APPENDIX A

HERTFORDSHIRE
safeguardingchildren
BOARD

Annual Report
April 2014 – March 2015

www.hertssafeguarding.org.uk

Essential Information

Annual Report compiled in June 2015 on behalf of Hertfordshire Safeguarding Children Board by:
Phillipa Scott, Acting Business Manager

Hertfordshire Safeguarding Children Board
Room 147, County Hall/ Postal point CHO 143
Pegs Lane
Hertford
SG13 8DQ
Tel: 01992 588757

Approved by the Strategic Board in September 2015.

Available on HSCB website: http://www.hertssafeguarding.org.uk/

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

Welcome to the 2014-15 Annual Report of Hertfordshire Safeguarding Children Board which sets out its accomplishments during the year and the Board's intentions for further progress in future. With over 250,000 children, the Board's remit is one of the largest in the country. The vast majority of those children are safe and well cared for within their families and local communities. However, a small minority of children need the support of one or more agencies to keep them safe and in some circumstances to remove them to a better circumstances. This report explains how effective those interventions by Hertfordshire agencies are and how the Safeguarding Board coordinates the work of its partners to ensure that their impacts on children's lives are most effective.

Safeguarding children across the County has continued to progress significantly over the past year. All public sector agencies have been confronted with great resource challenges and in my last annual report, I expressed my concern that as a result, partners might be forced to reduce their support for safeguarding. In practice, the opposite has occurred, with agencies reviewing their priorities and recognising that the welfare of children is a top priority. There is a very clear commitment of senior directors to the Board's work and a willingness to be open and challenge one another in the Board's regular discussions about performance. Commitment has also been evident in the response of elected representatives and chief executives to issues I have raised in my briefing to leaders, such as the need for improved support for victims of sexual abuse, the effectiveness of the strategic approach to children living in families with domestic abuse and the need for commissioning organisations to ensure that safeguarding is at the top of the agenda for service providers. Improvements put in place during the past year, such as the move to an electronic common assessment framework process show that significantly more children are being supported through the 'Early Help' than in previous years.

The Board regularly reviews the performance of professionals in working with children through its programme of multi-agency audits and by examining the results of single agency audit work. This work has included examining progress on cases where young people have been at risk of Child Sexual Exploitation (CSE). I am pleased to be able to say that the extensive work done in this field has not found any evidence of the significant gang and group related CSE which has featured in some other local authorities.

In addition to its audit work, the Board identifies ways to improve through its reviews of individual cases, including at the level of Serious Case Reviews. The learning from these cases is discussed in more detail in the following pages, but the way in which professionals from different background work together and share information is a continual focus of such reviews both locally and nationally. Hertfordshire safeguarding agencies have traditionally worked closely together with initiatives such as the Joint Investigation Team and the Targeted Advice Service. In response to issues raised in the audit and case review work of the Board, during the year partners agreed to further develop this approach by relocating staff into a full Multi-Agency Safeguarding Hub (MASH) which will come into operation early in 2015-16.

Partners are showing a considerable desire to further improve safeguarding by their commitment to the Family Safeguarding Project. In the past the Board has been concerned that services addressing the needs of adults have sometimes been insufficiently aware of risks to children. This initiative should ensure that coordinated support from a wide range of agencies addresses the needs of all family members and risks to children are identified effectively. The work is being strongly supported by the Department for Education. Government funding is enabling it to be implemented in a way which reduces the risks to children which can occur when public sector organisations undertake programmes of change.

The MASH and Family Safeguarding initiatives should help in addressing two ongoing challenges to the work of safeguarding professionals:

- Consistency of Practice – in an area the size of Hertfordshire, it can be difficult for managers to ensure that standards in safeguarding are equally good in all parts of the County. The Board's sub-groups which address training and 'improving outcomes' are very conscious of this challenge. Bringing some of their initiatives, such as the 'Graded Care Profile' approach, into the Family Safeguarding work should give a better basis for consistent standards. Using common approaches within all agencies should also help effective communication between diverse professionals and those working in different parts of the County.

- The Early Identification of Neglect when Parenting Deteriorate - The Board is very aware from its audit and case review work that identifying and reacting early to cases of neglect is a critical issue in safeguarding. This particularly applies to young children, those with disabilities and those who are in their teens when they first experience difficulties. Making progress on this issue needs all agencies to be aware of each other's strengths and weaknesses and closer working in the MASH should contribute significantly to this.

Progress on safeguarding is very much a 'team game' and has only been achieved by the hard work and commitment of professionals in many organisations. Although their efforts have improved the lives of thousands of children during the past year, their work is not always appreciated or understood by the children or their families, but it is highly valued by the Board. Progress for the Board itself has only been possible through the work of its administrators – their support during the past year and, particularly that of Phillipa Scott, the Business Unit's interim manager, has ensured that the Board's safeguarding work continues to improve.

Independent Chair
Hertfordshire Safeguarding Children Board

Local background and context for safeguarding children in Hertfordshire

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 284,300 children and young people aged 0-19 in Hertfordshire, representing around 25% of the overall population. This is predicted to rise to approximately 335,000 by 2037. The biggest increase will be in the 0-14 population with only a slight increase in the 15-19 age group. The majority of people living in Hertfordshire are white British. There are some areas, particularly in Watford, where the proportion of non-white people is much higher than it is elsewhere in the county. Hertfordshire has recently experienced migration of workers from Eastern Europe, particularly Poland, although actual numbers remain small. Amongst children, however, the population is more ethnically mixed, with the January 2014 school census showing that there were 26.7% of state-funded primary aged children in Hertfordshire from BME backgrounds (compared to 28.5% nationally). Hertfordshire performs better than the national average in the majority of measures in the Public Health Child Health Profile.

There are ten district/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. All ten local authorities have pockets of considerable deprivation within their boundaries and a number of communities 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.

Governance and accountability arrangements

Statutory and legislative context for Safeguarding Children 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 issued in March 2013.

Along with Hertfordshire, all local authorities are legally obliged to have a children's safeguarding board which 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 seeks to achieve these functions by:

- monitoring the effectiveness of what is done to safeguard and promote the welfare of children
- establishing effective communication and information sharing across agencies
- undertaking reviews of individual cases, including '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 show their commitment to ensuring the effective operation of the HSCB through a formal compact document which sets out the relationship between partner agencies and HSCB.

Independent Chairing

In keeping with the guidelines, HSCB has been independently chaired since 2009. The Chair, Phil Picton, is accountable to the Chief Executive of the County Council, John Wood, for fulfilling this role effectively and meets regularly with him to discuss progress and issues in safeguarding. In addition, Phil has ready access to Directors of all the partner agencies and meets with them as appropriate on a one to one basis to discuss safeguarding issues. Phil attends the safeguarding briefing with the Leader and Deputy Leader of the Council, Lead Member, Chief Executive and Directors twice a year.

As Chair of the Board, Phil is a member and active participant in the Children and Young People's Commissioning Executive Group which replaced the previous Children's Trust. This Group reports to the Hertfordshire Health and Wellbeing Board. That Board is attended by Phil annually when he presents the HSCB Annual Report and takes part in the discussion of safeguarding issues.

The HSCB Chair also meets regularly with key leaders from partners outside of Board meetings to update them on safeguarding issues and the work of the Board and where necessary to challenge them on progress within their own sphere of influence. For example during the past months, he has met with the Police and Crime Commissioner, the Chief Constable and the lead directors for the NHS Clinical Commissioning Groups. He also meets regularly with the Chair of the Hertfordshire Safeguarding Adults Board and the Chair of the Hertfordshire Health and Wellbeing Board.
The **Director of Children's Services** (DCS), Jenny Coles, has the delegated professional responsibility for the leadership, strategy and effectiveness of local authority children's services. She is a committed and active 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.

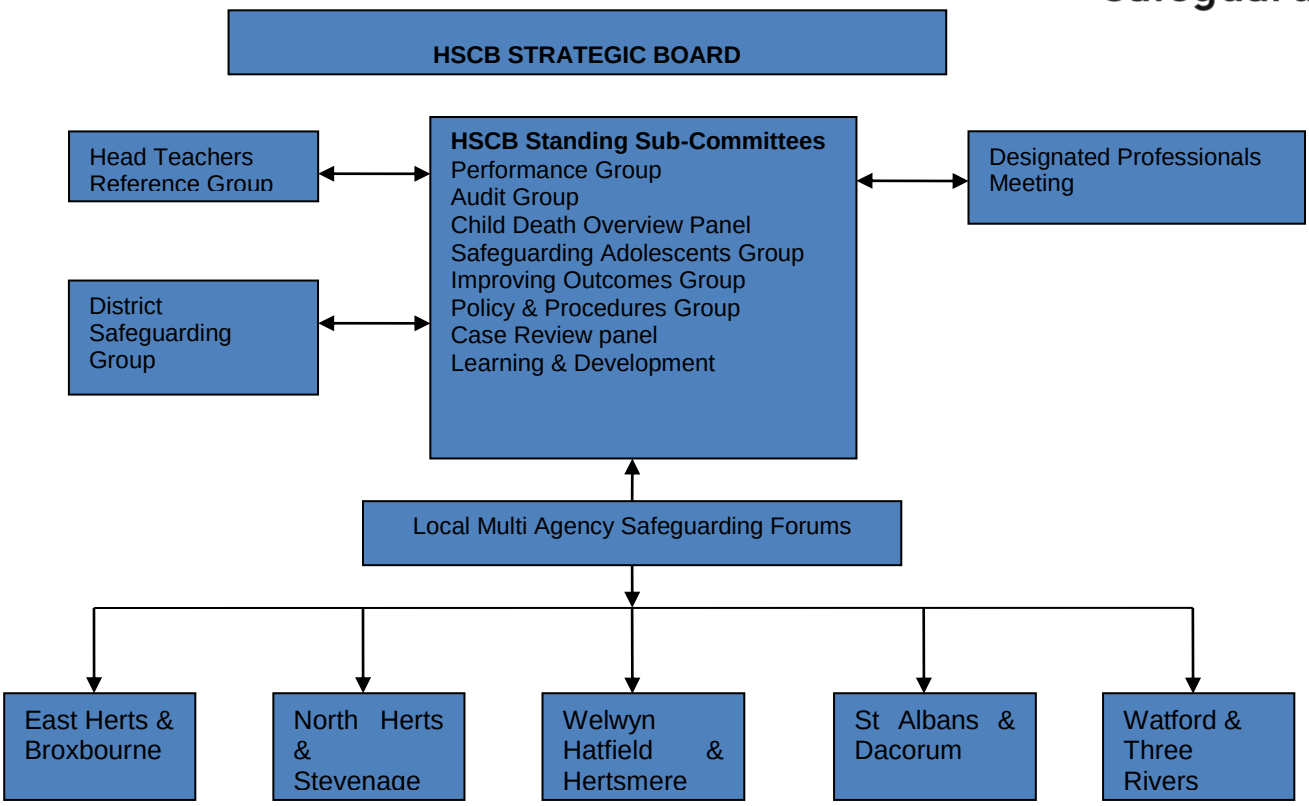
The work of HSCB is reviewed annually by the HCC Overview and Scrutiny Committee through the work of a topic group. At that meeting, the Chair, key Board members and sub-group chairs explain the issues and risks to safeguarding children and what has been and will be achieved by the Board. The report from the 2014 HSCB Committee can be accessed online, please **click here.** In addition the Chair occasionally attends other Scrutiny meetings to give evidence to the Panel or to observe discussions on safeguarding issues. For example, in March 2015 he observed the proceedings and gave evidence to the scrutiny of Child Sexual Exploitation.

Structure of HSCB

Hertfordshire has one of the largest children's populations in the country. As a result the Board has developed 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.
- Three special interest groups representing schools, district and borough councils and health professionals (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 developed and 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 directors and senior representatives from all the statutory partners and others concerned with safeguarding children. In addition the Board held an 'Extended Board meeting in March 2015 where all members of the sub groups, local safeguarding forums and district councils took part in the discussions. A Board development day was held in November 2014 when the Board reviewed its progress and agreed the aims and objectives for the coming year.



Membership

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

- District and Borough Councils
- Cafcass
- The two Hertfordshire Clinical Commissioning Groups
- NHS England
- NHS Trusts and Foundation Trusts –
    - East & North Herts Hospitals
    - Hertfordshire Community NHS Trust
    - West Herts Hospitals NHS Trust
    - Hertfordshire Partnership University 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 Public Health Service

- Hertfordshire National Probation Service
- BeNCH CRC (Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company
- 3 Schools
- Further education institution representing four Hertfordshire colleges

In keeping with the recommendations of the Munro Review and changes to legislation, the Board recruited two lay members who joined the Board during 2012. These lay members attend the Strategic Board and have an increasing role of contributing to the Board's work with the wider community. One of these lay members resigned from the board during 2014-15 and the other position is now coming to an end. These positions are currently in the process of being recruited to.

The attendance of board members at the Strategic Board is set out in Appendix 2.

Budget

Contributions for 2014/15 were are made from partner agencies as below:

Contribution Amounts	**£**
Herts County Council	195,958
Police and Crime Commissioner	16,800
NHS East and North Herts CCG	52,150
NHS Herts Valleys CCG	52,150
Probation	6,720
Cafcass	550
Total	**324,328**

Expenditure	**£**
Salary and salary related (including Transport)	250,783
Other HSCB Expenditure including training and case reviews – Case reviews spend totalled £75,982)	150,028
Total Expenditure	**400,810**

Due to the number of case reviews that were carried out during the 2014/15 period the Board overspent by £75,982, this overspend was covered by a reserve budget that had built up over several previous years. At the end of the 2014/15 the reserve budget stood at £101,018. It is anticipated that the reserves will reduce again during 2015/16.

The HSCB Business Plan

A two year 2013-15 business plan was agreed by the Board during 2013-14 and was in place until the end of March 2014. It was an ambitious plan and addressed a wide range of issues set out under four themes:

Theme 1: Information and Risk Sharing:
Theme 2: Early Intervention and Prevention:
Theme 3: Equality and Diversity:
Theme 4: Workforce Development

The end of year progress report against specific actions is attached at appendix 4, but the main areas of progress both against the plan and more generally are set out in the following pages. All actions were completed and a new plan has now been developed for 2015-16.

HSCB Dataset and Analysis of Performance

The Board takes particular interest in scrutinising the changing nature of safeguarding in Hertfordshire, the response of partners to changes and the impact of those responses. To achieve this, performance management is the first substantive item at the Strategic Board and is vigorously discussed. To support that discussion, the Board has developed an extensive dataset which continues to evolve. In the following paragraphs the dataset and performance in key categories is discussed.

The dataset is produced from partnership data and commentaries on a quarterly basis. APAG reviews the performance and highlight trends, increasing risks and opportunities to the Board. This dataset and performance issues are discussed at each Strategic Board meeting. Having contributed significantly to the regional work, during 2013/14 APAG began reporting on these indicators using the Eastern Region LSCB Framework which groups these indicators into categories addressing the needs of children and professionals involved in safeguarding. The Regional Framework has been developed by asking a series of questions about performance:

What does good look like:

- *For the child*
- *For the team around the child*
- *For the agency around the team*
- *For the board around the agencies*

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

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

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

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

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

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

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.

29 Key indicators then sit underneath these Strategic Outcomes to help measure the performance against them. A full list of the 29 indicators and additional context/process measures are contained in appendix 3.

During 2014-15 the Board also developed a Safeguarding Joint Strategic Needs Assessment (JSNA) to form a baseline profile for developing future priorities. The Safeguarding JSNA can be accessed by clicking here. The JSNA will form part of the Health and Wellbeing Board's JSNA and will be continually updated.

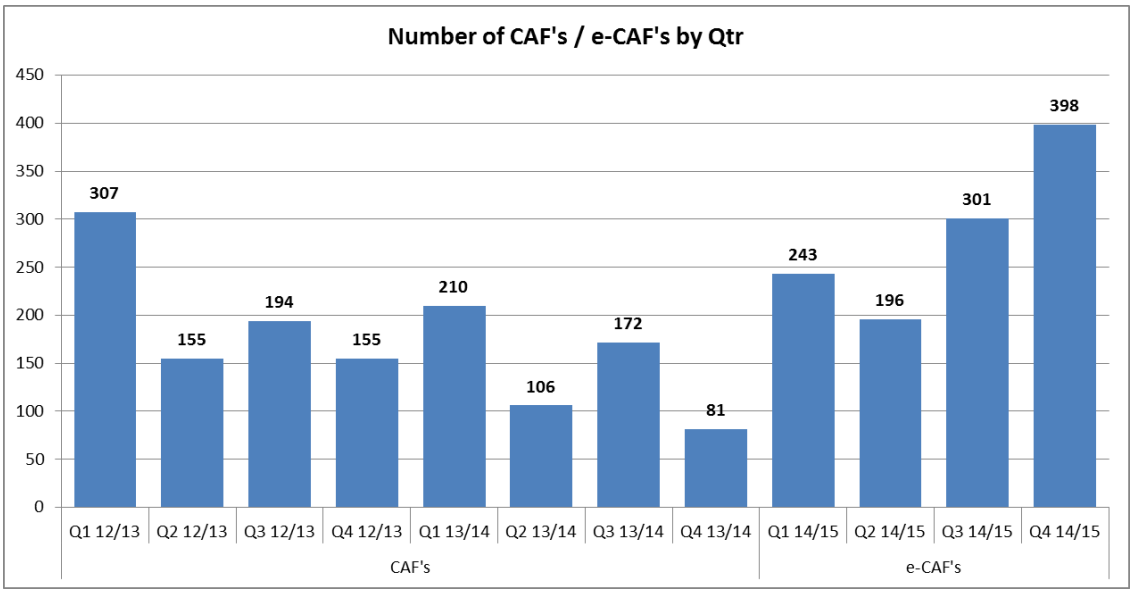
In discussing performance across the year, the Board has covered a wide range of issues and has particularly focussed on the risks and impact of early help (indicated by the Common Assessment Framework (CAF) process), the levels of partnership involvement with social care (through referrals and management of protection plans) and the risks to children associated with domestic abuse in families. These particular topics are discussed further below:

Common Assessment Framework.

The Common Assessment Framework (CAF) is a way of assessing the needs of a child and family to bring a number of professionals together to monitor and support safeguarding when children's welfare first becomes of concern. It involves the family working with the professionals (such as their teacher or health worker) to identify needs and the support available to them. The assessment covers many 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.

The Board recognises that the level of CAF work is an indicator of the impact of partners in providing early help to children with developing safeguarding issues, (often referred to as Early Help). Over the past two years the Board has been concerned that the relatively bureaucratic nature of the CAF assessment process was a disincentive for all professionals to use it proactively. In response to the issues raised by the Board, Children's Services carried out a review of the processes and throughout 2013/14 focussing on developing it as a whole family early intervention assessment. As part of this, there has been an operational transition from the use of paper CAFs to the development and implementation of an electronic whole Family assessment (Family eCAF) and the use of paper CAFs ceased at the end of March 2014. This approach complements the new

Families First partnership approach to Early Help which has been introduced by the Children and Young Persons Strategic Executive, which is a sub-group of the Health and Wellbeing Board. The Chair of HSCB sits on that sub-group and the Board receives progress reports on the Families First work. It will also be evaluating further aspects of the impact of that work during 2015-6

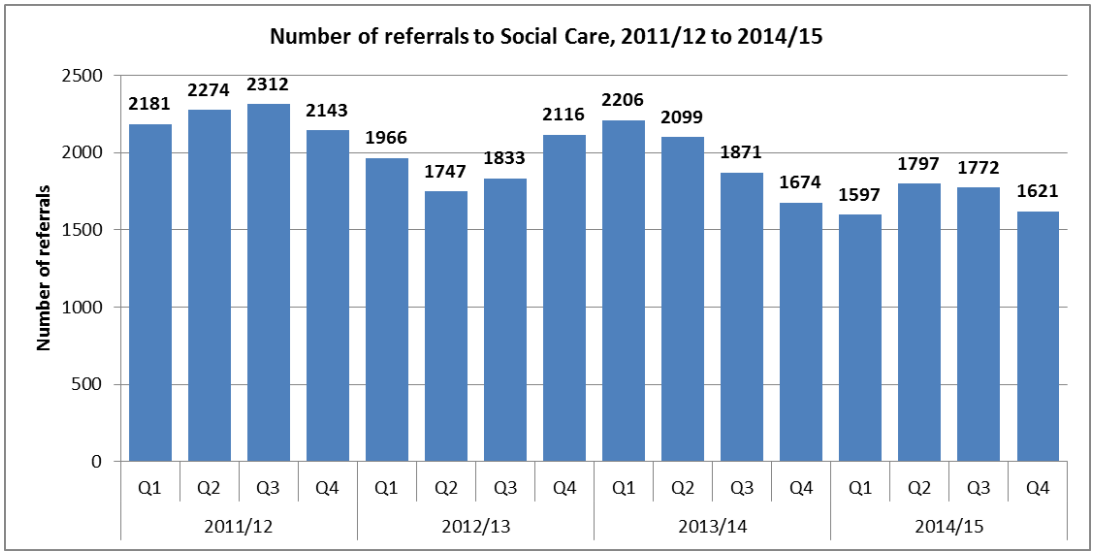


There were 398 e-CAFs completed during Q4 14/15, the largest number of electronic CAFs completed in a single quarter to date. As at the end of March 2015 there are now a total 1,685 children being supported through e-CAF assessments. The total number of children being supported through the CAF process during the financial year is now over 4000 compared with less than 700 last year. The number of eCAF assessments stepped up to social care increased in the final quarter and the number of cases stepped down into eCAF more than doubled, which was a significant and important increase demonstrating the service's ability to support families being stepped down from social care. 949 CAF assessments were closed in quarter 4. This increase in the number of closures reflects the targeted work to review all paper CAFs that were still open by end of March 2015 (working with Lead Professionals), to determine if the paper CAF needed to be closed or transferred to eCAF.

The change in the approach to CAF's and their increasing use is evidence of the Board's contribution to improving the impact of Early Help across all agencies.

Referrals to Social Care

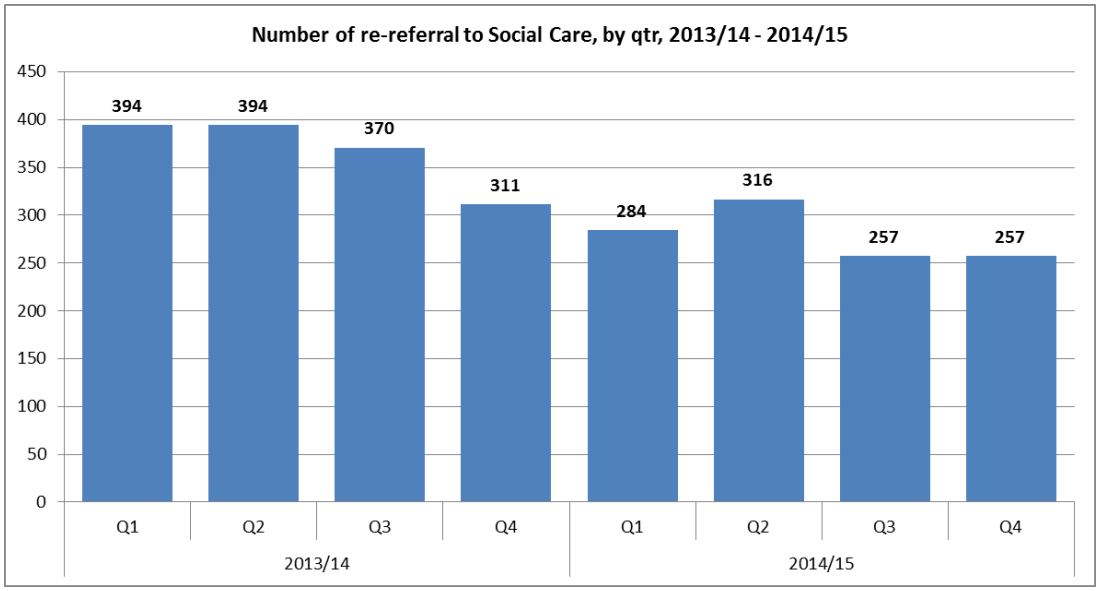
Referrals to Children's Social Care have reduced throughout the year, and they are the lowest for the last 4 years, falling from 8,910 in 2011/12 to 6,787 in 2014/15.



The 1621 referrals seen at the end of 2014-15 represents 62.7 referrals per 10,000 children

The reduction in the referral rate reflects the overall trend of a move to more support through Early Help services and its impact on cases managed by partners in the early stages of issues becoming apparent.

The numbers of re-referrals have also fallen over the last two years, reducing from 15.2 per 10,000 in Q1 2013/14 to 9.9 per 10,000 in Q4 2014/15. This represents 17.9% of the referrals in Q1 2013/14 down to 15.9% of the referrals in Q4 2014/15. This reduction is a key indicator for the Board in assuring it that cases are being increasingly managed in a way which reduces risk for individual children.

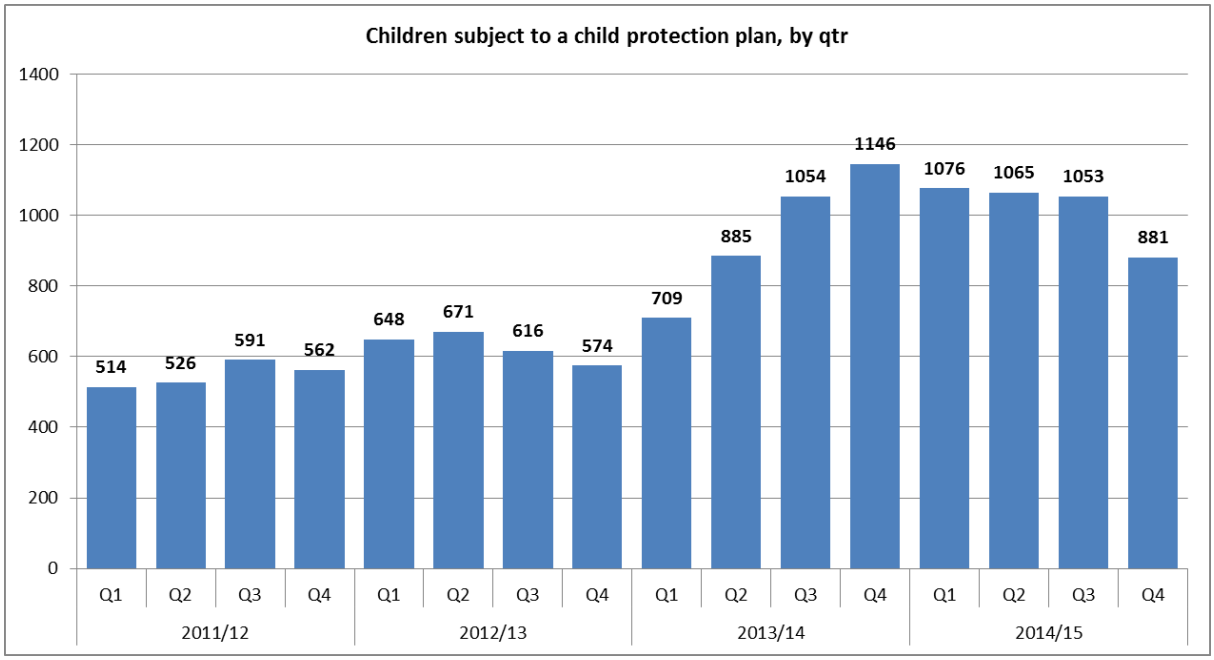


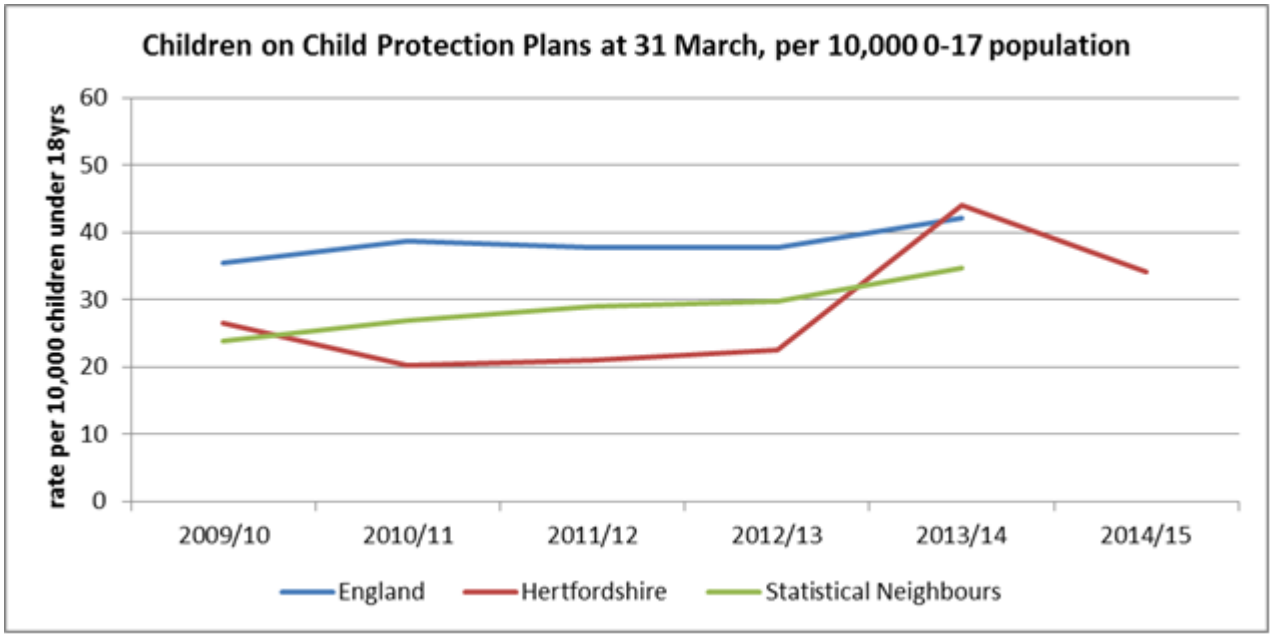
Children subject to a child protection plan

During 2013-14, the numbers of children on Protections Plans increased very significantly however the numbers decreased quarter on quarter throughout 2014-15 in contrast to the significant increases in previous years.

At the end of the year 2014/15 there were 881 children on a child protection plan compared with 1,146 at the end of 2013/14, this represents a 23.1% decrease since March 2014. Having traditionally had a very low rate per 10,000 of children subject to CPP compared to our statistical neighbours and nationally, Hertfordshire reached 44.8 per 10,000 at the end of March 2014, but has now fallen significantly to 34.1 per 10,000 as at the end of March 2015. (National and other Local Authority data is not available for comparison until October 2015)

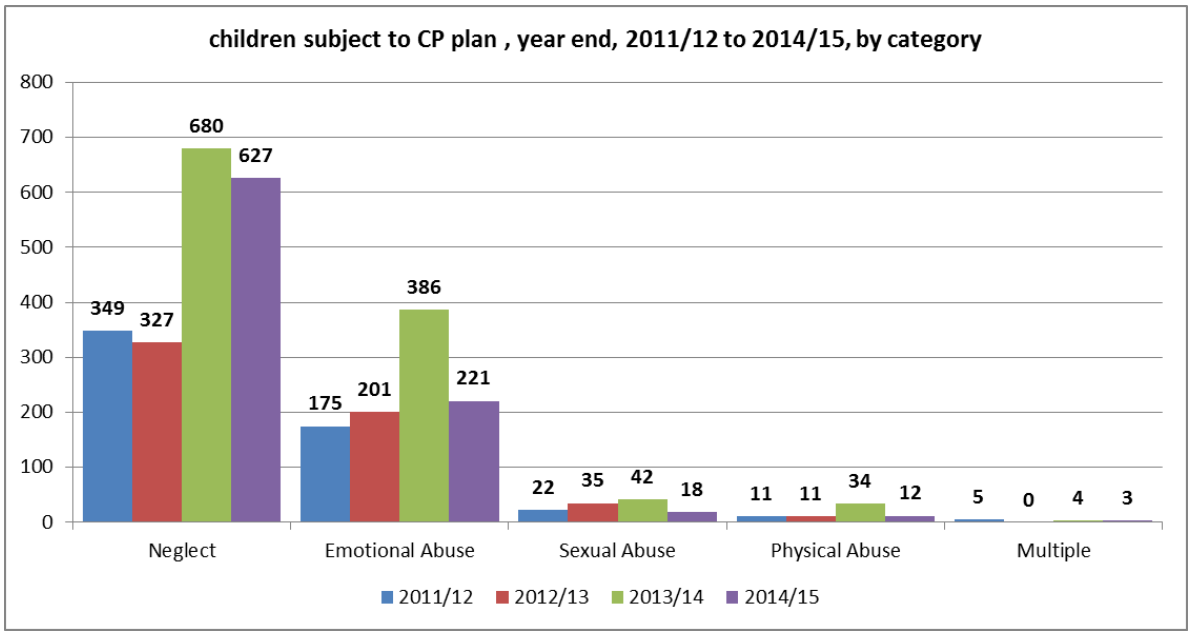
The Board had received regular reports and analysis of the changing numbers and discussed the impact of the increases and decreases on both professional workloads and children's lives. The Board was impressed that the 2014-15 decrease in children 'with plans' was in keeping with the predictions of Children's Services as they implemented new approaches to early help and more rigorous procedures.





Child Protection Plans by Category

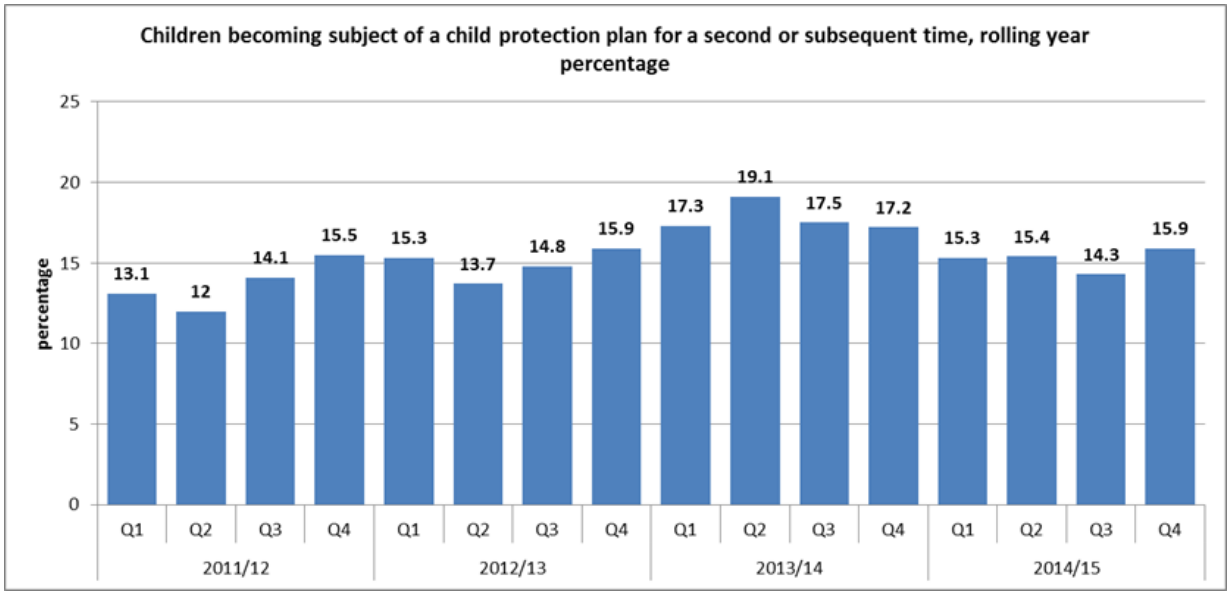
As can be seen below, the reduction in plans was less obvious in cases of neglect, at the end of March 2015 71.2% of the 881 child protection plans were for neglect, an 11.8% increase on the previous year, despite there being 23.1% decrease in the overall number of plans.



The Board's Improving Outcomes Sub-group continues to discuss the practicalities of agencies working with neglect cases and the use of tools such as the Graded Care Profile. During 2015-16 the Board will review its neglect protocol as part of its challenge to multi-agency working on neglect issues.

Children becoming subject of a child protection plan for a second or subsequent time.

The proportion of children with a child protection plan for a second or subsequent time has reduced to 15.9% at the end of March 2015 (rolling year) from 17.2% at the end of March 2014 (rolling year). High levels of children returning to a plan suggests that their cases may have been stepped down prematurely or the measures to support them as Children in need or within the early help system may not have been adequate. The downward trend in this indicator since the middle of 2013 has therefore assured the Board that measures are more appropriately being put in place to safeguarding children leaving the protection plan system. This positive change has been due to the change in step down processes, where a child is stepped down from a Child Protection Plan to a Child in Need plan for 6 months. This change was implemented in February 2013 in response to the Board's review of a number of cases in late 2012/13.



Domestic Abuse Cases.

There has been an increase in reports of Domestic Abuse incidents overall with 15,723 reports in 2014/15 which represents a 22.8% increase on the previous year.

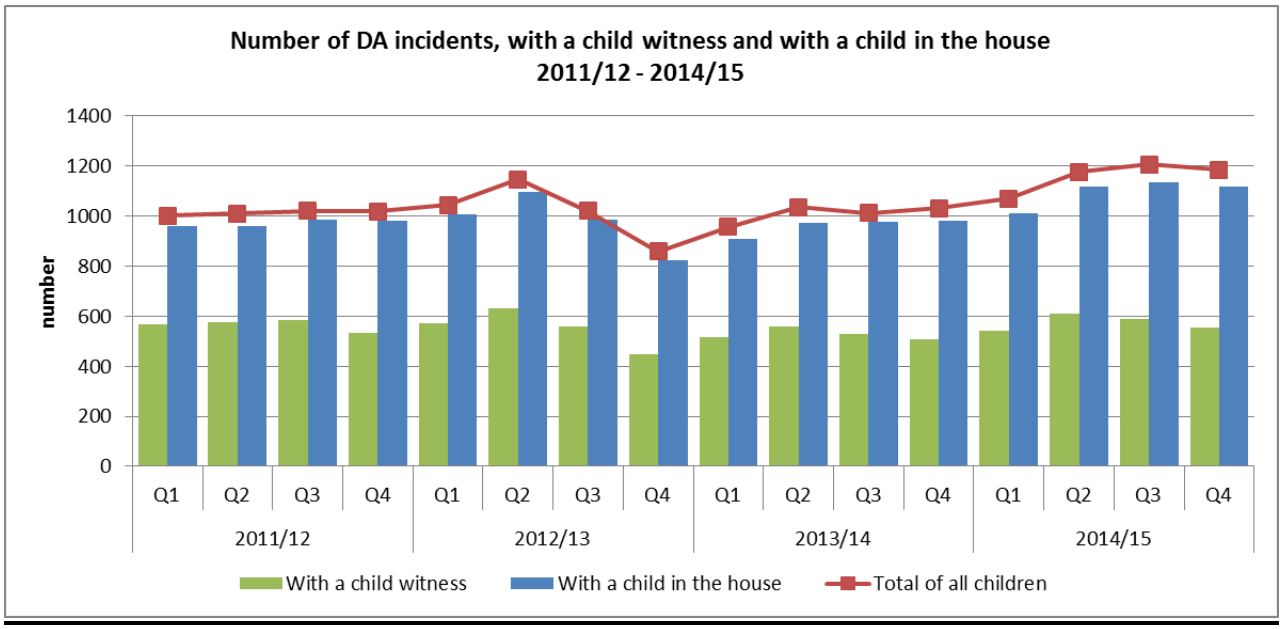
This increase has concerned the Board and it has been monitored and discussed on several occasions. The Board has concluded that the change represents additional cases being recorded for two reasons:

a) the definition of domestic abuse has been widened and
b) the police have been more accurately recording incidents officers attend'
There is no evidence that the underlying trend is increasing significantly.

However, the Board is concerned that as in other local authorities, the level of domestic abuse cases involving children is a key factor in the safety and welfare of children. The need for partners to improve impact on this topic was raised in the 2013/14 annual report and following publication was personally raised by the Board Chair with the Police and

Crime Commissioner, Chief Constable and Local Authority Chief Executive. This confirmed their own concerns and the County's strategic approach to Domestic Abuse has been completely overhauled in the past year. This should reap benefits for children in 2015/16. The Board's lead on the topic is now the Director of Children's Services who has also been appointed as the Chair of the Executive for the Countywide Domestic Abuse Partnership. Along with the new Domestic Abuse Strategy, this change has significant potential for impacting on children's lives. These changes are set out in more detail in the following pages.

The number of Domestic Abuse incidents with a child witness and with a child in the house



Audit and Challenge.

External Inspection and Audit

As part of its desire for improving performance, the Board regularly contributes to and discusses a wide range of reports from external auditors, inspection authorities and reviewers on the safeguarding performance of both individual agencies and their partnership work. Three reviews in particular were of note in 2014-15

The CAADA (Co-ordinated Action Against Domestic Abuse) Review of Domestic Abuse Services

Following issues raised by the Board and leaders in individual agencies, the Police and Crime Commissioner through the County Community Safety Unit, commissioned the independent charity Co-ordinated Action Against Domestic Abuse (CAADA) to thoroughly review how specialist domestic abuse services in Hertfordshire could be improved. (CAADA has since changed its name to SafeLives).

The review started in September 2014, and the report was published on 9 January 2015.It focused on the response of the specialist domestic abuse services (both commissioned and grant-funded), and the referral pathway into and out of these services from the main statutory agencies. Although it did not specifically review the direct response of the main statutory agencies, some of its recommendations are also relevant to them. The review included funding for domestic abuse services, staffing, ways of working and referral routes for the commissioned services. It also looked at data from the police and from domestic abuse services, and compared these with national benchmarks.

The CAADA (SafeLives) report highlighted where Hertfordshire is performs well, and the need for some focused improvements in governance and leadership arrangements, the consistency in which victims are referred to services and the provision of services and support for victims and perpetrators. A copy of the full report is available on the Police and Crime Commissioner's website.
http://www.hertscommissioner.org/fluidcms/files/files/caada_review_06015_hertfordshire.pdf

The Board welcomed the review and discussed a presentation on the report and the plans for actioning its recommendations. The improvement work will be overseen by the new Domestic Abuse Partnership' Executive which is led by the Director of Children's Services. The Board's comments about the need for services for children to be a particular focus in the Domestic Abuse Strategy has become a reality with a 'task and finish' Group specifically addressing their needs.

The Board will receive regular updates on progress and will continue to monitor improvement on this important issue.

National College of Policing CSE Peer Review

During March 2015 the Police underwent a National College of Policing Peer Review in relation to CSE; the final report is now awaited. **The findings of this review will be used in 2015/16 as the Board refreshes its strategic and operational work on CSE.**

HSCB Peer Review

This informal review was commissioned by the Independent Chair and Director of Children's Services to provide an external and impartial insight into the functioning of the HSCB to emphasise areas of strength and areas for potential development in the context of the statutory requirements:

The report set out the strengths of the Board and areas for development but in order to provide the best learning opportunities the review focused more strongly on areas for development, with the aim that this will be the most useful way of assisting the Board in its continued development.

The reviewers felt there to be a strong sense of partnership in Hertfordshire with Board members consistently reporting that there is a sense of collective challenge. However, the Review highlighted to challenge effectively the Board also need to be well informed with a shared and widely understood analysis about what is happening across the County.

The review highlighted several important areas of improvement for HSCB to take forward, these included:

- Strengthening the internal governance arrangements of the Board and strengthening the Board's communication and monitoring arrangements with its Sub-Group. Since the Peer Review the Board has reviewed its structure and has developed a new Executive Group to oversee the work of the sub-groups and take forward the Business Plan in between Strategic Board meetings.
- Increasing the Board's awareness of risks and short term actions. Since the Peer Review the Board has reviewed and updated its Risk Register which is now monitored at every Executive Group Meeting. Actions taken, as well as risks removed and risks raised for consideration are logged.
- Action plans need to be more outcomes focused and the annual reports received by the Board need to include stronger evaluation information which relate back to the business plan outcomes. Since the Peer Review the Board had developed a new business plan which includes SMART outcomes and Key Performance Measures. Board Annual Report templates have also been amended to include evaluation measures.

The Internal HSCB Approach to Auditing and Performance Analysis

Auditing

The Board has an Audit Sub-Group which meets quarterly and is made up of senior managers across the Partnership. The group takes forward the Board's Multi Agency Audits set out in its Business Plan or required to respond to issues which arise throughout the year.

The Audit Group's overall objectives are:

- To receive, analyse and challenge reports of single agency audits and identify issues that need to be monitored and raised to for the HSCB Board and to conduct multi-agency audits based on the HSCB Business Plan.

- To develop and monitor actions plans resulting from the multi-agency audits and oversee and monitor the audit component of the multi-agency Serious Case Review action plans, following up the difference made from the actions completed – 12 months after the plan is completed.

During 2014/15 the Audit group carried out the following multi-agency audits:

- Step Down Audit
- Neglect Audit
- Child Sexual Exploitation Audit
- Disabled Children's Audit

The recommendations from the Audits are followed through by the development and implementation of an audit follow up action plan.

Step Down Audit – September 2014

In 2012- 14 a number of case reviews had highlighted risks to children when they were stepped down from Child Protection Plans. This audit was planned to assure the Board that the lessons learnt from those cases were actually making a difference to safeguarding children and that the 'step down' process was now robust and reaching appropriate standards.

Due to there being no particular identifier on LCS showing whether the CPP was stepped down, the data was selected to include, the total number of Child Protection Plans that were ceased for the period specified that were not ended due to the following reasons:

- Child has died;
- Child has permanently left UK;
- Child has reached 18 years;
- Transfer to another local authority;

This means that the report also shows any Periods of Care that began during the CPP or within 4 weeks of the CPP ceasing which can indicate Stepping Up.

For the period chosen, 01/09/2013 to 31/08/2014 inclusive, 979 cases were identified.
A deeper dive audit was then carried out for 10 of the total number of with the results as follows:

- For 8 of those cases, no agencies felt that the CP plan should continue. In 1 case it was not clear from the notes and in 1 case the child's grandparent felt that the CP plan should remain in place.
- All 10 cases were stepped down into a CIN plan and follow-on supported was planned for the child and family. This was particularly important because this had been a key recommendation of the case reviews which had been carried out.
- In 6 cases the CIN plan was still in place at the time of the audit.

The results of the audit showed that the step down process seemed to be working well, however it was agreed that the same cohort of children should be audited again in six months' time to see if the results of the audit would change with more time given since the plans ended. This re-audit will therefore take place in April 2015.

Characteristics of "Neglect" cases on Child Protection Plans - December 2014

With child protection plans for the reason of Neglect on the increase, a report was produced looking at the cases that were open as at a point in time to understand why they were in this category.

As at 10 December 2014, there were in total 1,052 open CP cases. 691 were for the reason of neglect. 23% (173) of the plans had been open for 12 months or over, so this was the cohort that was looked at in more detail.

- 102 were identified that had an incident of Domestic Violence.
- 92 cases had Substance Misuse involving either or both drugs and alcohol.
- 45 cases had mental health issues as a factor.
- 69 Cases had 2 Issues recorded and 8 cases recorded all 3 issues.
- 19 Cases were related to other issues including not meeting the basic needs of a child and poor living conditions.

It was identified that in a large proportion of the cases, it was not clear from the notes if other agency key workers were involved to offer additional specialist support where needed. The findings of the report were feedback to Children Services Core Board and any actions identified were taken forward.

Disabled Children's Audit:

The Board carried out a Partnership Case Review involving a neglected disabled child in 2012 and a SCR on another neglected disabled child in 2013. The audit looked at disabled children on child protection plans to establish if they were subject to the same level of input as non-disabled children on child protection plans.

19 disabled children on child protection plans were identified and from them, 12 were selected for auditing. The children were not selected entirely randomly; a mix of ethnicity and age was included to be representative.

The audits were then sent to the following agencies for each child:
Children's Services (CS), Hertfordshire Community Trust (HCT), Hertfordshire Police (Police), East and North Hertfordshire Hospitals NHS Trust (ENHT), West Hertfordshire Hospitals NHS Trust (WHHT).

Summary of findings: It was clear from all the comments from this audit, that there was some lack of consistency in how these cases had been managed. The cases which had seen more input from multi agencies had seen more timely improvements within the family. In other cases, where fewer agencies were involved the children were being repeatedly put onto child protection plans and overall the plans were lasting a considerable/longer amount of time.

Each of the agencies surveyed identified actions that they internally needed to take forward – the implementation of these actions have been monitored by the Audit Group

Positives:

In general the comments across the cases show:

- Good safeguarding practice
- Good partnership working
- Child's needs are being considered

Areas of learning:

- Health and School professionals need to be kept more informed
- Documentation needs better use of groups and relationships to identify who is involved with child at a glance, and clearly identify the child's disabilities
- Case notes were not always up to date / finalised
- The Children Services Risk Assessment Tool will assist in ensuring that risks are fully evaluated
- Focus needs to extend around all members of the household

Child Sexual Exploitation (CSE) Audit:

Following its discussions of Child Sexual Exploitation, the Board required a multi-agency audit to test the effectiveness of partners' working on this complex topic. That audit took the form of surveys and questionnaires to a wide range of the childrens workforce. The audit was completed in December 2014/January 2015 that was looking to answer the following questions in relation to CSE:

1) **Do children who are known to be vulnerable to CSE being identified and safeguarded at an early enough stage?**

- **Desired Outcome:** Children and young people understand what CSE is, are protected in their communities and do not come to harm

2) **Are children who are known to be vulnerable to CSE appropriately protected?**

- **Desired Outcome:** Children and young people who are vulnerable to CSE are effectively safeguarded through professional action and do not come to harm

3) **Are children who have suffered CSE being effectively safeguarded and helped?**

- **Desired Outcome:** Children who have suffered CSE are known, have services which help them to recover and do not come to further harm

Several Recommendations were made and actions identified, these actions have been included within the HSCB multi-agency CSE action plan. More detail regarding this plan and the outcomes from the plan/audit are within the CSE section of this annual report.

Section 11 Self-assessments

Section 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. Within Hertfordshire, partners assess themselves against 11 Standards.

The audit is aimed at enabling agencies to improve safeguarding practice in order to keep children safe from harm and improve earlier intervention. It 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 3 year rolling plan to be audited and in 2014-15 the below partners were asked to carry out an audit:

- Hertfordshire Constabulary
- Hertfordshire Probation Trust
- NHS England
- East of England Ambulance Service
- British Transport Police – BTP are developing/undertaking this process nationally and will report back the findings when complete.

The results, which were discussed at the Audit Group showed good compliance overall across the Partners with some recommendations about raising awareness around the new eCAF System and training, raising awareness around the role of the LADO and reviewing some safeguarding policies.

The Health Providers in Hertfordshire are Section 11 audited on an annual basis by the two Clinical Commissioning Groups in Hertfordshire and the results and progress of any identified actions are reported back to the Board.

In 2015-16 District Councils will be the subject of the audit.

Reviewing Child Deaths

Hertfordshire has a Child Death Overview Panel 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 process 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. The Group produces its own detailed annual report, but key work is summarised below. The full CDOP report can be accessed by contacting the HSCB Business Unit Admin.HSCB@hertfordshire.gov.uk

In 2014/15, 45 deaths were reviewed by CDOP. In the previous year (2013/14) there were 55.

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

Recommendations and learning points arising from child death reviews

In relation to the 45 deaths reviewed during 2014/15 10 of these were considered to have modifiable factors, of these 10 cases 3 were neonatal deaths, 5 were Sudden Un-explained Death in Infancy, 1 drowning and 1 other. In relation to the remaining 35 cases there were not deemed to have any modifiable factors, 14 of these cases were neonatal deaths, 14 related to known life limiting conditions with the remaining 7 relating to several

different factors. More information regarding the modifiable factors identified throughout the year will be provided within the CDOP Annual Report which is due to be published mid September 2015.

In-depth Reviews of Individual Cases of Death or Serious Injury

The death of any child is a tragedy, particularly if there is a concern that more could have been done to protect them. The Case Review sub-group of the Board has an independent chair and is a multi-agency panel from the following organisations and agencies:

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

The sub-group meets on a monthly basis to discuss referrals to the group and recommend to the Board's Independent Chair whether a Serious Case Review, other form of multi-agency review or any other actions should result from the referral. In addition, once reviews have been carried out, the sub-group monitors the implementation of improvement plans and liaises with the Audit group to evaluate particular aspects of learning.

Criteria for carrying out a Serious Case Review are set out in Working Together 2015 however the cases reviewed during 2014-15 were reviewed under the criteria set out within Working Together 2015. In cases which do not require a SCR, the panel selects the most appropriate action for cases to be reviewed and learning to be identified. The Board has been innovative in developing its own approach to multi-agency learning reviews (PCRs) using workshops which are facilitated using digital media. These are known as Partnership case Reviews (PCRs)

Specific cases reviewed during the year

During the year 7 new cases were discussed by the Case Review sub-group**.** Of these, two cases were progressed into serious case reviews (a decision regarding 1 other case is still to be decided).
Case 1 relates to a young girl who was murdered by her father

Case 2 relates to a baby who died from unknown causes but following a post-mortem was found to have historical injuries.

Both cases had involvement from a range of multi-agency services.
During 2014/15 the SCR Sub-Group also carried out two Partnership Case reviews, one of which was a teenage care leaver who died whilst living outside of the county and the other related to a baby who was non-accidentally injured.

The SCR Group is now implementing an action plan to address the issues raised within the findings of these reports.

The Board's approach is to publish all Serious Case Review reports in full together with the Board's response to their findings. During 2014/15 the Board published 2 SCR's which were completed during 2013/14, these relate to the reviews of Child X and Young person B. These documents can be accessed on the Board's website along with the detailed Board Response to the findings of the reviews.

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

Learnings from reviews are developed as part of the Board's Learning and Improvement framework. For example, messages from reviews are also incorporated into the HSCB bulletins and disseminated via Local Multi-agency Safeguarding Forums, as well as being incorporated into HSCB and single agency training programmes.

Child Sexual Exploitation and Missing Children

The Hertfordshire Safeguarding Children Board (HSCB) includes CSE as a specific agenda item at most of its Strategic Board meetings. These items take a variety of forms such as an update on numbers of case referrals, outcomes of cases and resource demands, or a more general update on the progress of the HSCB CSE Action Plan and development of the multi-agency CSE Strategy. The items are usually either led by the Police HALO lead or are joint items with Children's Services, Probation, Health organisations or other partners, such as school heads. CSE and Missing issues are regularly discussed at three levels across the Board:

- Within the quarterly Strategic Board meeting which maintains an overview of the effectiveness of the CSE Strategy and performance against it.
- By the Strategic Safeguarding Adolescents Sub-Group which coordinates and develops the management approach including overseeing the implementation of the Board's CSE action plan, and
- In the SEARCH meetings where a wide variety of operational professionals discuss the risks and responses to be followed for children who are going missing or at risk of CSE

During 2014/15 HSCB set up a new sub-group called the Strategic Safeguarding Adolescents Group that focuses on Child Sexual Exploitation and Missing Children.

The aim of the Strategic Safeguarding Adolescents Group is to provide a local framework in which all partner agencies can work to deliver collectively the best protection for missing children and those at risk of CSE and trafficking through sharing best practice, improving data & intelligence collection and continuous monitoring of performance.

Specific outcomes achieved on the topic of CSE include:

- CSE Strategy in place and is currently being reviewed
- CSE Action Plan in place and is continually reviewed
- CSE Audit undertaken to identify any areas for improvement – any recommendations have now been added to the CSE action plan (please see details of the audit findings within the auditing section of this report).
- The Sexual Exploitation and Runaway Children Panel (SEARCH) is in place and continuing to meet – This is ann operational group that reviews specific cases of children who either go missing and/or may be at risk of CSE.
- CSE Specific page on HSCB Website
- Information leaflets/materials for young people, parents and carers and professionals continue to be reproduced and distributed
- Multi-agency CSE Training is an on-going part of HSCB training calendar
- Missing Children and CSE Data Dashboard has been developed by the Strategic Safeguarding Adolescents Group and cross references reported missing cases with HALO team data.
- Performance Group are continually looking as possible new performance indicators/measures
- Say Something If You See Something Campaign launched.

The HSCB Say Something if you see Something Campaign was launched in November 2014 by the Independent Chair of the Board, the Police and Crime Commissioner and the Local Authority Lead Member for Childrens Services. The campaign aims to raise awareness amongst the general public, young people and professionals. In particular the campaign targets the following professionals:

- Taxi drivers
- Hotel staff
- Licensed premises.

Information Packs were been produced for District Councils/Community Safety Partnerships to distribute through their Licensing Departments to taxi drivers and licenced premises. Pubwatch were also been briefed and a representative attended the Launch Event.

Police Safer Neighbourhood Teams continue to distribute materials to local hotels and bed and breakfast establishments in their areas as part of the on-going CSE action plan.

The Say Something If You See Something campaign materials were also presented along with a train the trainer presentation to the Bedfordshire and Hertfordshire Licensing Officers Group, to enable them to pass on this communication to taxi drivers and licensed premises in their local areas.

Following the Launch event in November contacts were also made with the Fire and Rescue Service and details have been included within their development training sessions. This is to raise awareness of looking out for the signs of CSE when visiting hotels and licensed premises when carrying out Fire Inspections or within homes when carrying out Home Fire Safety Checks.

Awareness posters were produced as part of the campaign and were distributed to the following locations:

- Libraries
- GP Surgeries
- Dentists
- Hospitals
- Sexual Health Clinics
- Pharmacists
- Secondary Schools
- Youth Clubs
- Colleges
- Leisure Centres
- Trading Standards
- Housing Associations/Registered Landlords
- District Councils
- Universities
- Police Custody Suites
- Courts
- Probation Offices
- Front of House Police Stations

- Sexual Assault Referral Clinics
- Victim Support Offices

The campaign has also been presented to the HSCB Local Multi Agency Forums and awareness was at School Governors Conference in November 2014

Data from the Sexual Exploitation and Runaway Children Panel (SEARCH):

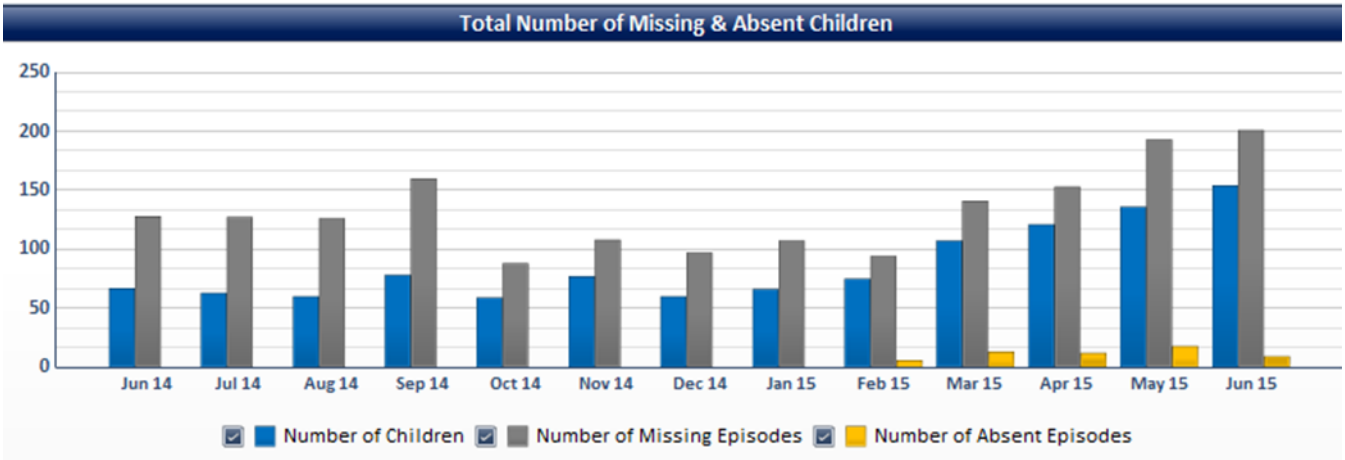
The SEARCH Panel is an operation group which reviews cases of missing children who may also be at risk of CSE, to develop multi-agency actions to reduce the risks of CSE to them.

Between April 2014 to May 2015

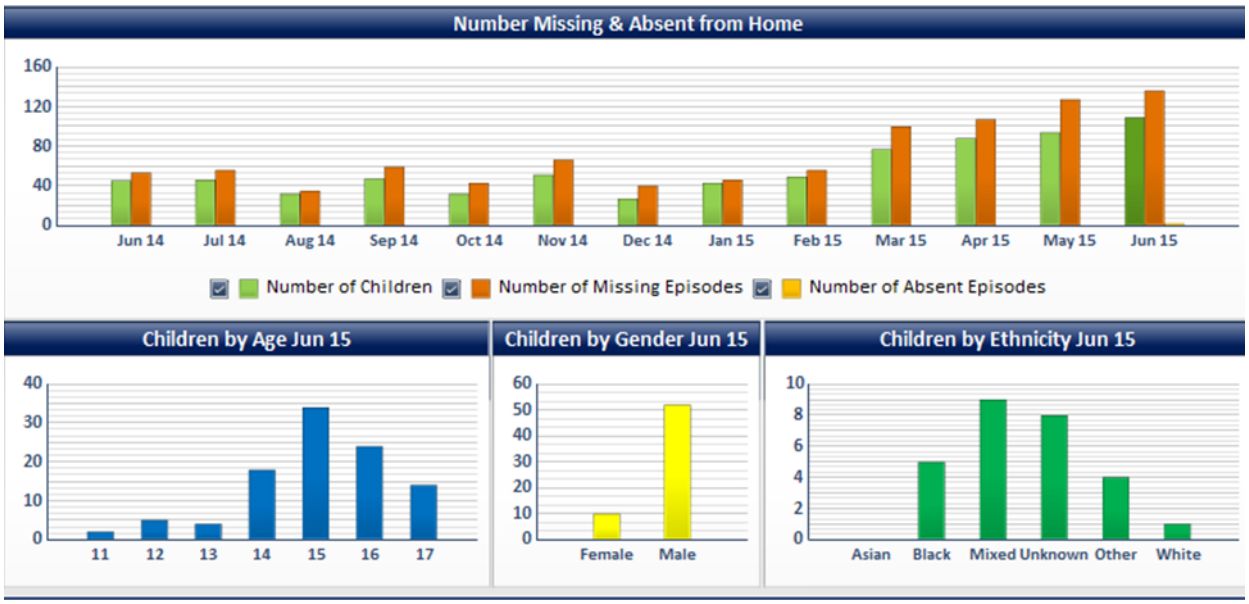
- The average age is 15 years old
- 68 young people received oversight and scrutiny by SEARCH panel
- 29 young people referred due to Missing episodes and no CSE identified from shared intelligence
- The risks for 18 young people were reduced and the cases discharged from panel and 24 young people were discharged on the basis that there were no ongoing concerns of CSE or Missing
- 51 cases are female and the average age is 15.35yrs
- 14 young people living at home, 53 were Looked After Children and 1 was a care leaver.

Below is data related to Missing Children:

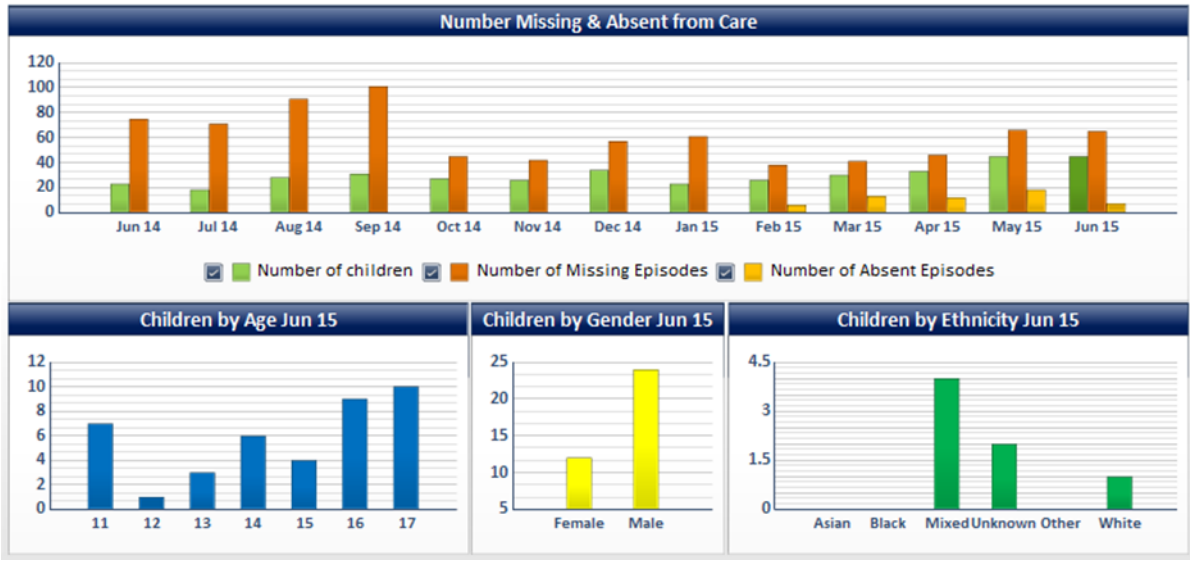
Total Number of Children Missing



Children Missing from Home

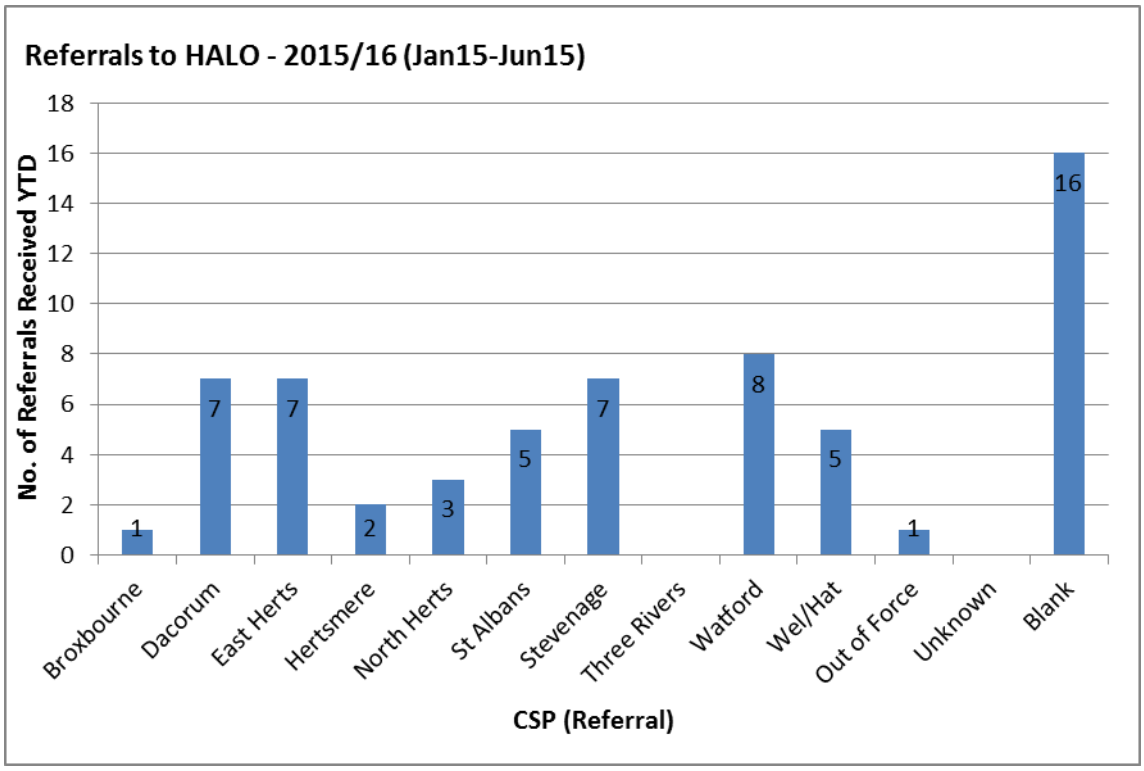


Children Missing From Care

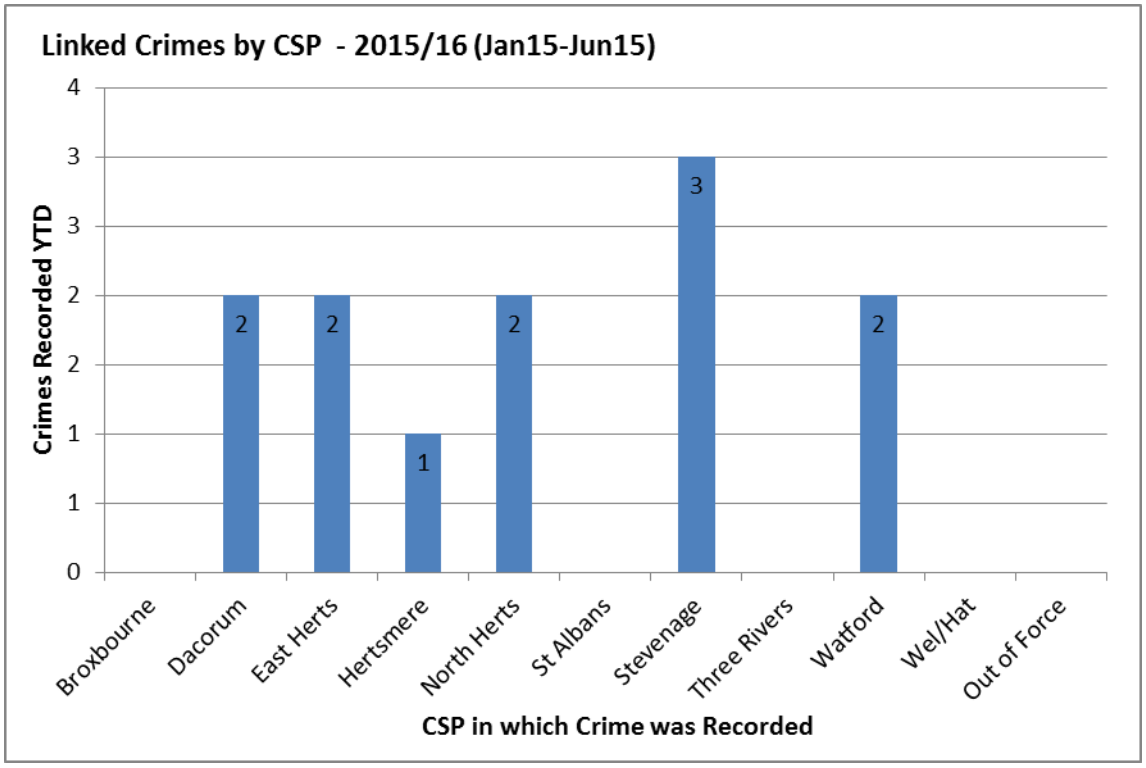


Below is data from the Police HALO Team which is a dedicated team specifically investigating CSE referrals.

Halo Referrals by Community Safety Partnership Area, 1 January – 30 June 2015



Halo Crimes by Community Safety Partnership Area, 1 January – 30 June 2015



Improving Operational Outcomes

To help improve operational work issues the Board has a sub group called the Improving Outcomes Group (IOG). The aim of the group is to ensure effective multi-agency working on operational issues relating to safeguarding children, and deliver elements of the HSCB business plan. It also oversees and monitors task and finish groups set up to improve outcomes for specific groups of children or young people.

During the year, IOG has achieved the following milestones:

- Reviewed and re-developed the Graded Care Profile – Hertfordshire's toolkit for assessing neglect, making it more accessible and easier to use. Awareness around the Graded Care Profile now needs to continue in order to help increase its usage.
- Implemented the Strengthening Families model for child protection conferences which has helped increase the engagement and participation of families in child protection conferences.
- Reviewed the use of the escalation process by partner agencies to better understand who is using the process and to what extent. The survey highlighted the need to continue raising awareness of the process and push for partners to use the process when needed.
- Received assurance from the Multi-Agency Safeguarding Hub (MASH) implementation group that the MASH project is being progressed. The aim of the MASH is to improve improving Information Sharing within Hertfordshire and the project is due to go live during Spring/Summer 2015 and will be evaluated during 2015/16.
- Developed a new multi-agency strategy for supporting Vulnerable Adolescents in Hertfordshire, to help front line practitioners support vulnerable adolescents in a more effective way.
- Overseen a task and finish group that has been reviewing the frontline use of the Bruising Protocol in Hertfordshire. This review has helped to identify improvements to the protocol to make it easier and clearer to use for front line practitioners. The updated protocol will be launched in 2014/15. Received assurance in relation to the work to raise awareness and increase the numbers of private fostering cases in Hertfordshire through the Private Fostering Annual Report.
- Carried out a research project in to the services available for young parents in Hertfordshire, to help ensure service provision is adequate this project is due to be completed in July 2015.

Going forward the a continued area of focus for the improving outcomes work will be evaluating the effectiveness of early help work in Hertfordshire, developing work around Female Genital Mutilation and reviewing and evaluating the effectiveness of Domestic Abuse Services available in Hertfordshire and evaluation the effectiveness of the newly set up MASH.

Multi-Agency Safeguarding Hub (MASH)

As mentioned above during 2014/15 Hertfordshire has been developing a MASH. The Board discussed info sharing and decide a MASH was necessary; therefore the Chair led the initial set up of the project to ensure full partner engagement and high level

commitment. Plans have been developed by a specific project group which has regularly updated the Board; the MASH will go live in early 2015-16.

Private Fostering

HSCB have clear policies and procedures in place for children living away from home including those who are privately fostered.

Throughout the year the HSCB Business Unit have helped to raise the awareness of Private Fostering in Hertfordshire by promoting the Private Fostering at the following events:

- HSCB Annual Conference
- Annual School Governors Conference
- Early Years – Childminders Conference
- Early Years – After School Clubs Conference
- Early Years – Children' Centres Conference
- Early Years – Pre-School Conference

Information has also been included within the HSCB information section of both the Early Years Designated Safeguarding Person (DSP) training and the School DSP training sessions

Ensuring Policy and Procedure Enable Improvement

HSCB has a Policy and Procedure Group in place to help review its inter-agency policies and procedures ensuring they are up to date with statutory requirements and also that improvements are made following audits and case reviews to reflect best practice for front line practitioners. The group also ensures that HSCB member agencies also have policies, procedures and guidance in place for safeguarding.

In particular during 2014/15 the group has reviewed and revised the following procedures:

- Referrals
- Single Assessments
- Child Protection Plans
- Children Looked After
- Child Protection Conferences
- Section 47 Enquiries
- Common Assessment Framework and Thresholds
- Child Sexual Exploitation
- Domestic Abuse
- Pre-Birth Protocol
- Female Genital Mutilation

The group also revised the LSCB Threshold document called 'Meeting the Needs of Children and Families in Hertfordshire'

- 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 the launch of an awareness campaign around Child Sexual Exploitation (CSE 'Say something if you see something campaign'

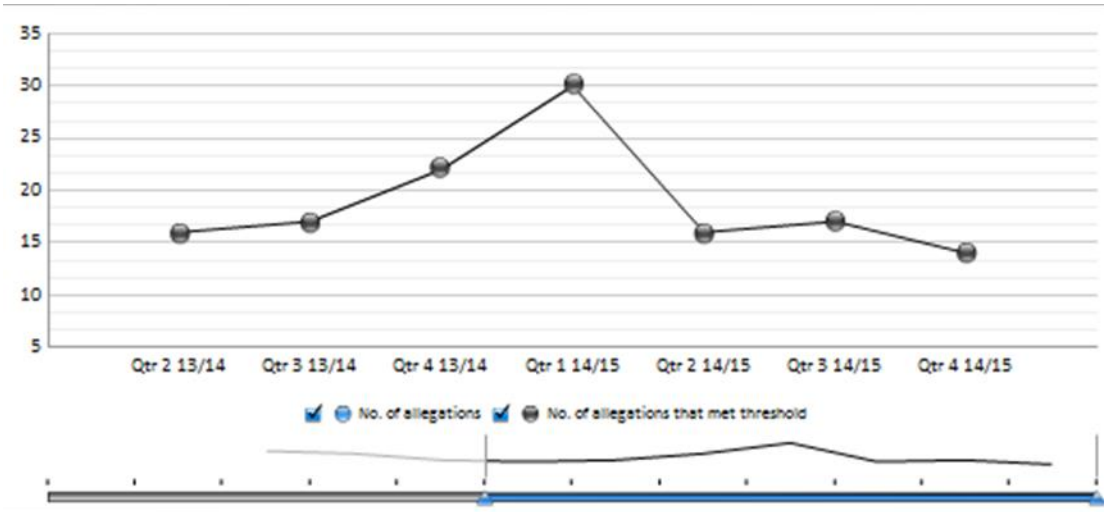
The group continues to raise take forward and raise awareness of the following publicity campaigns which were launched during previous years.

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

Allegations against members of the childrens workforce
The Local Authority Designated Officer (LADO) role applies to the whole children's workforce paid, unpaid, volunteers, casual, agency or anyone self-employed whose role involves working with children and young people. This workforce has been estimated to be over 30,000 people in Hertfordshire. LADOs capture the concerns, allegations or offences that may exist when those people become a risk to children and young people. Although there was an increase of referrals which met the threshold for LADO services during April, May and June, this was only an increase of 8 referrals over 3 months. They all occurred during term time and this increase only equates to one extra referral per week, so was therefore not seen as a significant increase.

Below are the LADO referrals for 2014/15

Number of allegations made against a member of the children's workforce received by the LADO that met the Threshold for LADO services.



	Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Qtr 3 14/15	Qtr 4 14/15
No. of allegations	174	194	166	228	222
No. of allegations that met threshold	22	30	16	17	14
% of allegations that met threshold	13	15	9	8	6

Learning and Development

Working Together 2013 placed a responsibility upon all safeguarding boards to develop a Learning and Improvement Framework. For HSCB this was a relatively straightforward process as it already had recognised the part played by audit, performance monitoring and case review in determining the need for improvement in the children's workforce. A formal Learning and Improvement framework was adopted by the Board in February 2014 and was later reviewed and updated during February 2015. This document is available from the HSCB Business Unit admin.HSCB@hertfordshire.gov.uk

The implementation of the framework is mostly achieved through the Training sub-group of the Board. It has the responsibility to maintain the 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 safeguarding training within Hertfordshire

HSCB currently provides the following multi-agency courses:

'Lite Bites' (short one or two hour sessions often delivered in a local workplace:

- The management of bruising, bites and suspicious marks on babies and children
- Serious and partnership case reviews and audits
- Preparing for court
- Child Sexual Exploitation
- Understanding parental substance misuse
- The Graded Care Profile

Training Courses: (i.e. more formal sessions in classroom or workshop environment)

- Working with parents and carers (2 day course)
- Referral and beyond
- The child protection process
- Understanding the impact of neglect
- Safeguarding children with disabilities
- The impact of parental mental health
- The impact of parental learning difficulties

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, made up of specialist practitioners from HSCB partner agencies and externally commissioned trainers. They are delivered in a variety of venues across the County to encourage local multi-agency working together.

The training sub-group has continued to evaluate all courses through delegate evaluation forms completed on the day of the course and follow up telephone/email interviews conducted at the end of each quarter to help assess if the training has helped delegates

improve their practice. During 2014/15 these follow up telephone interviews/email were conducted for all courses.

Below are some quotes taken from these follow up evaluations:

CSE Lite Bite

Quote:

"Training has given confidence, recommended to Youth Workers to attend, team event for information sharing planned on back of it, info shared with colleagues"

Safeguarding Children with Disabilities

Quote:

"Cascaded to relevant staff and linked to curriculum areas"

Bruising Lite Bite

Quote 1:

"I see babies hours after birth and will use this in clinic with babies, small children and siblings"

Quote 2:

"We have reviewed referrals process and implemented the pathway with staff and consultants"

Number of attendees by HSCB Training Course – April 2014 – March 2015

The table below shows the number of people trained by the HSCB during 2014-15 broken down by the course they attended.

Total number of attendees by course Apr 14 - Mar 15

Name of course	Total number of attendees	How many times the course ran
Inter-agency working together - referral and beyond	66	4
Inter-agency working together - the child protection process	38	2
Safeguarding children - the impact of parental learning difficulties	23	2
Safeguarding children - the impact of parental mental health	50	3
Understanding neglect – a half day refresher	23	2
Safeguarding disabled children	70	4
What to do if you identify a baby/child with bruises lite bite	32	2

Working with parents/carers	23	2
Child Sexual Exploitation Prevention, Protection and Investigation	38	2
Serious case and partnership case review lite bite	35	2
Preparing for court lite bite	27	2
Understanding domestic abuse lite bite	15	1
Graded care profile lite bite	100	5
Self-harm lite bite	46	3
Understanding the impact of substance misuse lite bite	36	2
Total	**622**	

Agency attendance breakdown Apr 14 – Mar 15

The table below shows the agency attendance breakdown from April 2014 – March 2015. Health includes the partnerships: - East & North Herts, Herts Community NHS Services, Herts Partnership NHS Trust, Public Health and West Herts Hospitals.

Total number of attendees per agency Apr 14 – Mar 15

Agency	Total number of attendees per agency
Children's centres	82
Children's Services	175
Colleges	12
District Council	6
Education	10
Health & Community Service	9
Health - East & North Herts NHS Trust	15
Health - Herts Community NHS Trust	105
Health - Herts Partnership NHS Foundation Trust	1
Health - NHS Hertfordshire	11
Health – Public Health	2
Health - West Herts Hospitals Trust	7
Herts Constabulary	11
Herts for Learning	2
Herts Young Homeless Group	2
Homestart	9
Housing Provider	7
HSCB	7
National Childminding Association	1
Nursery	2
Other	13
Pre-school	3
Schools	57
South West Herts Partnership	8
Voluntary sector	8
Women's Refuge	3
Total	**568**

*Single agency organisations also provide internal single agency training.

Quality Assurance of Single Agency Training:

The HSCB Learning and Development Sub-Group complete an annual Quality Assurance Audit of Single Agency Training. The audit aims to monitor the percentage of staff within organisations who have received appropriate safeguarding training to their role. The audit also looks at:

1. What actions do agencies have in place to provide training to staff who require the training but have not yet received it?

2. Are there any groups of staff that are not covered by the statistics? If so, has a risk assessment been carried on them not receiving training?

3. Does the agency have a learning and development strategy in place and does this cover safeguarding training?

4. If a strategy is in place, how often is this updated? If a strategy is not in place, how does the provision of safeguarding training fit within the agencies business plan?

5. Is the agency using the HSCB quality framework to assess the quality of your training provision? If not, why not and what is used instead?

6. What methods does the agency use to ascertain training needs?

7. What tools and methods does each agency currently use to evaluate the quality of training delivery and content?

8. Are the aims and objectives of the training clear and SMART (Specific, Measurable, Achievable, Realistic and Timely)?

9. How is the learning from the training embedded in each organisation?

10. Do managers include training and learning as part of the appraisal process? If not, what actions are in place to ensure managers support staff in their learning?

11. Is reflective practice i.e. how the learning can be implemented in the work role, built in to the appraisal process?

12. How do organisations measure the impact of the training in their organisations?

Headline results:

- The results of the audit showed that all agencies had a training strategy in place
- In relation to the percentage of staff who had received the appropriate level of safeguarding training varied between individual organisations with answers ranging between 66% - 100%

- Training of staff is reviewed within the appraisal process within individual organisations
- How the findings from SCR's are disseminated within organisations varies between organisations, going forward the Learning and Development sub-group will need to continue to monitor this area of work and assist with resources/materials if needed.

Annual Conference:

The training sub-group also oversees the provision of the annual safeguarding conference which is attended by a wide range of professionals from all parts of the children's workforce.

In September 2014, the HSCB held its annual conference titled 'Accessing the right services at the right time and meeting the needs of families and children in Hertfordshire' The conference provided attendees with information about different services available within the Early Help structure in Hertfordshire and how and when you should make referrals to them.

Evaluations showed that 192 people attended with 146 people completing evaluations. Of these 146 people 125 people scored the event either excellent or good in terms of usefulness. The remaining 26 people scored it satisfactory. Presentations at the conference emphasised the need for attendees to share their learning from the day with their peers and colleagues in the workplace.

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. Attendance is good in all areas with representation from relevant agencies.

In addition to their locally generated discussions, the forums have received presentations across the year including Thriving Families, the new e-CAF System, CSE, Special Educational Needs Statements transferring to Educational, Health and Care plans, Strengthening Families, One Herts and Keeping Children Safe in Education.

Moving Forward – The HSCB Business Plan 2015-16

The business plan for 2015/16 has now been agreed by the Board and the themes within the plans ensure that the Board will focus its work on:

- Evaluation of Early Help including:
    - The impact of early help services for 0-5 year olds within deprived areas
    - Evaluation of early help services in relation to Self-Harm
- Priority areas of risk to children and young people, specifically CSE, Domestic Abuse, Female Genital Mutilation
- Development of the Board and Partner Capacity
- Implementation of Learning from Case Reviews

The actions for the business plan sit with the various sub groups who review and action their progress with the support of the business unit. The 2015/16 annual report will include the progress made by the Board on these issues.

Appendices

Appendix 1 Glossary

CAF	Common Assessment Framework
CAFCASS	Child and Family Court Advisory Support Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CiN	Child in Need
CP	child protection
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
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
WHHT	West Hertfordshire Hospitals NHS Trust

Appendix 2 Attendance at Strategic Board meetings

Member / Agency / Organisation	Meetings attended
Assistant Chief Constable, Hertfordshire Constabulary	4/4
Assistant Chief Legal Officer, Adult & Children's Law, HCC	4/4
Deputy Director of Public Health, HCC	3/4
Executive Director Quality & Safety, Hertfordshire Partnership NHS Foundation Trust	4/4
Service Manager, CAFCASS	3/4
Designated Doctor for Child Protection & Consultant Paediatricians, NHS	4/4
Designated Nurse, Safeguarding Children & Children Looked After, E & N Herts CCG	3/4
Director of Children's Services, HCC	3/4
Assistant Director, National Probation Service	4/4
Director of Interventions, Community Rehabilitation Company	4/4
Director of Quality & Governance, Hertfordshire Community NHS Trust	4/4
Director of Quality & Patient Experience/Nursing, Hertfordshire & South Midlands NHS England	2/4
Director of Nursing & Patient Experience, East & North Herts NHS Trust (From January 2014)	2/4

Director of Nursing & Quality, Herts Valley CCG (usually represented by Director of Nursing & Quality East & North Herts CCG)	2/4
Director of Nursing & Quality East & North Herts CCG	3/4
Chief Nurse & DIPC, West Hertfordshire NHS Trust	3/4
Director of Family Safeguarding, HCC	3/4
Assistant Director, Commissioner for Education Services, HCC	0/4
Head teacher, Primary Schools	4/4
Head teacher, Secondary Schools	3/4
Head teacher, Special Schools	2/4
Deputy Principal, Further Education	0/4
Chief Executive, District Councils (from Feb 2014)	4/4
HSCB Business Manager	4/4
Independent Chair	4/4
Lay Member #1	0/4
Lead Member Children's Services	2/4

Appendix 3 Dataset key indicators

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.	
1a	The percentage of initial assessments for children's social care carried out within 10 working days of referrals
1b	The percentage of core assessments for children's social care that carried out within 35 working days of their commencement
1c	The percentage of children becoming the subject of a child protection plan for a second or subsequent time
1d	Number of CAFs by assessment
Strategic outcome 2: prevent neglect and abuse, in the family, of those identified as being at risk through effective and early multi-agency intervention	
2a	The percentage of quoracy achieved at child protection conferences
2b	The percentage of child protection cases reviewed within required timescales
2c	Number of 'Cruelty and Neglect of Children' Offences
2d	Number of children with a child protection plan without an allocated social worker
2e	Under-18 hospital admissions for injuries, mental health, self-harm and substance misuse
2f	Numbers of domestic violence incidents and crimes where children are present
2g	Numbers of repeat cases referred to MARAC involving children *-rolling year measure*
Strategic outcome 3: ensure the safety and wellbeing of children and young people in care through effective risk management and support	
3a	The number of children looked after aged 10 to 18 committing offences
3b	The percentage of children looked after cases for whom all reviews during the year were reviewed within required timescales
3c	Total number of children looked after
3d	Total number of children in a private fostering arrangement
Strategic Outcome 4: Ensure children and young people are safe and secure from all types of harm including bullying and when accessing technology.	
4a	Number of child deaths
4b	The number of violent crimes involving a victim aged under 18
4c	The number of missing children
4d	The number of crimes involving children accessing technology (i.e. bullying/harassment)
4e	Number of youths accused of being involved in an offence
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	
5a	The percentage of statutory workforce who have completed safeguarding training appropriate to their role *-annual measure*
5b	The percentage take-up of HSCB training
5c	*Removed*
5d	Number of allegations against a member of the children's workforce received by the LADO
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	
6a	Rate of proven re-offending by young offenders aged 10-17 (formerly NI 19) *-annual measure*
6b	First time entrants into the Youth Justice System aged 10-17 (formerly NI 111)
6c	Number of statutory school age children receiving a permanent exclusion
6d	Numbers of under 18s seeking treatment for a substance or alcohol misuse problem
6e	Under 18 conception rates (formerly NI 112) *-biennial measure*

Appendix 4

2013/15 – HSCB Business Plan Progress Report (as at the end of March 2015)

Theme 1: Information and Risk Sharing

Outcome	Actions	Lead	Progress Feb 14	Status
1.1 The needs of children and young people in Hertfordshire are identified and responded to effectively by appropriate organisations ***Source: response to local and national learning***	• review the effectiveness of information and risk sharing processes around targeted advice service (TAS) and joint child protection team/assessment team	HSCB Strategic Board / **Jenny Coles**	Report regarding Information Sharing was presented to the Board in September 2014 and the Board agreed in principle to progress a MASH project. A project lead officer has now been agreed along with a project group. MASH Project now being taken forward.	G
1.2 Improved partnership working results in better outcomes for children and young people ***Source: Working Together 2013; response to local learning***	• each agency provides HSCB with information on how they monitor their staff attendance at multi-agency safeguarding meetings • HCC provide regular dip samples into their step down process	HSCB APAG **Steve Johnson-Proctor**	Step Down Audit completed in October 2014. Same Cohort to be audited to again in 6 months' time to see if there is any change (due to be completed March 2015) Agencies to provide information on how they monitor attendance at multi-agency safeguarding meetings (Strategies, Conferences and Review Meetings) – Information has been requested and collated. Results show that the overall majority of	G

			agencies do record this information.	
1.3 Consistent, clear and high standards of safeguarding practice throughout the county ***Source: Working Together 2013***	• review partner agency safeguarding policies and procedures • review consistency in practice standards across County	HSCB P&P Group Heather Moulder	Partner agency policies are reviewed through the Section 11 Audit process. District Councils – 2014 HCC Directorates – 2013 Health/Police/Probation – 2014	G
1.4 Agencies across children and adult services work together effectively with a consistent, clear and joint focus on safeguarding of children and young people ***Source: response to local and national learning; Working Together 2013***	• evaluate the quality and effectiveness of arrangements to safeguard children through the policies, procedures and practice of adult services, especially relating to mental health, alcohol and substance misuse and domestic abuse.	HSCB P&P Group Oliver Shanley	The interface team have now completed the audit between children services and adult mental health services, this was presented to the July APAG meeting and an action plan is being completed and progress will be reported back to APAG in January 2015. Policies from CRI, HPFT and Domestic Abuse Services have now been received.	G
1.5 Adult and children's services effectively share information about children and young people that may be at risk or in need ***Source: response to local and national learning; Working Together 2013***	• publicise information sharing processes • ensure learning from domestic homicide reviews is shared with relevant children's services. • ensure learning from serious case reviews	HSCB strategic board/Jenny Coles	Information sharing practice guidance note sent out in April 2014 Links with DHR made for direct notification to HSCB in cases of DHR with children DHR learning will be	G

	and partnership case reviews is shared with relevant adult services		shared across services as part of L & I framework SCR/PCR learning will be shared across services as part of L & I framework. HSCB On line procedure has been amended to detail this process. Materials have been produced and circulated to agencies via r the Learning and Development Sub-Group.	
1.6 All agencies effectively share information about children and young people that are at risk by transition processes ***Source: response to local learning***	• record and information sharing is done effectively and timely • all agencies review their services and processes in light of local lessons learnt • transition processes are effectively risk assessed and managed between and across services to provide ongoing stability of care and safeguarding for children and young people	HSCB SCR and training and development sub group/Sue Williams	HCC practice guidance note on information sharing sent out 14 April 2014 Implementation of the VC PCR Action Plan On-going Review of MU PCR Case Review.	G

Theme 2: Early Intervention and Prevention

Outcome	Actions	Lead	progress Feb 14	Status
2.1 Early and appropriate identification of need based on a family	• develop and implement a programme of audits, including single agency	HSCB APAG/Justin Donovan	APAG have created a programme/schedule of audits for 2013-15 and all	G

focussed assessment to support and service provision prevents escalation into child protection services. ***Source: Working Together 2013;*** ***Ofsted reviews of LSCBs, Nov 2013.***	and multi-agency audits, relating to the embedding of the common assessment framework (e-CAF) and the provision of early help based on a holistic view of the family.		audits completed. Early intervention was audited as part of the Child's Journey Audit.	
2.2 Targeted help services are provided that address the assessed needs of children, young people and their families. ***Source: Working Together 2013; response to local and national learning***	• undertake a review of service provision for young parents particularly those with alcohol or substance misuse and/or domestic abuse issues, to inform further development of the early intervention and prevention commissioning strategy	HSCB IOG/Jan Norman	Task and finish group set up to review provision for young parents and results were presented back to IPG at the November meeting	G
2.3 HSCB has a clear 'children at risk of sexual exploitation' (CSE) strategy and action plan for the county ***Source: office of the children's commissioner's inquiry into child sexual exploitation in gangs and groups, final report, Nov 2013; CSE and the response to localised grooming - government response Sept 2013***	• collate and analyse performance information and other intelligence to develop a CSE dataset that identifies prevalence of key risk factors relating to CSE. • develop a local strategy to implement the local elements of the national CSE action plan in Hertfordshire.	HSCB IOG Mick Ball	A victim profile, an offender profile and a gang profile have been completed. Missing children data continues to be reviewed as a part of the dataset and information regarding victims accessing the Halo team is collated. Strategy and action plan have been reviewed and action leads identified. The action plan is now being taken forward by the new CSE Sub-Group.	G

			Say Something if you See Something Campaign launched on 19th November 2014.	
2.4 All organisations have training, knowledge and understanding of child sexual abuse, to include CSE with clear policies and processes to follow. ***Source: Office of the children's commissioner's inquiry into child sexual exploitation in gangs and groups, final report, Nov 2013; CSE and the response to localised grooming - government response Sept 2013***	• develop and implement an awareness raising campaign of the factors that increase the risk to children of sexual exploitation across all agencies • ensure all agencies review policies, procedure and practice in light of the government's CSE action plan and HSCB's CSE strategy.	HSCB IOG and e-safety Mick Ball	CSE Breakfast conference for schools took place in March 2014 and another session booked for June 2014 CSE awareness and training delivered across county in 2013-14. HSCB Training Course has been developed and is now part of the annual training programme. Say Something if you See Something Campaign launched on 19th November 2014. CSE Audit being completed Dec – Jan 15 Chelsea's Choice Production carried out in Schools across Hertfordshire in connection with Hertsaid.	G
2.5 All organisations recognise and respond to cases of missing children,	• ensure that all agencies are aware of changes in legislation regarding	HSCB IOG/SEARCH/HSCB APAG	A new Multi-Agency Missing Children Protocol is being developed.	G

using multi agency communication and tools ***Source: DfE statutory guidance on children who run away or go missing from home or care Jan 2014***	missing children and review their policies and procedures accordingly	Mick Ball	The Police have recently updated their missing children policy and presented it to the P&P group. HSCB have a new policy in relation to CSE for its Child Protection Procedures, on the website in March 2014. New HSCB CSE Website page launched in Dec 13.	

Theme 3: Equality and Diversity

Outcome	Actions	Lead	progress Feb 14	Status
3.1 The views of children and young people inform the safeguarding services they receive ***Source; Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• collate and share existing intelligence relating to the voice of the child from all agencies within HSCB • identify opportunities for regular dissemination of this information • carry out an audit of children subject to CPP to evaluate the extent to which their views have informed CP conferences and CP plans. • liaise with other groups working with children and young people to	HSCB APAG/HSCB business unit Katie Clark	Links made with HCC and CICC and Herts Youth parliament. Attendance at December 2013 meetings to discuss ways of taking forward work with these young people. Plans in place to introduce care leaver/yp to Board- needs Board approval Audit for the Voice of the Child has taken place and the findings were discussed at the April 2014 meeting and the action plan has been	G

	gain their views on safeguarding		completed – The need for raised awareness around the NYAS Service raised – PGN Issued. Contact made with Hertfordshire Children, Young People and Families Forum – response: they are currently not meeting. Links made with the HPFT Young Persons Involvement Officer. Consultation with the Care Leavers Group carried out in relation to taking forward PCR action plan.	
3.2 Children with additional needs access appropriate and effective services when they need them or when needs are identified for them ***Source: response to local learning; Working Together 2013***	• board to direct the development and completion of an audit of cases of children with special needs who are subject to Child Protection Plans • ensure all agencies are aware of learning relating to cases involving children with special needs following SCR/PCR/Child Death processes • raise awareness of wider safeguarding	HSCB APAG, e-Safety and SCR. HSCB training sub group/Jenny Coles	Disabled Children's Audit completed in October 2014 and action plan/ recommendations to be presented to APAG in January 2015. Agency learning will be scheduled as part of SCR learning and outcomes – Dissemination materials produced, awaiting publication of SCR. Annual Disabled Children Conference now being	G

	issues relating to children with disabilities		held.	
3.3 All partners across Hertfordshire keep abreast with the cultural changes in the population and adapt their services to meet the differing needs presented ***Source: response to local learning***	• each agency to review individual approaches ensure they are meeting the differing cultural needs of their client groups • develop opportunities to share good practice and raise awareness across the partnership. • HSCB to implement a cultural awareness in safeguarding e-learning course.	Individual agencies/HSCB business unit Justin Donovan	Cultural Awareness Training has been organised through the East of England Government Association and will take place in January 2015. This action is now being reviewed through the JSNA.	G

Theme 4: Workforce and Board Development

Outcome	Actions	Lead	progress Feb 14	Status
4.1 HSCB and agencies are compliant with Working Together 2013 and other national legislation ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• review all HSCB procedures and appropriately revised with changes integrated into all relevant HSCB training programmes and practice • ensure that the HSCB website updated to reflect all changes in a timely and well-publicised manner. • ensure that all partner agencies have robust implementation plans to ensure compliance with	HSCB strategic board/all HSCB sub groups and partner agencies/Jan Norman	A Working Together implementation update plan was sent to the February Board Meeting. HSCB is Working Together Compliant.	G

	Working Together 2013 and that they are auditing practice to ensure required changes are happening.			
4.2 Safeguarding training is relevant, timely and available to all agencies across Hertfordshire ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• ensure all multi-agency training is reviewed regularly to ensure its continued relevance so that it is updated in line with legislation and meets local and national needs • monitor attendance at multi-agency training events and escalate any concerns to relevant agencies	HSCB training subgroup/Sheilagh Reavey	All HSCB training materials have been reviewed and updated QA process scheduled to visit and evaluate all HSCB multi agency training Attendance monitored and reported to training sub group quarterly Telephone evaluations are now being completed.	G
4.3 Learning from serious case reviews (SCR), partnership case reviews (PCR) and child death reviews is taken forward across the county to improve safeguarding practice ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• ensure any serious case reviews undertaken meet the new criteria set out in WT13 • continue to identify cases below the SCR threshold where potential learning outcomes or concerns justify a partnership case review • ensure the learning and improvement framework clearly articulates how learning from reviews will be taken forward	HSCB SCR/CDOP HSCB training/Katie Clark	Current SCRs are all being undertaken following WT13 criteria Role of SCR sub group is to discuss and identify cases of potential learning that do not meet the SCR criteria L & I framework approved by Board Feb 14 Awareness raising and learning will commence on outcomes of SCRs and PCRs completed	G

	and that training is developed to reflect this. • develop awareness raising campaigns that highlight issues emerging from specific reviews			
4.4 The learning and improvement framework supports improvement in the quality of safeguarding practice ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• revise and publish the HSCB learning and improvement framework • review and refresh the L & I framework yearly to detail changes to process and training programme as appropriate • all improvement in practice is able to be measured by the evidence of the impact of the work	HSCB APAG SCR Training/Sheilagh Reavey	L & I framework approved by Board Feb 14, now on HSCB website	G
4.5 The board has effective communications with the community, including the voluntary sector ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• develop and undertake a programme of quality assurance work with the non-statutory sector. • ensure HSCB has an appropriate presence with relevant community groups across Hertfordshire including outreach work as well as existing safeguarding networks.	HSCB business unit/all sub groups/Katie Clark	To be scheduled IN progress – CVS met and contributed to, faith groups etc on schedule Contact has been made with faith groups via a mail out to start trying to raise awareness about the HSCB with faith groups. Meeting scheduled between Chair of the	G

			Board, Business Manager and Lay Member in September 2014 to discuss improving CVS involvement. Police CSE Officer is also working with voluntary agencies around gangs. Commissioning Safeguarding Standards have been agreed by Children's Commissioning Groups for all services commissioned – including those from the Voluntary Sector	
4.6 The board undertakes its role in an appropriate cost effective way. ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• review current income and expenditure of the HSCB to assess value for money. • develop proposals for 2014/15 budget based on new requirements of WT13 and agree appropriate contributions from organisations across the partnership. • review of the structure and service focus of the board's sub groups to ensure they are meeting revised legislation and statutory	HSCB Business Unit/HSCB strategic board/Katie Clark	Review of income and expenditure completed and revised budget agreed by Board for 2014-15 Further review of structure and workings of HSCB sub groups reported and approved by Board Feb 2014.	G

	responsibilities			
4.7 The board uses a performance dataset created from a base profile on what safeguarding in Hertfordshire looks like. ***Source: Working Together 2013; Ofsted reviews of LSCBs, Nov 2013.***	• HSCB to collate partner information to create a base profile of safeguarding in Hertfordshire • refresh the HSCB dataset to incorporate understanding of all aspects of the child's 'journey' and key local data across all agencies • ensure the framework reflects the best practice identified through the eastern region model outcomes framework • the dataset to include early intervention data	HSCB Business Unit/HSCB strategic board/Katie Clark	Dataset Profile has been produced and will be presented and discussed at Board Planning Day in November 2015. The profile will be reviewed and refreshed annually.	G

Key:

(R) Red – Actions not yet started
(A) Amber – Actions underway but not yet complete
(G) Green – Actions complete

Appendix 5

Monitoring the Outcomes following the implementations of actions which have arisen due to recommendations from a Case Review or Audit.

Issue	Actions Taken	Impact/Outcome
Transferring of School Records: If information is not promptly transferred about pupils at the time when they move schools, particularly when there are welfare concerns, then the new school's ability to address any safeguarding concerns or to meet the pupil's academic, social and emotional needs could be compromised.	Raised awareness of the issue with school designated safeguarding staff and with Head Teachers. Also developed Guidance Tools for Schools.	A sample of 31 cases was selected. 11 where the child changed school while on a CiN plan and 23 cases where the child changed school while on a CP plan. Each school was asked : *Dear* *I am writing to you on behave of Hertfordshire Safeguarding Children Board, who are currently carrying out an audit to review the transfer of safeguarding records between schools when a child on a Child Protection Plan (CPP) or a Child in Need Plan (CIN) transfers to a new school. (This follows a recommendation from a recent local Serious Case Review when the records were not transferred)* *Attached are the details of a child who recently transferred to your school and is on a CPP or CIN Plan.* *Please can you confirm by return email if you have received a safeguarding record/file (Yes/No) as part of their transfer?*

		Response 11 CiN cases. • 8 responded “Yes” • 2 responded “Yes” but had to chase to get the file transferred • 1 response not returned 23 CP Cases. • 16 responded “Yes” • 2 responded “Yes” but had to chase to get the file transferred • 2 responded “No” • 2 were “N/A” as the school was out of county • 1 response not returned
GP Records: Safeguarding Training for GPs should encourage safe, accurate, precise record keeping with use of codes	The local ‘named’ doctor for safeguarding has worked with the GPs in the surgery (mentioned within a specific SCR) to ensure that practitioners are fully aware of the latest national standards and comply with them. In addition, all GPs now receive annual ‘level 3’ training in safeguarding, which includes a component on report writing and the use of codes and chronologies in note-taking. The Hertfordshire and South Midlands Area Team of NHS England, who are represented on the Board, now carry out randomised audits of GP records to ensure that the standards are achieved with advice or additional training being given as appropriate.	An audit of GP records were carried out and this recorded that legibility was an issue due to majority of proforma’s being hand written, with medical jargon used in some cases. Social workers are not medically trained and are unable to interpret medical jargon. Faxing forms also impacts on legibility and 10 out of 12 requests were faxed to the surgery and information was also returned by fax. Emailing the request would greatly facilitate typing of proforma’s that can be returned by email. A list of email addresses for all GP surgeries had been provided at the time and has since been resent to enable this to happen. Legibility will no longer be an obstacle if

		both partners adhere to email.
School CSE Awareness: A CSE Audit completed by HSCB showed that not all our school DSP's are trained or 100% confident that they would know what to do if they have any concerns.	CSE information is now included within the School DSP Training Sessions	170 Training sessions completed with up to 80 people attending each course – raising awareness of CSE amongst school staff.
Awareness relating to the Dangers of shaking/heavy handling of babies: Research identifies that non-accidental head injuries are the leading cause of death and long-term disability in babies who are maltreated. [1] Hogg, S. and Coster, D. (2014) Helping parents cope with babies' crying: evidence from a pilot programme to support parents and keep babies safe. London: NSPCC (p4)	At the statutory new birth visit the health visitor discusses at length shaking baby and implications to potential non-accidental injuries. There is now a template within the System One electronic health records that has to be completed. Within the 'maternal advice given' template shaking baby has to be ticked following the discussion. Audits are carried out to check compliance.	HCT reviewed the records of 40 children born in November 2014 during March 2015. Of those 28 had the box ticked that stated advice had been given on safety issues, which include the dangers of shaking babies. It is quite possible that advice was given in more cases than this, but we can only be assured in that 70%. This will be communicated to the health visiting teams, in order to remind them of the need to give this advice and to record that this has been done.
Accident and Emergency Referrals to Children's Services in relation to mental health wellbeing and self-harming: There should always be consideration of the need to make contact with Hertfordshire Children's Services when a young person presents with significant mental ill-health, especially in relation to	The development and commencement of HPFT Crisis Assessment and Treatment Team (CCATT), operating in both A&E departments 9am-9pm Mon to Fri and soon weekends 9am-1pm. Audit undertaken by West Herts Hospital Trust and East and North Herts Hospital Trust to review/confirm referrals are being made.	Audit completed by West Herts Hospital Trust showed very good practice and documentation for young people who attend A and E with mental health concerns. All the young people who were included in the audit had referrals made to CCATT and to Children's Services. All young people in the audit had a mental health assessment before they left the hospital which was clearly documented in

self-harming and where there are concerns about the impact the family dynamics may have on the young person in terms of any risk or protective factors.		the hospital records. All staff in both emergency departments and in CCATT/RAID are aware that they need to document clearly an assessment and plan in the hospital records. Staff work together to ensure this occurs. The review of records by the Safeguarding Nurse on the next working day is an excellent safety net to ensure all referrals have been done. This review now includes all 16 and 17yr olds who attend with mental health issues. The ED records include a safeguarding section that needs to be signed by the discharging clinician and is further signed by the safeguarding nurse on review the following day. This ensures that safeguarding is considered for all young people who attend with mental health issues.
Circulation of Child Protection Conference Minutes: Minutes from Child Protection Conferences to be shared with all those invited, irrespective of personal attendance.	"A copy of the written record of the Conference should be sent within ten working days of the Conference to all those who attended or were invited to attend, including family members (except for any part of the Conference from which they were excluded)." – is already included within the HSCB Child Protection Procedures but awareness was carried out to remind practitioners of this.	An audit was carried out for 47 case conferences during January and February 2015 and the conclusions were as follows: Of all the cases audited, it is recorded that minutes were sent out to all professionals (other than translators and advocacy agencies) following all the Conferences. There was evidence that a father was not invited to a Conference as his address was not provided, however his address was recorded on ICS.

		It is of note that fathers who did not have PR were not sent minutes from one Conference; however this may have been an individual case decision based on the dynamics of that particular family. There were other specific reasons for fathers not receiving minutes including that these were being shared by the social worker and in another case, due to the imprisonment of a father
Ensuring all background information and previous referrals are included within Child and Family Assessments: Background and historical information is sufficiently verified and accounted for in the body Child and Family Assessments.	Practice Guidance Note issued to Children's Services Assessment Teams	23 cases where Child and Family Assessments had been carried were audited between April and July 2014. The audit showed the following: Assessments evidenced all appropriate sources of information were used in 17 (74%) of cases. In two cases involving asylum-seekers, attempts had not been made for the purpose of assessment, to contact the family. Information was sufficiently verified in 17 (74%) of cases. Developmental needs were considered to have been addressed well or reasonably well in eighteen (78%) cases. Good practice examples included: proactive attempts to obtain information from varied sources for the purpose of analysis.