's Strategic Commissioning Group.

What have been some of the key features of the Board's work during the year?

The high national media profile of sexual exploitation helped the Board to raise local awareness of this issue and implement key parts of the Government's Child Sexual Exploitation Action Plan. This had been an area of work which had not been highly prioritised in Hertfordshire in the past. As a result the work has involved significant commitment from professionals at all levels and briefing sessions have been very well attended. The establishment of wide ranging regular multi-agency meetings to discuss individual cases where young people are at risk of sexual exploitation is a great step forward.

As a result of a number of incidents in which young babies had been injured by their parents or carers, the Board carried out a detailed multi-agency audit of some cases and in depth reviews of those which had caused particular concern. The common factors identified were parental substance abuse, domestic violence and poor experience of parenting in their own childhood. This was not surprising as they repeatedly appear in national research into similar incidents. However, the work highlighted that all partners need to be particularly aware of the risks created by these factors when children are born to parents who are young and emotionally ill-equipped. It is in circumstances such as this where partners need to be very good at sharing information and their appreciation of risks, and then coordinating their interventions.

Throughout the year, the Board also audited and reviewed a range of individual child protection cases to both monitor performance and identify issues for improvement and learning. There were no cases which required a Serious Case Review and the audits did not show a persistent failure in one or more specific aspects of the safeguarding system. The challenge is more one of achieving a consistent approach to safeguarding in all cases by:

- encouraging professionals to effectively share information and be prepared to challenge their peers when assessing risk;
- ensuring that the child is always the focus when dealing with complex family circumstances, and
- keeping the basics of safeguarding children at the forefront of professionals minds at all times.

These factors are consistently reiterated in the Board's briefings and both multi-agency and individual partners' learning events, but there is an obligation on all partners to ensure that this learning brings sustained improvement in practice. This is particularly challenging in a County the size of Hertfordshire where getting consistency in standards of safeguarding practice need to be the goal.

During the coming year, partners will need to continue to improve their approaches to sharing information to capitalise on the progress already made by the establishment of a joint investigation team and a joint advice service for early help (known as the Targeted Advice Service – TAS).

So has safeguarding improved during 2012-13?

At the end of the year Ofsted carried out a full inspection of safeguarding in Hertfordshire. It included examination of a wide range of over 80 cases and discussions with partners and Board members to assess the strength of partnership working. Ofsted's grading of 'Adequate' was the same as the previous inspection in 2010. Whilst this was disappointing as there was not a clear improvement, it has to be seen against the much tighter approach to inspection that Ofsted has adopted and I feel much more confident that their work reflects the true nature of operational safeguarding rather than merely an assessment of policies, procedures and potential. The grading has also to be considered in light of the financial and management pressure on partners and the degree of change that was taking place during the year. As in our own audits and case reviews, the Ofsted inspection highlighted the challenge of achieving consistency in all safeguarding cases. During 2013-14, the areas for improvement identified during the inspection will be taken forward by a specific plan led by Social Care.

However, there are considerable pressures building in the safeguarding system and these could derail good progress if they are not appropriately managed…..

What are these pressures and the risks to continuing improvement in safeguarding?

These pressures include:

- increasing demands upon all services either because cases become more complex cases or numbers of referrals rise
- challenges to recruiting and retaining experienced staff in services such as social care, and
- the general increasing pressures on public sector budgets, which may severely test the commitment of organisations to keep safeguarding as a real operational priority in the long term.

Such issues are exacerbated in the landscape of changing structures and responsibilities; for example as schools, which are at the frontline of protecting children, become academies and services for children are increasingly provided by commissioned organisations.

In addition, there is a backdrop of:

- the new Working Together safeguarding guidelines, and
- the demands upon operational staff created by increasing numbers of referrals, assessments and protection plans.

These changes and risks will be regularly discussed in the HSCB Board and sub-committee meetings in the coming months to ensure that they are brought to the attention of partners and stakeholders if action is needed. Safeguarding systems rely very much upon the goodwill and personal commitment of professionals at all levels to share problems and identify solutions. Effectiveness can change relatively quickly if resourcing and resilience falls by the wayside, so this will need to be borne in mind in all of those Board discussions.

What are the Board's priorities for 2013-14?

The Board has priorities for three thematic areas of safeguarding to focus on in the 2013-15 period. These are:

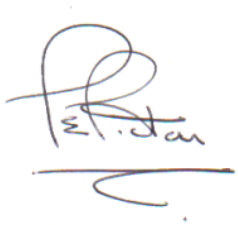
- Information and Risk Sharing
- Early Intervention and prevention
- Equality and Diversity

The Board will be endeavouring to ensure that partners are fully aware of their effectiveness in addressing these issues.

In addition to these priorities, the Board has identified a fourth priority 'Workforce and Board Development'. With the new Working Together guidelines creating the need for new structures and processes, the Board needs to make sure that they are fully embedded across all partners and every opportunity for better working is seized.

I have mentioned how safeguarding relies so heavily on the commitment of individuals and I would like to take this opportunity to particularly thank the members of the HSCB Business Unit and the lead representatives in each partner agency for the effort and willingness they have shown over the past year. Many of them have carried on unceasingly working to improve safeguarding even when they have been uncertain of their personal circumstances as their organisation or network of peers change. It is this commitment to children that gives me the optimism that the challenges and issues can be positively tackled in future.

In the following pages the report sets out the considerable efforts put into safeguarding children and the achievements of the Board and partners over the year. I have highlighted some of that work but for a fuller understanding of the state of safeguarding in Hertfordshire, I urge you to read on…..



Independent Chair
Hertfordshire Safeguarding Children Board

Local background and context for Safeguarding Children

Hertfordshire is located just to the north of London, covering an area of 634 square miles, with a population of around 1.1m, making Hertfordshire one of the most densely populated shire counties in England. There are approximately 278,300 children and young people under the age of 19 years. This is 24.9% of the total population of Hertfordshire. This is predicted to rise to approximately 303,000 by 2020. The biggest increase will be in the 0-14 population with only a slight increase in the 15-19 age group. The proportion of children entitled to free school meals in Hertfordshire is lower than the national average. School-aged children and young people from minority ethnic groups account for 24.1% of the total population, compared with 25.4% in the country as a whole. 2011 Census information shows that the largest minority ethnic groups in Hertfordshire are Asian (6.5%), Black African and Black Caribbean (2.8%) and a notable Eastern European population (1.3%). The proportion of pupils with English as an additional language (11.6%) is below the national average (15.9%) with the main languages other than English being Urdu, Polish and Gujarati.

There are ten district and borough council areas in the county. Watford and Stevenage are relatively densely populated wholly urban districts. East Hertfordshire and North Hertfordshire, outside their main urban towns, have large areas of rural countryside. The remaining districts of Broxbourne, Dacorum, Hertsmere, St Albans, Three Rivers and Welwyn Hatfield are more mixed. The 'Index of Multiple Deprivation' shows that Hertfordshire is consistently one of the least deprived areas of England; however, the general prosperity of the county is not evenly spread, and there are a number of pockets of deprivation and considerable variation across the county. All ten local authorities have pockets of considerable deprivation within their boundaries and a number of communities in Hertfordshire suffer from a range of elements of socio‐economic deprivation, including child poverty, overcrowding and dependence on welfare benefits. Examples of local authority wards experiencing such deprivation are Borehamwood, Cowley Hill, Northwick, Bedwell, Oughton, Meriden, and Waltham Cross.

During 2012-13 Ofsted inspected Hertfordshire's local authority arrangements for the protection of children. A copy of the full report is available here:
http://www.ofsted.gov.uk/local-authorities/hertfordshire

The findings of the report are as follows:

Local authority arrangements for the protection of children

Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate

Governance and accountability arrangements

Statutory and legislative context for Boards

The functions of the Board are set out in primary legislation (sections 14 and 14(a) of the Children Act 2004) and statutory regulations (Local Safeguarding Children Regulations 2006). The work of the Board during the period covered in this report was governed by the statutory

guidance in Working Together to Safeguard Children 2010. This was revised at the end of 2012-3 and implementing the new requirements in will be a priority area for HSCB in 2013/134

Board role and structure

All local authorities are legally obliged to have a children's safeguarding board as the mechanism for agreeing how the statutory partners work together to safeguard and promote the welfare of children, and ensure that this work is effective.

The HSCB has two statutory objectives and functions:

"(a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) To ensure the effectiveness of what is done by each such person or body for those purposes. "

The HSCB achieves these functions through the following:

- monitoring effectiveness of what is done to safeguard and promote the welfare of children
- establishing effective communication and information sharing across agencies
- undertaking serious case reviews
- collecting and analysing information about child deaths, and agreeing procedures to ensure a co-ordinated response to unexpected child deaths
- developing policies and procedures for safeguarding and promoting the welfare of children
- evaluating the effectiveness of agencies working together and advising on ways to improve these crucial relationships
- developing, coordinating and delivering relevant multi agency training.

All partner agencies in Hertfordshire are committed to ensuring the effective operation of the HSCB. This is supported by a formal "compact" setting out the relationship between partner agencies and HSCB.

Independent Chair

HSCB has been independently chaired by Phil Picton since 2009. During the period of this report, he was accountable to the DCS, however at the end of the year with the new national guidelines published, this accountability moved across to the Chief Executive of the County Council.

Phil has ready access to Directors of all the partner agencies and meets with them on a one to one basis to discuss safeguarding issues.

The **Director of Children's Services** (DCS), Jenny Coles, has professional responsibility for the leadership, strategy and effectiveness of local authority children's services. In Hertfordshire the DCS is also the Director of Safeguarding and Specialist Services for Children. She is a member of the Board and leads for the council on the effectiveness of the Board and also for Safeguarding Children Jenny is very active within the Board and she meets

frequently with the Chair to discuss the progress of safeguarding and sometimes individual cases which have caused concern.

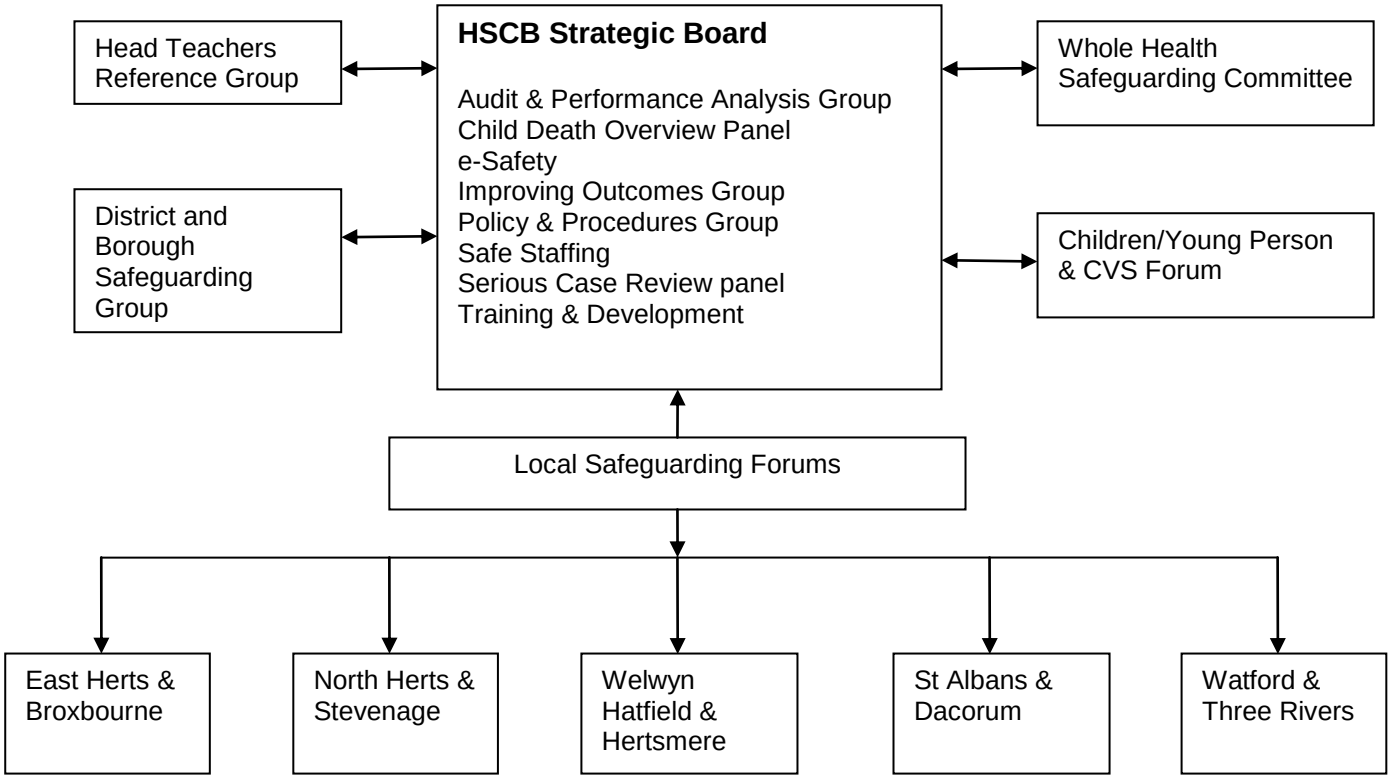
The elected councillor who is **Lead Member for Children's Services,** Richard Roberts, is a 'participating observer' of the HSCB as required by the Working Together guidelines. He attends Board meetings and receives all of the Board papers. This enables him to join fully in Board discussions and to challenge the DCS and Board members on appropriate issues.

The work of HSCB is reviewed annually by the HCC Overview and Scrutiny Committee through the work of a topic group. At that meeting Board members and sub-group chairs explain the issues and risks to safeguarding children and are about what has been achieved and the future plans of the Board. The report from the 2012 HSCB Topic Group can be accessed at **click here**

Hertfordshire is a large County with one of the largest children's populations in the country. As a result the Board has had to develop a significant structure of sub-groups to achieve its work. As shown on the below diagram the Board has three types of sub-group:

- Standing Sub-committees (shown in the central box) which particularly address the priorities in the HSCB Business Plan and the statutory requirements for reviewing child deaths and serious cases. The work of these groups is discussed further in the following pages of the plan, but they are all made up from managers drawn from across the range of the Board's partners.
- Four special interest groups representing schools, district and borough councils, health professionals and the voluntary sector (shown to the left and right of the main box). These groups allow specific discussions to take place about the risks and issues to safeguarding
- Five local forums which provide the opportunity for local networks of professionals who work in safeguarding to be strengthened and to ensure that a link exists between frontline practice and the strategic Board.

The Strategic Board meets four times during the year and has a membership made up of representatives from all the statutory partners and others concerned with safeguarding children. Annually the Board has an extended Board meeting where all members of the sub groups, local safeguarding forums and district councils can attend and in addition there is a Board development day annually where the Board reviews the year and agrees the aims and objectives for the coming year and the business plan.



Membership

The key partners show considerable commitment to safeguarding by the level of representation at Strategic Board meetings with directors invariably attending. Across the Strategic Board and its sub-groups the statutory safeguarding partners are also well represented. These statutory partners are:

- District councils
- Cafcass
- Hertfordshire Primary Care Trust

NHS Trust and NHS Foundation Trusts –

  - East & North Herts Hospitals
  - NHS Hertfordshire Community Health Trust
  - West Herts Hospitals NHS Trust
  - Herts Partnership NHS Foundation Trust

- NHS England - Hertfordshire and South Midland Local Area Team
- Hertfordshire Constabulary
- Hertfordshire County Council Children's Services - Education & Early Intervention (includes Youth Offending Team)
- Hertfordshire County Council Children's Services - Safeguarding & Specialist Services
- Hertfordshire County Council Health and Community Services
- Hertfordshire Probation Trust
- Maintained school
  - Hitchin Girls School (Secondary Schools)
  - Lakeside School (Special Schools)
  - Broadfield Primary (Primary Schools)
- Further education institution

In keeping with the recommendations of the Munro Review and changes to legislation, the Board has recruited two lay members who joined the Board in late autumn 2012. These lay members attend the Strategic Board and will become involved in the Board's work with the wider community.

Budget

The Board has have been reasonably fortunate in the commitment to financing it which has been shown by the partners in recent years. However as we look forward the budget is to be reviewed in light of ever increasing demands on agency's finances and resources and also to reflect the new Working Together 2013.

Contributions are made from partner agencies as below: for 2012/13

Contribution Amounts	**£**
Herts County Council	317,937
Police and Crime Commissioner	18,167
Hertfordshire Primary Care Trust	99,918
Probation	4,542
Cafcass	550
Total	**441,114**

Other Income	**£**
Courses & Activities	3,375
Miscellaneous income	3,125
Total income 12-13	**447,614**

Expenditure	**£**
Salary and salary related	281,396
Transport	5,685
Supplies and Services	96,517
Total Expenditure	**383,598**

Child Protection Performance and Activity

HSCB Dataset

HSCB Originally commissioned a dataset in 2010 and since then has continued to develop it as each version has been published. This work has been carried out within the Audit and Performance Analysis Group (APAG).

There are 6 Strategic Outcomes in the dataset which are the focus of the performance:

Strategic Outcome 1: Correctly identify the children and young persons most at risk of neglect and abuse through effective and timely application of established processes.

Strategic Outcome 2: Prevent neglect and abuse, in the family of those identified as being at risk through effective and early multi agency intervention.

Strategic Outcome 3: Ensure the safety and wellbeing of children and young people in care through effective risk management and support.

Strategic Outcome 4: Ensure children and young people are safe and secure from all types of harm including bullying and when accessing technology.

Strategic Outcome 5: Protect children and young people by rigorous recruitment, training and vetting procedures in relation to those adults coming into contact with them.

Strategic Outcome 6: Ensure children and young people are kept on the right track and provide appropriate levels of support to reduce the number involved in offending/at risk of offending.

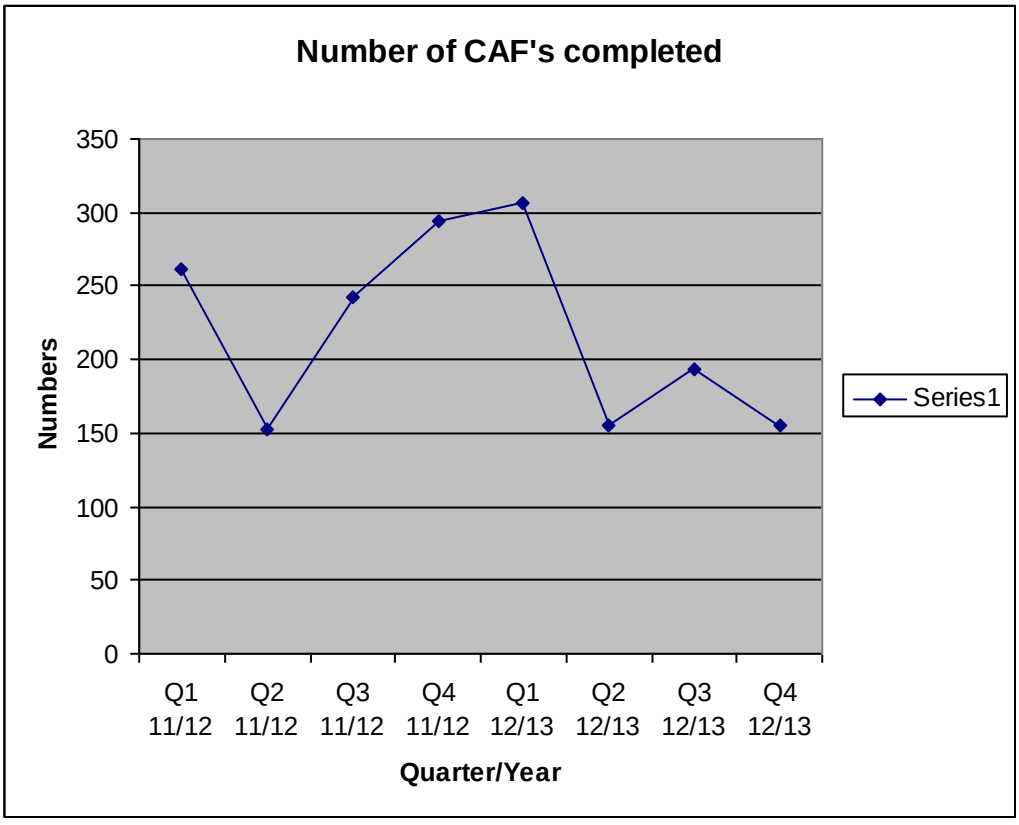
28 key indicators then sit underneath these Strategic Outcomes to help measure the performance against them. A full list of the 28 indicators and additional context/process measures are contained in appendix 3.

The dataset is produced from partnership data and commentaries on a quarterly basis. APAG then review the performance and highlight trends, increasing risks and opportunities to the Board. An up to date version is discussed at every Strategic Board meeting.

The number of CAFs by Assessment.

The Common Assessment Framework (CAF) is a way of assessing the needs of a child. It includes filling in an assessment form with a family and someone who works with the child (such as their teacher or health worker). The form covers lots of different areas of the child's life, including their school work, social development, health and home-life. Once a CAF is completed, the practitioner shares it with the parent/carer and then identifies other practitioners who can assist the family and child. The CAF is an early intervention tool and is used prior to referrals to Children's Social Care

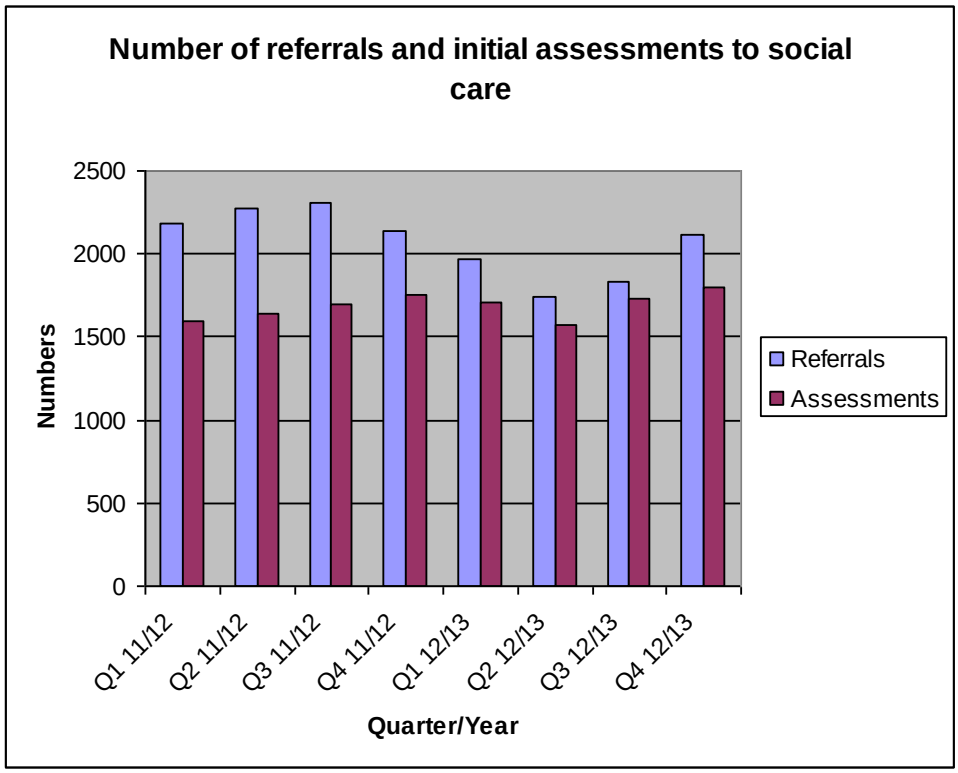
There was a significant decrease in the number of CAF's completed after Quarter 1 of the year, which then remained at a lower level throughout the rest of the year. In comparison to the previous year, there were 811 CAF's completed during 2012/13 which is a decrease from 950 during 2011/12.



Referrals to Social Care

Having dropped during the first two quarters of the year, the number of referrals to social care increased toward the end of 2012/13, as there were 2116 referrals during Quarter 4 and 1795 Initial Assessments carried out.

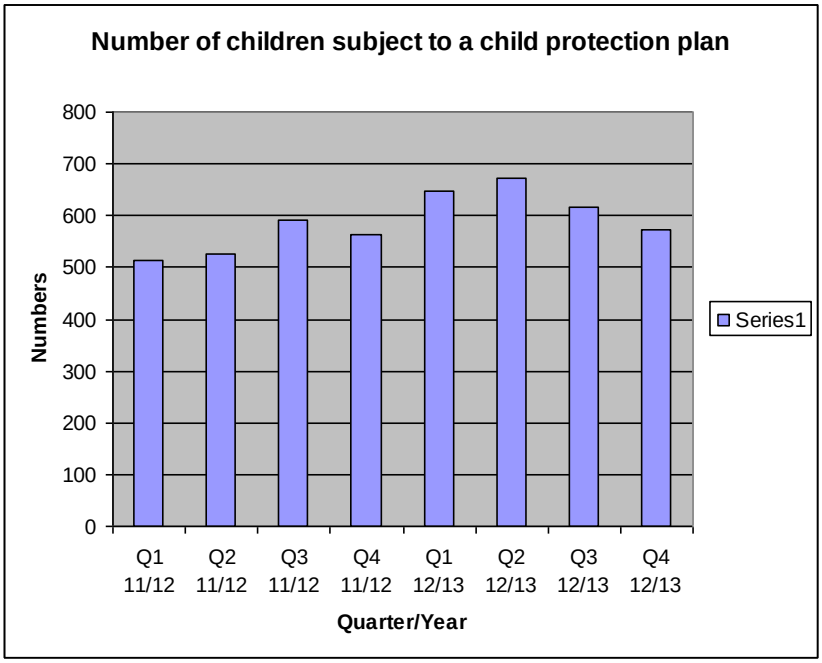
Overall the total number of referrals received during 2012/13 was 7662 compared to 8910 during the previous year. The total number of initial assessment carried out during 2012/13 was 6796 compared to a total of 6694 during the previous year. An increase in referrals and assessments creates higher workloads for staff across all agencies as they need to spend more time sharing and analysing information and risk assessments. However the closer relationship between the number of referrals and assessments suggest that professionals are referring cases more accurately in terms of the thresholds which apply to safeguarding.



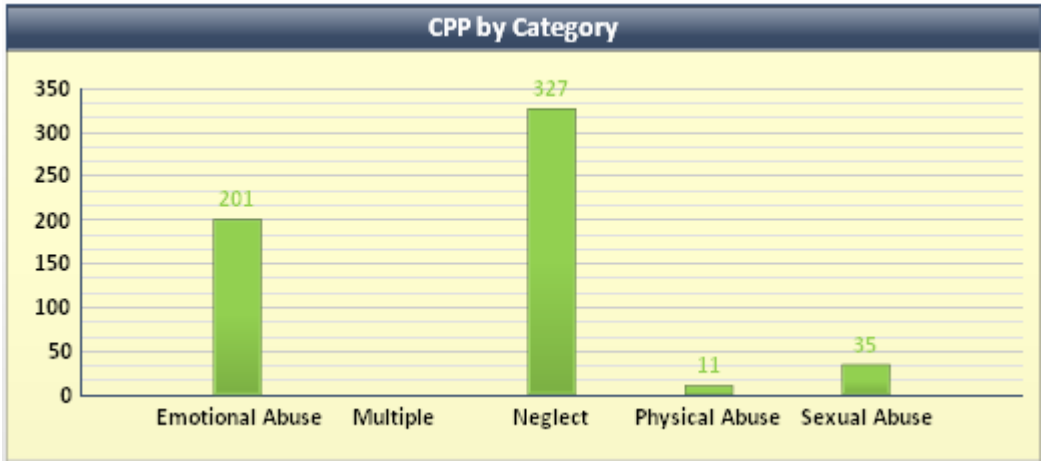
The number of children subject to a child protection plan

The number of children subject to a child protection plan peaked between Quarter 1 and Quarter 2 of the year of 2012/13, and has since reduced during the last two quarters of the year.

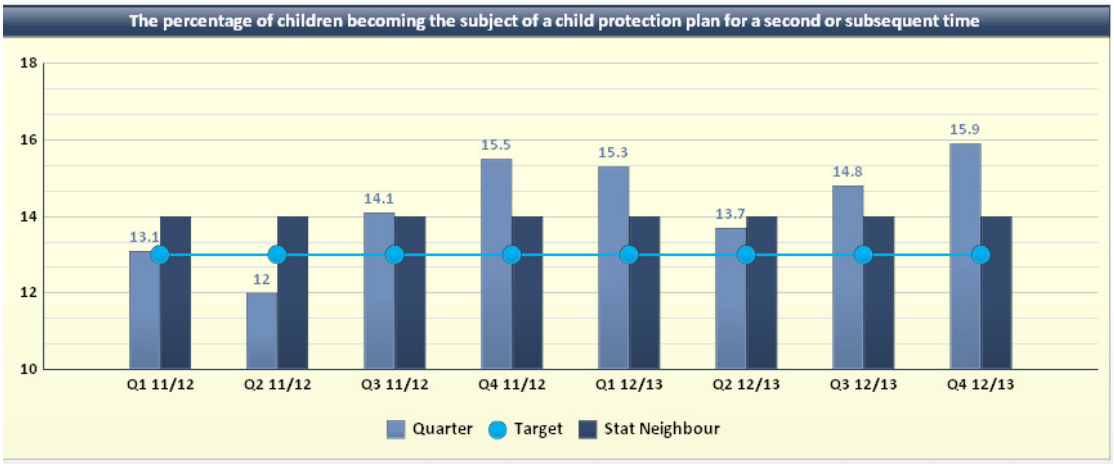
At the end of the year 2012/13 there were 574 children on a child protection plan compared with 562 at the end of 2011/12



Breakdown of Child Protection Plans by Category at the end of 2012/13



The percentage of children becoming subject of a child protection plan for a second or subsequent time.

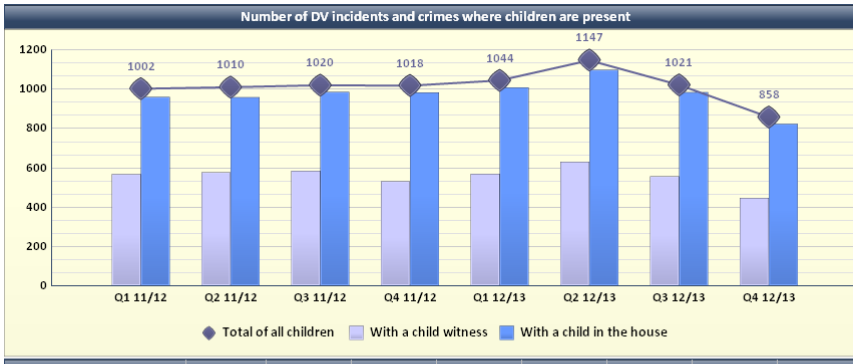


	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Number becoming subject to CPP (Rolling Year)	543	542	653	663	714	779	728	734
Number becoming subject to CPP for 2nd or sub time (R	71	65	92	103	109	107	108	117
% becoming CPP for a second or subsequent time	13.1	12	14.1	15.5	15.3	13.7	14.8	15.9

Although children returning to be on Child Protection Plans is a relatively small number of children, the Hertfordshire data is generally higher than other similar authorities. An excessive number of children returning to plans may reflect the level of support which families receive when a plan has finished and the child returns to a less supportive situation (known as stepping down). At the end of the year, his was still identified as an issue of risk by the Audit and Performance Group and as a result an audit is planned for April 2013 to see if there is any specific pattern for repeat protection plans. The results of this audit will be available later in the year.

The Number of Domestic Violence Incidents where Children were present.

The number of domestic violence incidents were children were present that occurred during 202/13 saw an increase during quarter 2 of the year but then reduced during quarter 3 and again in quarter 4. In total 4070 incidents of this nature occurred in 2012/13 compared to a total of 4050 during 2011/12. Parental domestic abuse is recognised nationally as a significant issue in creating emotional and other harm to children. The decline in numbers in the second half of the year is to be welcomed, but a longer term view will need to be taken to identify whether this is an on-going trend and whether particular initiatives can be seen to be creating this effect. There is a Domestic Abuse Strategy Group in place that works across the county including organising training to help tackle domestic abuse.



	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Total of all children	1002	1010	1020	1018	1044	1147	1021	858
With a child witness	568	577	585	531	570	631	557	447
With a child in the house	960	959	986	983	1008	1098	985	823

The HSCB business plan

At the start of 2012/13, HSCB set itself a very ambitious plan to address a wide range of issues. As you will see from the following pages, the priorities were generally accomplished, however there is still a need to both maintain performance and improve in specific areas, This will be achieved by activities within individual organisations and through joint working. The priorities of the 2012-13 Plan were:

Theme1: Improve safeguarding of children and young people through improved multi-agency working around the child and family and ensure children's safeguarding needs are met effectively at appropriate levels of intervention

Theme 2: Improve our response to known parental and family risks for safeguarding children including addressing issues relating to mental health, learning disabilities, substance misuse and neglect

Theme 3: Evaluate how effectively children from particular minority groups are safeguarded and ensure partner agencies respond to identified areas for improvement

Theme 4: Effective training supports practitioners to safeguard children and young people

Theme 5: Monitoring and evaluating the effectiveness of partners work to safeguard children through this period of organisational change and budget reductions including:

- improved use of multi-agency data
- multi-agency audits and other qualitative measures
- improved use of single agency performance monitoring including qualitative measures

The progress on the business plan is very much the work of the standing sub-groups of the Board. In the following pages the work of those groups and their accomplishments and impact is discussed in detail. It is this work which has brought the objectives of the Business Plan to fruition.

In addition to the above objectives the Board looked to improve its communication with young people and as such the HSCB has a Youth Apprentice who has regularly attended meetings of the Children in Care Council and in particular the Care Leavers Group and has fed information to and from the group.

Audit and Challenge.

One of the core functions of HSCB is to monitor and evaluate the effectiveness of safeguarding and to advise organisations on ways to improve. This involves carrying out case reviews and audit work but also learning from the judgements of external inspections and audits, such as Ofsted and the Care Quality Commission (CQC). This audit, challenge and improvement work has been on-going all year mostly through the detailed work of the APAG sub-group and by reports to the Strategic Board.

External Inspection and Audit

Ofsted Inspection – Inspection of local authority arrangements for the protection of children

This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they talked to children, young people and their families. In addition the inspectors analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

The inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

The overall effectiveness of the arrangements to protect children in Hertfordshire was judged to be adequate and although this inspection grading was the same as previous inspections the methodology was significantly more focused on the experience of children and families and quality of practice with children and families rather than the robustness of policies and procedures as in earlier inspections.

Areas for improvement:

In order to improve the quality of help and protection given to children and young people in Hertfordshire, Ofsted made the following recommendations/actions to the local authority and its partners should take the following action.

Immediately:

- Ensure initial assessments are signed off by managers once agency checks have been received and considered
- Ensure that all assessments have sufficient focus on the voice and journey of the child, their individual needs and contain an effective analysis of risk
- Ensure that all children being stepped down from child protection plans receive support and monitoring appropriate to their assessed needs
- Ensure that all child in need and protection plans are robust, specific and have clear timescales which enables parents to have an effective evaluation of progress
- Ensure that action is taken to reduce waiting times for the cases held by the targeted advice service.

Within three months:

- Ensure children and young people are able to access advocacy services and are routinely encouraged and supported to attend case conferences in order that their experiences, wishes and feelings are effectively considered by professionals
- Ensure that chronologies are effectively used to inform assessment and planning processes and that these are updated regularly
- Ensure that the equality and diversity needs of children and young people are effectively considered within assessment and planning processes
- Ensure that performance management and quality assurance arrangements are fully embedded and lead to sustained improvements for service provision and support to children

Within six months:

- Ensure service planning is better influenced by the views of children, young people, parents and carers.

Inspectors noted “a good level of attendance and commitment” to the HSCB and “effective partnership working across Hertfordshire with clear reporting arrangements between the LSCB and its member organisations.”

Ofsted also highlighted a number of areas for improvement and through this business plan and the ongoing work of the subgroups, the HSCB will seek to work with partner agencies and maximise efficiency in safeguarding children by addressing the issues raised.

The areas for improvement are being actioned through a specific plan, led by the local authority, involving partners as appropriate and monitored by HSCB.

Youth Offending Inspection

During 2012/13 there was also a Core Case inspection of Youth Offending work in Hertfordshire by the Inspection of Youth Offending and Joint Criminal Justice Joint Inspection Service.

The Core Case Inspection of youth offending work in Hertfordshire focused exclusively on the work undertaken by Youth Offending Teams with children and young people who have already committed an offence. Its purpose was to assess if the work was of a sufficiently high standard to protect both the public from any harm resulting from the child or young person's offending behaviour and the child or young person themselves, whether from their own behaviour or any other source.

The inspection was based on a rigorous examination of a representative sample of cases supervised by the Youth Offending Team. Overall, Hertfordshire Youth Justice Service performed reasonably well in this inspection. There were examples of creative, thoughtful case management and effective engagement with children and young people and families. However, the Service had been through a period of significant transformation less than a year before the inspection, and was still at the 'bedding in' stage. In this context, the inspection found there were a number of key areas of practice, especially in relation to Risk of Harm and Safeguarding that needed to be improved.

The Inspection made the six following recommendations to the Hertfordshire Youth Justice Service:

1) Quality Assessment and intervention plans are completed to good quality using Asset at the start of the Order

2) Timely and high quality assessment of vulnerability and risk of harm is completed at the start of the case

3) Intervention plans reflect learning styles and diversity factors and set realistic goals and timescales and is clearly sequenced

4) Assessments including vulnerability and risk of harm are regularly reviewed and updated following receipt of important new information, intelligence and reports of harmful behaviour or the commission of new offences

5) Management oversight is effective in ensuring the quality of assessment and plans to manage vulnerability or Risk of Harm to others, and ensures that planned actions are delivered

6) sufficient attention is given to the safety of victims throughout the course of the sentence

The action plan for improving against the inspection recommendations was discussed at the Strategic Board and will return during 2013-14 for an assessment of its success.

Audit and Performance Analysis Group

The Audit and Performance and Analysis Group (APAG), a multi agency group met four times across the year and was made of colleagues at senior manager level from organisations across the Partnership. APAG's overall objectives are:

To analyse safeguarding performance data and identify any risk to performance, receive and analyse reports of single agency audits, conduct multi-agency audits and oversee and monitor the audit component of the multi-agency Serious Case Review action plans.

Since 2010 APAG have been developing a multi-agency dataset, which it continues to develop. The dataset which draws on 28 key indicators (see appendix 3) is used to identify emerging issues and risks. All partners have secure access to the dataset.

The Performance Management Framework used by APAG and the dataset are informed by the model developed in the Eastern Region. Work continues to develop regional indicators to help measure and benchmark performance against other Safeguarding Children's Boards in the region. Board members have been regularly involved in meetings and workshops supporting the development and implementation of this regional work.

During the last year APAG has completed two large scale multi agency audits on the following themes:

The first Audit

- A multi-agency audit of seven young babies subject to serious non-accidental injury (NAI) who were apparently not known to services. This audit was to establish to what extent the families were known to services, what if anything was missed and ultimately, if the injury was considered to be potentially preventable.

- The Audit focused on:
    - the demographic background of the baby/parents/family
    - to what extent the families were known to services
      - was this appropriate
      - what if anything was missed

The second Audit

- A Partnership Audit following the Child's Journey, where 10 cases were chosen from across Hertfordshire, falling in to the following categories:

- Two cases of Child in Need
- Two cases involving Child Protection Plans
- Two cases where there was No Further Action (NFA) or case 'stepped down to CAF x 2
- Two re-referrals (TAS)
- Two cases involving the Targeted Youth Support (Adolescents) (TYS)

This audit measured:

- The effectiveness of the help and protection provided to children, young people, and their families and carers
- The quality of practice
- Leadership and governance
- Overall effectiveness, including areas for development

In general partners taking part in the audit felt that Partnership working was good, they felt information was shared and partners felt comfortable to escalate concerns if needed. The areas were partners felt improvements could be made were sharing information more timely with Children's Centres and Schools.

The above audits have produced recommendations that have been developed in to SMART Action Plans, which have been taken forward through the work of APAG. Some outcomes have included:

- Partnership Case Reviews carried out on individual cases
- Raised awareness/promotion of key chapters within the HSCB Procedures (i.e. the Bruising flowchart and pre-birth protocol)
- Development and commissioning of training courses
- Raised awareness about existing training courses
- Improved Inter-agency communications

APAG also completed a Section 11 Audit of the District and Borough Councils within Hertfordshire.

Safeguarding children is everyone's responsibility. S.11 of the Children Act places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

It is important to remember that S.11 does not give agencies any new functions, nor does it over-ride their existing functions. Instead it requires you to carry out your existing functions in a way that takes into account the need to safeguard and promote the welfare of children

The audit is aimed at enabling agencies to improve safeguarding practice in order to keep children safe from harm and improve earlier intervention. The audit is part of HSCB's responsibilities to monitor the effectiveness of agency practice in this area. The different partners of HSCB are scheduled on a rolling plan to be audited and in 2013-14 the County Council will be the subject of an audit. The Audit is a self assessment process completed by the individual agencies.

Any areas for improvement which were identified during the audit process were discussed with the individual district/borough councils and are being taken forward by them

The following standards were seen as possible risk areas:

2.3) When other organisations are commissioned to provide services on the organisation's behalf there are mechanisms in place to ensure that those organisations also have regard to the requirements of section 11

3.3) Staff/volunteers are aware of what their personal responsibilities are if they are concerned about a child/young person

6.1) The organisation has an accessible safe recruitment policy which covers how to recruit safely for staff who have contact with children, including what checks need to be undertaken to determine suitability.

Five of the district councils had areas where improvements were recommended and four out of the five have provided updates on these recommendations.

Reviewing Child Deaths

Hertfordshire has a Child Death Overview Panel; the purpose of the Child Death Overview Panel (CDOP) is to review all deaths of children and young people up to the age of 18 who are normally resident within the County. The broad purpose of the review is to identify any

modifiable or avoidable factors or learning which could help to prevent similar deaths in the future. Themes or emerging patterns are reported to the Strategic Board or used to develop practice in the individual agencies or across the partnership.

The CDOP group is chaired by a representative from public health and includes representation from the key partners.

In 2012-2013 83 deaths were reviewed by CDOP. 32 of these deaths occurred in 2010 or 2011 but the review had been delayed to await the coroners inquest. There were 62 child deaths during 2012/13 compared to 78 during 2011/12.

The panel or a sub-group of the panel met eight times during the reporting year.

Key events and learning

The panel identified 15 deaths with modifiable factors -18.1% (meaning with factors that could have been changed for a different outcome). It is probably the most important function of the panel to identify these factors and to put in place plans to minimise their recurrence.
All cases of sudden unexpected unexplained death (SUUD) had modifiable factors which are now well recognised (co-sleeping and smoking being the commonest). This is in keeping with the national analysis of such deaths. In other categories of death the modifiable factors were related to home safety, parental behaviour and problems with medical care including recognition of the seriousness of the medical problem, and either non-adherence to protocol or inadequacy of an existing protocol.
Where there was a question about the quality of health-care the cases have been the subject of a serious incident (SI) enquiry and in one case where there was concern about multi-agency involvement it was subject to an in-depth partnership case review (see the following section)

During this year, it appeared that we were seeing a larger than expected number of deaths from mitochondrial disorders (when body's mitochondria fails to function properly – mitochondria are the cell's power producers. They convert energy into forms that are usable by the cell). This prompted an enquiry to other CDOPs to ascertain whether they had also seen an increase. The group also enquired of Great Ormond Street hospital (our local referral centre for such children) as to whether they had seen an increase in cases. The rise in numbers in Hertfordshire was not reflected elsewhere and therefore is likely to be a chance finding rather than an increasing trend.

CDOP also raised concern about policies related to failure to attend appointments with the children's mental health service (CAMHS). The immediate response to a child's death in a few cases highlighted the need for further training for GPs, adult services and paramedics. The need for ongoing training to new members of staff (especially in the police service) was also made clear. Training and information has been provided for all these services and will continue to be offered.

The work of CDOP is not merely about identifying areas for improvement. It was also possible to note good practice, including end of life planning for children with life limiting conditions and excellent bereavement support. The panel is now aware of the availability of support for families when children die in surrounding hospitals as well as resources within Hertfordshire.

Campaigns about safe sleeping, blind cord safety and water safety were launched within the year as a result of learning from previous years. Our blind cord safety campaigns have

influenced attention to this issue, both with parliament and local business and significant safety changes are being made.

Following a national report on the factors associated with sudden unexpected unexplained death (SUUD), and concerns raised about the possibility that 'safe sleeping' campaigns might discourage breast feeding, additional questions were added to data collection systems relating to infants and neonates (infants under four weeks old). These record whether children had been breast fed, and the body mass index (BMI) of the mother at antenatal booking. It should be possible to report on these factors in coming years.

Reviewing Individual Cases of Death or Serious Injury in Particular Depth

The Serious Case Review (SCR) sub-group has an independent chair and is a multi-agency panel represented from senior safeguarding representatives from the following organisations and agencies:

- Children's Services
- Education
- Health
- HSCB
- Mental Health Services
- Police

The panel meet on a monthly basis (or as required) to discuss referrals to the group and recommend to the Chair of the Board whether a serious case review, other form of multi-agency review or any other actions should result from the referral. The final decision whether to commission a Serious Case Review lies with the Independent Chair of the Board.

Although there are now new guidelines regarding case reviews, under *Working Together 2010*, HSCB was required to carry out a serious case review (SCR) if a child dies and abuse or neglect was known or suspected to have been a factor in the death. It was also required to consider carrying out a SCR where a child has been seriously harmed; abuse or neglect was known or suspected to have been a factor, and the case gave rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of the child. An SCR should also have been considered in cases where there was a Domestic Homicide Review (DHR).

Key events and learning from the cases

No cases reached the threshold for a decision to hold a Serious Case Review in 2012-2013.

During the year of this report 10 cases were referred to the SCR group**. Three** of these cases were progressed into Partnership Case Reviews (PCR) - a model developed by HSCB to review serious incidents that do not meet the criteria for a serious case review.

A 4th partnership case was commissioned following the death of a 19-year old care leaver where it was considered there was joint learning for services for children and adults. This PCR was led by the Hertfordshire Adult Safeguarding Board (HSAB) with the support of HSCB.

A summary of the 4 PCRs is illustrated in the table below.

PCR	Issues	Summary of Learning
PCRs 1 and 2	Non accidental injuries to babies under one year old, vulnerable young parents, mental health issues	• Failure to regularly use and collate relevant family history by individual agencies, and share this with other agencies • Information sharing and professional communication across county boundaries a challenge • Lack of an effective step down process from CP plans left families without any level of coordinated support. • If there is any question or likelihood of [recognising] non-accidental injury by a professional, then this must generate the need to follow Child protection procedures. • There is a danger in taking an over optimistic view of parenting ability.
PCR 3	Attempted injury to a young baby, vulnerable young parents, domestic abuse, mental health issues	• To have a pre-birth initial child protection conference (ICPC) just prior to the birth significantly compromises the ability for key actions to address levels of risk to be undertaken. • A failure to utilise the specific guidance and procedures such as those contained in the Hertfordshire pre-birth protocol, will mean that an important resource and framework for intervention is underused, and as a consequence, will unnecessarily adversely affect practice that is undertaken. • There is a need to ensure that prospective fathers are separately assessed in terms of their background and parenting abilities. • All agencies have the responsibility to escalate their concerns if they consider that actions by other agencies are not being undertaken in line with good practice or local procedures. • A communication system which can flag up to relevant agencies that a young person who is in receipt of services, is pregnant, would improve the multi-agency response to the pregnancy and ensure that appropriate services are in place at an early stage. • Information sharing and professional communication across county boundaries a challenge
PCR 4	Death of a 19-year old care leaver, concerning behaviours and mental health issues	• Where patterns of concerning behaviours of vulnerable young people fluctuate over time, then there is a need for an assessment process which is continual. • There is a need for a better understanding of the interface between clinical care planning and social care planning and of ways in which they can be integrated most effectively • There is the need for the development of more effective and consistent practices for the transition of care leavers into adult life • There is a need for clearer guidelines in respect of the sharing of information and confidentiality in respect of young adults who are considered as vulnerable, especially those who are leaving the care of the Local Authority.

In addition to multi-agency reviews, the group also oversees single-agency independent management reviews and actions arising from cases that do not meet the criteria for full reviews.

A joint individual management review (IMR) was commissioned from a school and Children's Services' Targeted Advice Service (TAS) following the death of a 15 year-old girl who was believed to have committed suicide. The report made recommendations to the school and TAS regarding improving their procedures.

Learning from all of these reviews has been incorporated into the HSCB bulletin and disseminated via Local Safeguarding Forums as well as being incorporated into HSCB training programmes. These have included a particular focus on:

- training for professionals working with children with disabilities
- Awareness raising and training for professionals, providers and retailers around the use of and sale of butane.

Single and multi-agency agency processes and procedures have been improved including;

- Holistic questioning of pregnant women by midwives
- Improvements to the police's Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) form which now includes questions around pregnancy and parentage;
- Improvements to the assessment and review of vulnerable young people living in semi-independent accommodation
- Improvements to the commissioning processes around semi-independent accommodation
- Improvements to information sharing around young people living in semi-independent accommodation
- Improvements to Child in Need procedures including mandatory use of the Graded Care Profile for all cases of suspected neglect.

Work and Accomplishments of the HSCB's other Sub Groups

e-Safety

This sub-group was formed to address the risks to children and young people from the use of digital media such as mobile phones and internet access. More specifically, the aim of the e-Safety sub group is to:

Develop a strategic approach to the management and support of e-Safety incidents in Hertfordshire, ensuring that all agencies are able to support parents, carers, professionals and young people with e-Safety issues by providing advice, guidance and training.

The group linked into the work of the SEARCH (Sexually Exploited and Runaway Children) sub group (that sits under IOG) to further strengthen links with CSE and e-Safety

During the term of this report, the e-Safety sub group has achieved the following milestones:

- reviewed e-Safety policies and procedures to reflect the latest national and local advice
- promoted Safer Internet Day 2012 across the county including schools, children's centres and libraries
- developed specific e-Safety advice and guidance for parents and carers.
  Mind the Gap was designed to help to start conversations around internet safety and provide clear practical guidance:
  http://www.thegrid.org.uk/eservices/safety/parents.shtml

- Facebook and the increasing use by the under 13s. New resources developed to raise awareness of the potential risks to children using Facebook and the practical actions parents/carers can take: http://www.thegrid.org.uk/eservices/safety/social_networking/facebook_personal.shtml
- produced termly e-Safety newsletters to inform and educate professional which are distributed widely across all children's settings and beyond: http://www.thegrid.org.uk/eservices/safety/news/newsletters/

Hertfordshire was praised by the lesbian, gay and bisexual charity, Stonewall for their anti Homophobia work regarding bullying which often involves the use of digital media. The County was recognised for carrying out regular surveys among its primary and secondary pupils about bullying to help shape anti-homophobia work.

Improving Outcomes Group

The aim of the Improving Outcomes Group (IOG) is to:

Ensure effective multi-agency working on operational issues relating to safeguarding children, and deliver agreed elements of the HSCB business plan that focus on partnership working and integrated delivery of services. It also oversees and monitors task and finish groups set up to improve outcomes for specific groups of children or young people.

During the term of this report, IOG has achieved the following milestones:

- Established an interface project to build bridges between probation, mental health, learning disability services, substance misuse services and children's services, there are now four new Interface workers in post.
- There has also been interface between adult and children's services, promoting opportunities for joint working and co-location of teams and professionals to better protect children and share information
- Developed and rolled out district local safeguarding forums, there are now 5 forums operating within Hertfordshire, each taking place 4 times a year.
- Implemented a new step up/step down process, which once fully imbedded will be audited by APAG.
- Piloted and implemented the Graded Care Profile which it continues to train on and embed
- Establish protocols to enable organisations to communicate securely
- Raised awareness of protection needs of children with disabilities
- Led the county response to the Department for Education (DoE) Action Plan and responded to the recommendations made by the Office of the Children's Commissioner on relation to Child Sexual Exploitation.
- Raised awareness and action groups for children sexually exploited

Child Sexual Exploitation

Specific outcomes from the CSE work mentioned above include:

- The development and implementation of a multi agency Child Sexual Exploitation action plan
- Creation of the SEARCH Panel which monitors and responds to cases or missing children who may also be vulnerable to sexual exploitation.

- Implemented Operation Halo, which is a multi agency campaign to raise awareness, prevent and tackle cases of child sexual exploitation within Hertfordshire.
- HSCB supported a Children in Care Council event around healthy relationships and provided an experienced practitioner to take part in the event.

A continued area of focus for the IOG will be developing new approaches to identifying and monitoring private fostering, when -

a child under the age of 16 (18 if disabled) is cared for and accommodated by someone other than a parent or close relative for more than 28 days.
The numbers of reported cases of this type of arrangement continue to be low (currently 16) and the true figure is considered to be much higher. The group will continue to receive reports on the numbers and drive activity to raise awareness with professionals to appropriately refer instances that they become aware of. For more information on Private Fostering see the HSCB website

Policy and Procedure Group

The aim of the Policy and Procedure Group is to

Ensure that the HSCB produces, reviews and updates its procedures for inter-agency working to safeguard and promote the welfare of children as required by Working Together to Safeguard Children 2013 and also ensures that HSCB member agencies also have policies, procedures and guidance for safeguarding and promoting the welfare of children in place.

The group also leads the implementation of HSCB's safeguarding publicity campaigns. During the last year the Policy and Procedure Group have delivered a communications plan that included

- a schools' safety awareness competition, which involved children designing safety awareness bookmarks,
- increased awareness around Child Sexual Exploitation (CSE), including running 5 workshops around Hertfordshire and
- raised awareness around Water Safety Week, Domestic Abuse Awareness Week and the Barnardo's 'Cut them free' campaign (which is linked to CSE).
-

The Group has also reviewed an updated the 4th Edition of Recognition of Child Abuse Chapter on its website particularly around chastisement.

The group continues to raise take forward and raise awareness of the following publicity campaigns:

- Blind cord safety
- Child Sexual Exploitation
- Safer Sleeping
- Water Safety

Safe Staffing

The aim of the Safe Staffing Group is:

To support a co-ordinated approach to safe staffing across partner organisations and develop and maintain a culture of vigilance and awareness of safe staffing across the county.

Over the past year the Safe Staffing Group has continued to develop and update the Safer Staffing Handbook and more recently the group has been sharing and reviewing approaches to implementation of the new Disclosure and Barring Service (DBS) changes across organisations including:

- Criteria for DBS checks
- Single certificates
- Criteria and use of basic disclosures
- Implementation of the update service
- Contractual implications of update service

The group has also reviewed and endorsed the Hertfordshire Sports Partnership's Coachmark Scheme, which:

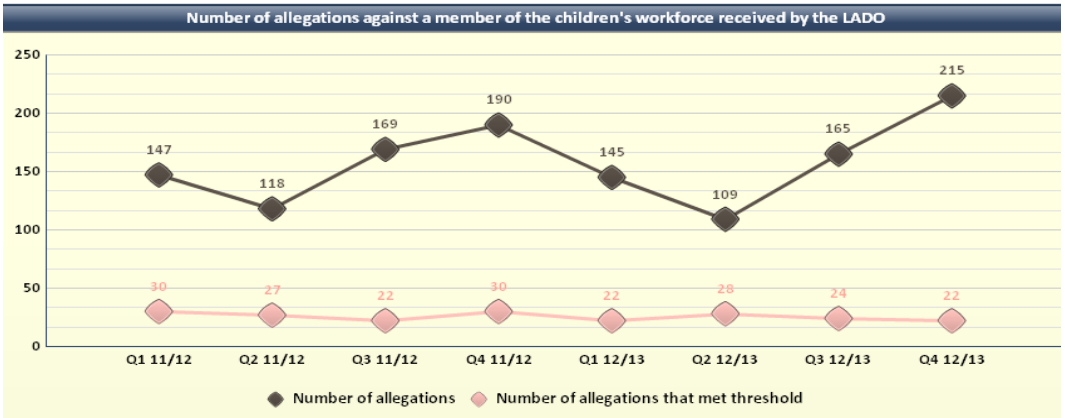
- allows coaches to operate in schools across the county with just one DBS (the new CRB) clearance from Hertfordshire County Council
- ensures that coaches working in schools have attained a minimum operating standard - known nationally as Minimum Standards for Deployment
- overcomes potential problems caused by differences in interpretation of procedure between schools
- safeguards young people who take part in sport

Work of the Local Authority Designated Officer (LADO)
(The work of the LADO is monitored by the Safer Staffing Group)

The LADO role applies to paid, unpaid, volunteers, casual, agency or anyone self employed whose role involves working with children and young people. They capture concerns, allegations or offences that involve children and young people.

During 2012/13 the numbers of referrals made to the LADO dropped after quarter 1 of the year, but since then continued to rise steadily. The increase in referrals over the past 2 quarters of the year is due to a large increase in referrals from the 'Private and Voluntary sector' which is possibly due to LADO rolling out training within this sector of organisations.

Although there has been an increase in the number of referrals made to the LADO, the number of allegations that reached the threshold continued to remain generally consistent from quarter to quarter.



Training

The Training sub group has the following responsibilities:

Maintain an inter-agency safeguarding children training strategy and delivers a programme of generic stage two and specialised inter-agency safeguarding children training and learning events.
The group also monitors evaluates single and multi agency training within Hertfordshire

HSCB currently provides the following courses:

Lite Bites:
- Witchcraft and spirit possession
- Fabricated and induced illness
- Domestic abuse
- Discipline and chastisement
- The management of bruising, bites and suspicious marks on babies and children
- Serious and partnership case reviews and audits

Training Courses: (i.e. more formal sessions in classroom or workshop environment)
- Working with parents and carers
- Referral and beyond
- The child protection process
- Understanding the impact of neglect
- Safeguarding children with disabilities
- Child sexual exploitation
- The impact of parental mental health
- The impact of parental learning difficulties
- Fabricated and induced illness
- Train the trainer

The HSCB courses have been developed from learning needs identified though Serious and Partnership case reviews, case audits as well as training needs identified via training course evaluations. New courses and lite bites continue to be developed and delivered in response to concerns and needs identified both locally and nationally.

HSCB courses are delivered by the HSCB Training Pool, the HSCB Training Officer, specialist practitioners from HSCB partner agencies and externally commissioned trainers.

The training is delivered in a variety of venues across the County to encourage local multi agency working together.

The training sub-group has identified that it needs to strengthen the approach to evaluating the benefit of course. During 2013-14 it plans to strengthen its training evaluation work further, by carrying out telephone surveys with course delegates to see how they have implemented their training since the course. This will be in addition to course evaluation forms completed on the day of training

Annual Conference:

In 2012, the HSCB and the 5 local safeguarding forums planned and delivered conferences in venues across the County on Child Sexual Exploitation (CSE) the aims of the conferences were to:

- Support practitioners in identifying and dealing with the impact of sexual exploitation on children, young people and their families
- Offer an opportunity to share ideas and experiences and help shape future practice in local areas
- Support inter-agency working by providing a forum where practitioners could come together and network with others

The conferences were well attended and following these events the Safeguarding Board commissioned a number of training sessions to help raise awareness of CSE further. These were commissioned through the Training Sub-group

HSCB Training Courses

Number of attendees by course – April 2012 – March 2013

The table below shows the number of people trained by the HSCB during 2012-13 broken down by the course they attended.

Total number of attendees by course Apr 12 - Mar 13

Name of course	Total number of attendees	How many times the course ran
Inter agency working together - referral and beyond	187	11
Inter agency working together - the child protection process	156	11
Safeguarding children - the impact of parental learning difficulties	14	1
Safeguarding children - the impact of parental mental health	55	3
Safeguarding children - understanding the impact of neglect	70	4
Safeguarding disabled children	114	5
Train the trainer	16	3
Understanding the impact of fabricated & induced illness lite bite	18	1
What to do if you identify a baby/child with bruises lite bite	162	8
Working with resistant and reluctant families lite bite	65	4
Working with parents/carers	91	7
Understanding the impact of domestic abuse lite bite	57	4
MAPPA Awareness	22	1
The impact of mental health on the whole family lite bite	31	2
Ways to improve engagement and co-operation by family members challenged by substance misuse lite bite	25	2
Witchcraft and spirit possession lite bite	44	2
Local safeguarding forum practitioner workshop - sexual exploitation	430	5
Child sexual exploitation prevention, protection and investigation	90	5
Serious and partnership case reviews and audits lite bite	63	3
Total	**1710**	**138**

Agency attendance breakdown Apr 12 – Mar 13

The table below shows the agency attendance breakdown from April 2012 – March 2013. Health includes the partnerships: - East & North Herts, Herts Community NHS Services, Herts Partnership NHS Trust, NHS Hertfordshire and West Herts Hospitals.

Total number of attendees per agency Apr 12 – Mar 13		
Agency	**Total number of attendees per agency**	**Total % attendance over the year per agency**
Children's centres	170	14.9
Children's Services - non social care	68	6
Children's Services - social care	202	17.7
District Council	16	1.4
Drug and Alcohol Service	9	0.8
Education	14	1.2
Herts Fire Service	4	0.4
Health & Community Service	29	2.5
Health - East & North Herts NHS Trust	23	2
Health - Herts Community NHS Trust	177	15.5
Health - Herts Partnership NHS Foundation Trust	19	1.7
Health - NHS Hertfordshire	31	2.7
Health - West Herts Hospitals Trust	8	0.7
Herts Constabulary	23	2
Herts Young Homeless	8	0.7
Homestart	20	1.8
Housing Provider	8	0.7
Nursery	26	2.3
Pre-school	17	1.5
Herts Probation	12	1.1
Schools	195	17.9
Voluntary sector	29	2.5
Total	**1108**	

Local safeguarding forums

The HSCB local safeguarding forums were set up in October 2010 to improve communication and referral pathways in child protection, at both the strategic level and the operational level. The aim of the forums is to facilitate practitioners getting together at a local level to problem solve, implement case review recommendations, share organisational changes, promote local networks and to be a conduit for the HSCB to escalate local partnership issues to the strategic level.
Five ‘double district’ forums are now established in the Children’s Services locality groups of Broxbourne and East Herts, St Albans and Dacorum, Watford and Three Rivers, Welwyn Hatfield and Hertsmere and North Herts and Stevenage. A wide range of statutory and voluntary agencies are represented, with most groups chaired by a local practitioner and led by local agendas so that the subject matter reflects the needs of the area.

The primary functions of local safeguarding forums are to:

- Support and enhance links between the strategic and local operational safeguarding children agenda.
- Promote and co-ordinate good child protection practice at a local level
- Monitor and quality assure local child protection practice
- Enhance the links between children and adult services
- to contribute to the work of the HSCB and raise issues (escalate where) appropriate.

Presentations the forums have received during the year include:

Family Nurse Partnership, Intensive Family Support Team, Caring Dads, Drop off and collection of children at school successfully, Targeted Youth Support Service, Signs of Safety.

Summary

To summarise, it can be said that there has been positive progress made to continue the work of safeguarding children across the County, significantly via the Board's sub groups. As always, in making improvements and changes, we also identify areas of improvement needed and these are being addressed and will continue to be worked on in 2013-14.

The Board continues to work hard in both ongoing challenge and improvement, of its partner agencies but also of itself and this is a key focus of the 2013-14 Business Plan, working alongside the changes and recommendations we expect in the new Working Together 2013.

We will continue to make high demands of ourselves and our partners as we work together to ensure that safeguarding 'is everyone's responsibility'.

Moving Forward

The priorities and themes within the HSCB Business Plan for 2012/13 are:

Theme 1: Information and risk sharing
Sharing of information amongst professionals working with children and their families is essential and in many cases it is only when information from a range of sources is put together that a child can be seen to be vulnerable, in need or at risk of harm. Appropriate sharing with other practitioners and agencies is essential to identifying children and families in need of support and services before problems become serious.

Theme 2: Early Intervention and prevention
Providing early help is more effective in promoting the welfare of children than reacting later. Effective early help is dependent on local agencies working together to identify children and families who would benefit from early help; undertake assessments of the need for early help; and providing targeted early help services that significantly improve outcomes for children. In particular, we want to focus on children and young people who are at risk of sexual exploitation or of going missing and families with young parents, especially when there are issues relating to alcohol, substance misuse or domestic abuse

Theme 3: Equality and diversity
We recognise that effective safeguarding systems are child centred and that too often failings in safeguarding systems are the result of losing sight of the needs and views of the children within them. Children want to be respected and their views heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. All

children and young people have a right to be protected from harm, irrespective of their background, and no child should be treated less favourably than others in being able to access effective services which meet their particular needs.

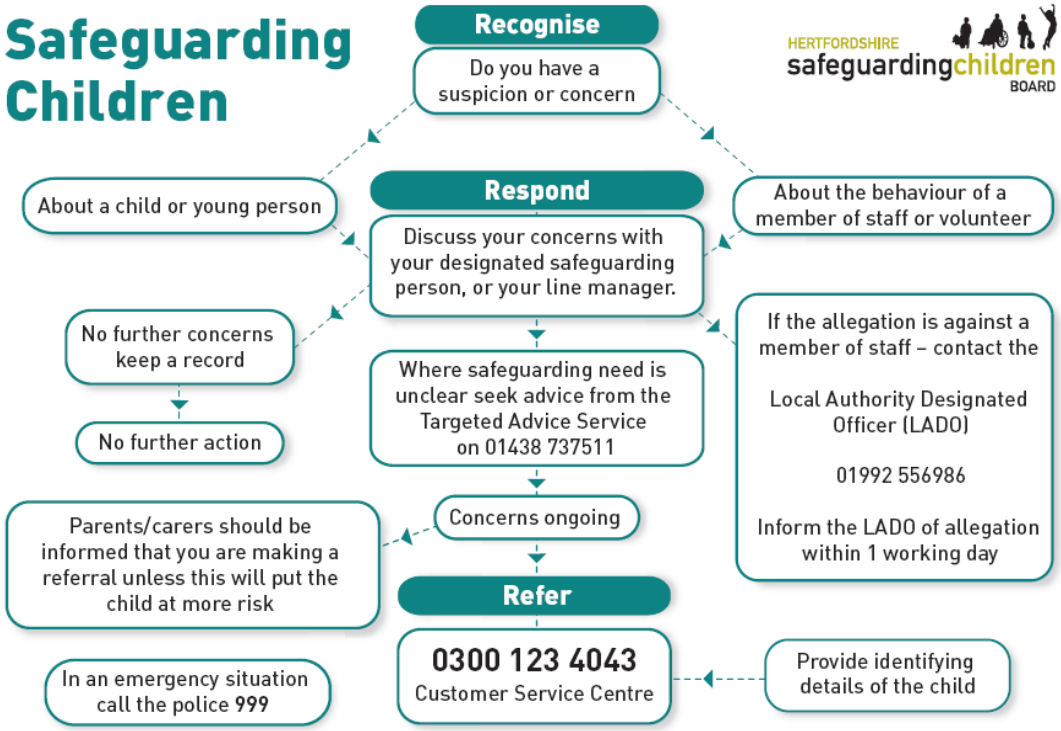
Theme 4: Workforce and Board Development

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.

Appendices

Appendix 1 Glossary

CAF	Common Assessment Framework
CAFCASS	Child and Family Court Advisory Support Service
CDOP	Child Death Overview Panel
CiN	Child in Need
CP	child protection
CQC	Care Quality Commission
CRB	Criminal Records Bureau
ENHT	East & North Hertfordshire Hospitals NHS Trust
HCC	Hertfordshire County Council
HCNT	Hertfordshire Community NHS Trust
HMIC	Her Majesty's Inspectorate of Constabulary
HPFT	Hertfordshire Partnership Foundation NHS Trust
HSCB	Hertfordshire Safeguarding Children Board
ISA	Independent Safeguarding Authority
LADO	Local Authority Designated Officer
PCR	partnership case review
SCR	serious case review
SMART	Specific, Measurable, Achievable, Realistic, Timely
VBS	Vetting and Barring Scheme
WHHT	West Hertfordshire Hospitals NHS Trust



Appendix 2 Attendance at Board meetings

Member / Agency / Organisation	Meetings attended
Assistant Chief Constable, Hertfordshire Constabulary	3 / 4
Assistant Chief Legal Officer, Adult & Children's Law	4 / 4
Assistant Director, Learning Disability & Mental Health	3 / 4
CAFCASS	1 / 4
Deputy Director, Services for Children & Young People	1 / 4
Designated Doctor for Child Protection & Consultant Paediatrician	3 / 4
Designated Doctor of Child Protection East and North Herts NHS Trust	2 / 4
Designated Nurse, Safeguarding Children &Children Looked After	3 / 4
Director, Education & Early Intervention, HCC	3 / 4
Director of Operations, Hertfordshire Probation Service	4 / 4
Director of Quality, Herts Community NHS Trust	1 / 4
Director of Quality & Governance Hertfordshire Community NHS	2 / 4

Appendix 2 Attendance at Board meetings

Member / Agency / Organisation	Meetings attended
Director of Quality & Patient Experience/Nursing, NHS Hertfordshire	3 / 4
Director of Safeguarding and Specialist Services	3 / 4
Director of Safeguarding Operations	2 / 4
Executive Director Quality & Safety Hertfordshire Partnership NHS Foundation Trust	4 / 4
Head of Crime, Hertfordshire Constabulary	3 / 4
Head teacher, Lakeside School	1 / 4
Head teacher Hitchin Girls School	4 / 4
Head teacher Wheatfields Junior School	3 / 4
HSCB Business Manager	4 / 4
HSCB Coordinator	4 / 4
HSCB Development manager	4 / 4
Independent Chair	4 / 4
Lay member #1 (as of Jan 2013)	1 / 1
Lay member #2 (as of Jan 2013	1 / 1
Lead Member Children's Services	3 / 4

Appendix 3 Dataset key indicators

HSCB dataset strategic outcomes, indicators & lead

Strategic outcome 1: correctly identify the children and young persons most at risk of neglect and abuse through effective and timely application of established processes.		
Ref	**Indicator**	**Agency & lead responsible for providing commentary**
1a	The percentage of initial assessments for children's social care carried out within 10 working days of referrals	**Sue Williams** Children's Services
1b	The percentage of core assessments for children's social care that carried out within 35 working days of their commencement	**Sue Williams** Children's Services
1c	The percentage of children becoming the subject of a child protection plan for a second or subsequent time	**Maria Barnett** Children's Services
1d	Number of CAFs by assessment	**Christine Oker** Children's Services

Strategic outcome 2: prevent neglect and abuse, in the family, of those identified as being at risk through effective and early multi-agency intervention		
Ref	**Indicator**	**Agency & lead responsible for providing commentary**
2a	The percentage of quoracy achieved at child protection conferences	**Maria Barnett** Children's Services
2b	The percentage of child protection cases reviewed within required timescales	**Maria Barnett** Children's Services
2c	Number of 'Cruelty and Neglect of Children' Offences	**Stuart Orton** Police
2d	Number of children with a child protection plan without an allocated social worker	**Sue Williams** Children's Services
2e	Under-18 hospital admissions for injuries, mental health, self harm and substance misuse - *annual measure*	**Ruth Vines** West Herts Hospitals NHS Trust
2f	Numbers of domestic violence incidents and crimes where children are present	**Sarah Taylor** Hertfordshire County Community Safety Unit
2g	Numbers of repeat cases referred to MARAC involving children - *rolling year measure*	**Sarah Taylor** Hertfordshire County Community Safety Unit

Strategic outcome 3: ensure the safety and wellbeing of children and young people in care through effective risk management and support		
Ref	**Indicator**	**Agency & lead responsible for providing commentary**
3a	The number of children looked after aged 10 to 18 committing offences	**Jeanette Williams** Children's Services
3b	The percentage of children looked after cases for whom all reviews during the year were reviewed within required timescales	**Dawne Brent** Children's Services
3c	Total number of children looked after	**Sue Williams** Children's Services
3d	Total number of children in a private fostering arrangement	**Lorna Forde** Children's Services

Strategic Outcome 4: Ensure children and young people are safe and secure from all types of harm including bullying and when accessing technology.		
Ref	**Indicator**	**Agency & lead responsible for providing commentary**
4a	Number of child deaths	**Rachel Bagenal** HSCB
4b	The number of violent crimes involving a victim aged under 18	**Stuart Orton** Police
4c	The number of missing children	**Lindsay Edwards** Children's Services
4d	The number of crimes involving children accessing technology (ie bullying/harassment)	**Stuart Orton** Police
4e	Number of youths accused of being involved in an offence	**Stuart Orton** Police

Strategic Outcome 5: Protect children and young people by rigorous recruitment, training and vetting procedures in relation to those adults coming into contact with them		
Ref	**Indicator**	**Agency & lead responsible for providing commentary**
5a	The percentage of statutory workforce who have completed safeguarding training appropriate to their role - *annual measure*	**HSCB training sub group**
5b	The percentage take-up of HSCB training	**Jo Woolf** HSCB
5c	*safe staffing indicator - under revision*	**Safe staffing sub group**
5d	Number of allegations against a member of the children's workforce received by the LADO	**Mel Leicester-Evans** Children's Services

Strategic outcome 6: ensure children and young people are kept on the right track and provide appropriate levels of support to reduce the numbers involved in offending / at risk of offending		
Ref	**Indicator**	**Agency & lead responsible for providing commentary**
6a	Rate of proven re-offending by young offenders aged 10-17 (formerly NI 19) - *annual measure*	**Jeanette Williams** Children's Services
6b	First time entrants into the Youth Justice System aged 10-17 (formerly NI 111)	**Jeanette Williams** Children's Services
6c	Number of statutory school age children receiving a permanent exclusion	**Craig Tribe** Children's Services
6d	Numbers of under 18s seeking treatment for a substance or alcohol misuse problem	**Simon Gentry** Children's Services
6e	Under 18 conception rates (formerly NI 112) - *biennial measure*	**Simon Gentry** Children's Services/ Health