

ANNUAL REPORT



2015-2016

Essential Information

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Annual Report compiled in June 2016 on behalf of Hertfordshire Safeguarding Children Board by:
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Contents

1.	Foreword – Phil Picton, Independent Chair of the Hertfordshire Safeguarding Children Board (HSCB)	Page 4
2.	Background to Hertfordshire	Page 5
3.	HSCB Structure and Governance	Page 6
4.	HSCB Structure Chart	Page 7
5.	Ofsted	Page 8
6.	HSCB Sub-Group Highlights 2015-16	Pages 9-10
7.	Progress against Priorities	Pages 11-19
8.	What’s Next?	Page 20-21
9.	Budget	Page 22
10.	Appendix 1: Membership and Attendance of HSCB	Page 22 – 26
11.	Appendix 2: Training Attendance	Pages 27-28

Summary of the Effectiveness of Safeguarding Children in Hertfordshire

by Phil Picton

In the following pages of this Annual Report, you will read highlights of the Safeguarding Board's achievements in 2015-16. This year, we have altered the format of the report to try to make it focus more on the issues and impacts in safeguarding rather than describing how the Board works, owing to this, the report contains less detailed information. However, you will find links to additional information if you are interested in a particular issue.

It has been a very successful year for the Board, culminating in an Ofsted inspection which rated both the Board and the County Council's Children's Services as 'Good' with very complimentary comments. Perhaps most satisfying in the comments about the Board is its assessment that the members' *"outstanding partnership working has enabled the board to respond to emerging safeguarding issues and develop strategic responses that positively impact on practice with children and their families"*. This Ofsted success reflects the willingness of professionals at all levels in Herts to work together and learn from each other in the interests of children. The positive Ofsted outcome is particularly pleasing as it has been achieved in the context of budget restrictions and structural change within many partner agencies. The full Ofsted report can be read here <http://reports.ofsted.gov.uk/local-authorities/hertfordshire>

However, whilst the vast majority of children in Hertfordshire have safe and fulfilling lives, there are still thousands who live in circumstances where support from agencies is necessary to keep them from harm. There is therefore still much to do.

Overall, the Board's work shows that services are generally well delivered and are making a real difference to children. However, it also highlights the need for greater consistency in approaches to the provision of services across the County and between agencies. The introduction of the 'Family Safeguarding' model for the delivery of multi-agency safeguarding, the roll out of the early help 'Families First' work and the introduction of the Multi-Agency Safeguarding Hub (MASH) by partners are all helping to address such issues. During 2016-17, the Board will examine how these initiatives are progressing and will look for continuing improvements in the way services develop.

Our auditing of cases, combined with the implementation of action plans from individual case reviews when children have come to harm or died, have led to significant changes. For example, the Board is leading the implementation of a County-wide Neglect Strategy to focus workers more clearly on children who suffer from a lack of care.

The Board has made good progress with its approach to monitoring and ensuring partners commitment to specific threats to children and young people – such as Child Sexual Exploitation (CSE), Radicalisation and Female Genital Mutilation (FGM). This progress was endorsed by Ofsted with suggestions about how to further develop CSE processes. However, the most prevalent issues for children lie in the families affected by multiple issues (domestic abuse, substance misuse and mental ill health). Research suggests that there is a strong correlation between families with these issues and the likelihood of a child suffering harm. During the past year, the Board has particularly focussed on monitoring the changes to domestic abuse processes, services for substance abusers and the developments in early help for these children. In the next two years it will expect to see evidence of the impact those changes have actually had on their lives.

Overall, safeguarding children in Hertfordshire is going well. There is, however, no room for complacency and as partner organisations experience change, I am very conscious that the robustness of child protection is always at risk. The Board has set itself ambitious two-year aims which are set out at the end of this report. We will be coordinating our plans with the work of other partnerships, including the Adult Safeguarding Board and the Health and Wellbeing Board, to ensure that all agencies across Herts are working together to make children safer.

In the following pages, you will read more detail of the work which has taken place; the issues which continue to challenge agencies and the desire to improve the protection of children. The specific work of the Board relies heavily on the dedication of managers from partner agencies who are prepared to commit to meetings and action plans. Their efforts are supported by the professional approach of the Board Manager, Caroline Aitken, and her administration team. We have become used to those managers and administrators going to great lengths to deliver the Board's agenda. I would like to take this opportunity to thank them for their efforts and achievements. It is their work which makes it possible for multi-agency safeguarding of children to continue to improve.

Phil Picton



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 over **250,000 children and young people aged 0-18 in Hertfordshire**, representing around 23% of the overall population. 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 **some migration from Eastern Europe, particularly Poland**, although actual numbers remain small. Children and young people from minority ethnic groups account for 17% of all children living in the area, compared with 22% in the country as a whole. Hertfordshire performs better than the national average in the majority of measures in the Public Health Child Health Profile. For example – infant mortality, childhood obesity, under 18 conceptions, children living in poverty are all significantly better than the National Average.

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, including child poverty, overcrowding and dependence on welfare benefits.



HSCB Structure and Governance

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 2015.

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.

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 'Joint Board meeting in March 2015 with members of the Adults safeguarding children board. A Board development day was held in November 2015 when the Board reviewed its progress and agreed the aims and objectives for the coming year. The Board has developed a significant structure of sub-groups to achieve it's work (please see overleaf for examples of sub-group activity in 2015-16.).

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. Please see appendix 1 for a list of partnership members.

Designated Health Professionals Meeting



Head Teachers Reference Group

HSCB Strategic Board

Executive Group

Audit

Case Review

Child Death
Overview
Panel

Improving
Outcomes

Learning and
Development

Performance

Policy and
Procedure

Strategic
Safeguarding
Adolescent

SUB-GROUPS

District Safeguarding Group

Broxbourne and
East Herts

St Albans and
Dacorum

Stevenage and
Watford

Watford and Three
Rivers

Welwyn Hatfield and
Hertsmere

LOCAL MULTI-AGENCY SAFEGUARDING FORUMS

So How Good is the Board at its Work?

During an Inspection by Ofsted in September 2015, the Hertfordshire Safeguarding Children Board was judged as 'Good'. The formal report states

“ This is an effective LSCB which is meeting it’s statutory responsibilities. Under the leadership of a strong independent chair, it has engaged leaders at the highest level across the partnership in promoting children’s safety, and has a strong influence on commissioning across public services. It has a good understanding of need and uses multi-agency data, audit, case review and child death review findings to monitor the quality of safeguarding practice and to identify areas for improvement” - Ofsted 2015

Building on this good inspection result the HSCB has continued to focus on key priorities for the County to further improve services to children and their families.



HSCB STRATEGIC BOARD

HSCB EXECUTIVE GROUP

Highlights of Sub-Group Work 2015-2016

Policy and Procedure

Over 40 Multi-Agency Safeguarding documents updated or created for practitioners which included: Child Sexual Exploitation Strategy, Concealed Pregnancy, Domestic Abuse, Female Genital Mutilation, Guide to Child Protection Conferences for young people

Learning and Development

HSCB Annual Conference held on Findings from Serious Case Reviews Multi Agency Safeguarding Training and Lite Bites on Child Sexual Exploitation, Self Harm, Neglect, Serious Case Reviews and the Graded Care Profile

Local Multi-agency Safeguarding Forums held in Five locations across the County: Welwyn Hatfield and Hertsmere Broxbourne and East Herts St Albans and Dacorum North Herts and Stevenage Watford and Three Rivers Providing front line practitioner feedback and awareness sharing of Safeguarding issues

Serious Case Reviews

Three Serious Case Reviews completed and 1 Partnership Case Review. Monitors the implementation of actions

Child Death Overview Panel

56 Child Deaths Reviews took place in 2015-16. 14 had modifiable factors. Supported the development promotion of safer sleeping for babies leaflet and stop smoking campaign

HSCB STRATEGIC BOARD

HSCB EXECUTIVE GROUP

Highlights of Sub-Group Work 2015-2016

Audit

Multi-agency Audits included Graded Care Profile and Self-Harm. Scrutiny of Single Agency Audits
All audits consider, Voice of the Child, Management Oversight and Children with Disabilities

Strategic Safeguarding Adolescents Group

Raising Awareness of Child Sexual Exploitation 'Say something if you See something' campaign
Development of Vulnerable young persons intelligence data.

District Safeguarding Group

Brings together District leads for Safeguarding for both adults and children and the Local Multi-agency Safeguarding Forum chairs

Contributed to the launch of the Child Sexual Exploitation Campaign and problem profile
Changes to DSP
Checks and impact on leisure contracts
Input into training review

Performance

New HSCB Dashboard
New data Collections for health and missing children
Comprehensive Reports to Boards and Partners

Improving Outcomes

Reviewed the strategic approach to Domestic Abuse to include Voice of the Child, Early Help Services, Graded Care Profile, Joint Child Protection Investigation Team. Monitor the progress of the launch of Multi-Agency Safeguarding Hub

Learning and Development

HSCB Annual Conference on Findings from SCR's Multi Agency Safeguarding Training and Lite Bites on Child Sexual Exploitation, Self Harm, Neglect, Serious Case Reviews

Evaluation of Early Help Intervention

So Why is this a Priority?

Without Early Help for some families, difficulties can escalate, family circumstances deteriorate and children are more at risk of suffering significant harm. There is increasing evidence to show that Early Help not only prevents needs escalating to more expensive specialist support but also improves immediate outcomes for children and well into adulthood.



Progress and Outcomes

Over the last 18 months Families First have been working to ensure that providing help earlier to families when problems emerge, using the 'Families First Model' which is a holistic model of family support, building resilience, delivering services locally so families can access the right support at the right time. Work to establish the 'Continuum of Need' has been conducted during 2015-16 and will be finalised in 2016-17. This will assist partners to understand what their responsibilities are in delivering early help.

An **evaluation of early help for 0-5 years** in Hertfordshire was undertaken. It found that **Families First** (Hertfordshire's early help initiative) had made good progress in raising the profile of early help in Hertfordshire. There were encouraging signs that CAF's continue to rise, with schools remaining the biggest contributors. The use of the graded care profile has remained disappointingly low; however this has been taken forward as a priority for 2016-17 as part of our multi-agency response to tackling neglect.

Training for early help has been assessed via the Early Intervention Maturity Matrix. This has been beneficial in order to see where there is a need for further development. The self-assessment has shown that a full workforce needs analysis should be undertaken to ensure that all staff are suitably equipped and confident. In addition a workforce shadowing programme has been introduced which enable practitioners to shadow each other and understand different roles. There is now a practitioner toolkit launched as part of Families First information portal.

HSCB commissioned an audit which looked at **early help and self-harm** as the Board needed to be assured that children who are identified as at risk of self-harm are being effectively and appropriately managed and that staff are knowledgeable and feel sufficiently confident to work with young people who self-harm.

The audit asked 14 questions around each case including partnership working, management oversight and the voice of the child. The audit demonstrated some very positive early help work among professionals; however the main issues arose around access to CAMHS. The following recommendations were agreed:

'The main recommendation arising from this audit appears to be about access to services / treatment provision. It is evidenced that staff that responded to this audit did not have a clear understanding around the framework for provision.'

1. It is recommended that commissioners for CAHMS and Step 2 provision urgently consider the possibility of a single point of contact for professionals referring self-harm cases - one number that can be called which will be able to deal with requests for Step 2 or CAMHS referrals.

2. It is recommended that all partner agencies ensure that staff are aware of the appropriate response to issues of self-harm when they are disclosed

Networking events to be set up in localities to train front line staff, including GP's in what is the appropriate response to self-harm issues and what is the correct referral route. This to be co-ordinated by the CYP 'Spot the Signs' Campaign

All training/ awareness raising to include reference to HSCB procedures for self-harm including Section 6.19 Self-Harm and Suicidal Behaviour, with particular reference to point 7 Baseline Risk Assessment Tool: - 'Questions and guidance'.

Self-harm awareness lite bite courses were run during 2015-16. 3 courses ran with 53 participants in total.

CAHMS transformation project has also been conducted during 2015-16 which arose after the Government launched 'Future in Mind'. This highlighted the national need to address the gaps in children's and young people's mental health and wellbeing provision.

The report summaries the key priorities to improve services over the next five years :

Focus on prevention and early intervention, this includes: The Spot The Signs, Save A Life suicide prevention campaign was one of the four sites of the 'Zero Suicide' Programme developed across the East of England (EoE). The campaign, jointly funded by EoE Strategic Clinical Network and East & North Herts CCG, was launched by Hertfordshire Partnership University Foundation NHS Trust (HPFT). The Self-harm audit recommendations will be incorporated into this campaign in order deliver awareness training to practitioners across the County.

The CAHMS transformation project is also focusing on making improvements to the accessibility of psychological therapies, bringing together education and mental health services through joint training .

There have also been planned development around community eating disorder services, with a much stronger focus on delivering services within the community in order to avoid in-patient admissions. The Eating Disorder Team is a specialist intervention that provides a more holistic response, providing support for the whole family and increasing access to talking therapies to ensure that in addition to treating the illness an intervention is given that addresses the root cause of the issue.

The project also aims to improve perinatal care, particularly for new mums-to-be and new mothers as there is a strong link between parental mental health and children's mental health. To this end Infant Mental Health Online (IMHOL) training has commenced and a questionnaire has been developed to look at help seeking behaviours of mum's in the perinatal period, which is disseminated via Children's Centres.

Hertfordshire Transformation Plan for Children and Young People's Mental Health and Wellbeing is available at-

<http://www.enhertscg.nhs.uk/transforming-mental-health-services-children-and-young-people-camhs>

Risk to Children and Young People

Child Sexual Exploitation

So Why was this a Priority?

Child Sexual Exploitation is both a local and national priority. The HSCB felt this should be a priority for Hertfordshire in order to reduce the risk that children and young people will become victims of CSE and also to mitigate the impact of CSE. The Board also wished to be assured about actions taken against those intent on abusing or exploiting children or young people.



Progress and Outcomes

The Strategic Safeguarding Adolescents Group has **completed the multi-agency action plan within their subgroup**. Performance has been monitored through the creation of vulnerable young person's dashboard, which considers information from partner agencies, around missing children and those at risk of CSE. Police data is also available and has enabled the partnership to monitor and challenge work around the HALO team (Hertfordshire Constabulary's CSE Team). Links are established with District Councils to ensure they are engaged with CSE awareness raising.

The Chelsea's Choice production ran in the secondary schools in Hertfordshire. The Board promoted Chelsea's Choice to schools that had previously not seen the production in 2014. Funding was obtained from Children's Services and surplus HSCB monies from the previous year. Chelsea's Choice is a 40 minute long Applied Theatre Production that has proven highly successful in raising awareness amongst young people of the issues surrounding Child Sexual Exploitation. The play is followed by a 20 - 30 minute plenary session exploring the issues raised in the play.

The analysis of the production showed that young people became more aware of what a healthy relationship is, how to recognise a risky situation, what the child grooming process is, who to talk to if they were worried and how to keep safe on the internet. A total of 8392 young people and 100 professionals saw the production in 2015. Also after viewing the play around 30 young people sought further clarification on various aspects of CSE. HALO also reported that they received 1 referral as direct result of the play.

The 'Say Something if you see Something' campaign ran successfully in 2015-16. The campaign was part of the Board's programme to raise awareness of Child Sexual Exploitation and was targeted at young people themselves. A range of mediums were used – social media 'eye selfies' plus a formal launch at Watford's Youth Connexions.

There was also a two hour CSE summit at Board on 8/5/15 which reviewed actions of all LSCB partners and the Police and Crime Commissioner. Also a draft revised Strategy was presented. The New CSE strategy was agreed, the CSE action plan was revised in light of the strategy and referrals to Operation Halo to be part of Board Performance Monitor. This event gave all partners the opportunity to ensure that their direction of travel on CSE complimented or supported other agencies work.

Training courses continued to be run by the Board around CSE during 2015-16. 3 courses were held with 55 number of participants.

Domestic Abuse

So Why was this a Priority?

Domestic Abuse detrimentally affects the life of children. The HSCB chapter in the Joint Strategic Needs Assessment (2015) noted that there had been an increase in recorded crimes and that 11% of all calls to the police were about a domestic abuse incident. Also approximately 80% of child protection cases had an element of domestic abuse. Therefore the HSCB felt that this was a priority area for Hertfordshire.



Progress and Outcomes

The Board were holding the domestic strategic arrangements to account for progress on the SafeLives action plan with particular reference to its impact on children. The overall recommendation of the SafeLives review was that Hertfordshire should create an effective care pathway for domestic abuse from initial identification to set-down and recovery so that families living with domestic abuse can be made as safe as possible.

The Board has been prominent in working on the delivery the new vision for Domestic Abuse *'Women, men and children in Hertfordshire are kept safe from domestic abuse and have opportunities leading to healthy and happy lives'*, which is underpinned by the Theme 2 'Areas of risk to Children and Young People of the HSCB business plan 2015-2016.

Progress on the domestic abuse improvement programme was delivered to the Board in March 2016. The Domestic Abuse Programme is being delivered in tandem with three other multi-agency projects; Family Safeguarding Team, MASH and Adults with complex needs pilot.

The HSCB supported the suggestion that a champions network be set up in Hertfordshire around Domestic Abuse. The HSCB Executive Board has also agreed to look at commissioning arrangements particularly around long term sustainability of the services.

The HSCB has representatives that sit on the Domestic Abuse Board and in addition the HSCB Business Unit seconded a member of staff to support this process during 2015-2016.

Learning from Domestic Homicide Reviews include information sharing, safety planning and risk assessment, also identified following themes – training for front line staff from all agencies, third sector, more robust information sharing process With regard to monitoring the impact – the strategic plans are monitored by the Domestic Abuse Executive Board Partnership Board and various sub-groups. Performance reports have also been developed to assist with monitoring.

Female Genital Mutilation

So Why is this a priority?

Female Genital Mutilation (FGM) is both a local and national priority. It is an offence in the UK to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. HSCB mirror the national priority around FGM. Hertfordshire takes a proportionate response to tackling FGM in light of the demography of the County.



Progress and Outcomes

The Board has been updated in light of the change in legislation in 2015. The Board has updated and highlighted to practitioners the indicators of possible FGM being planned and indicators of when it has taken place.

The Board has highlighted this year that, safeguarding girls at risk of FGM poses specific challenges as the families involved may give no other cause for concern and the developed policies and procedures reflect this.

As well as the underpinning policies available on the HSCB website, all health providers including Maternity services cross Hertfordshire have clear pathways in place to support staff that come into contact with FGM. In addition posters, flowcharts and information for professionals and parents have been disseminated to all GP practices in Hertfordshire.

Training has been commissioned with the National FGM centre plus additional specific health training.

There have been no reports of adverse incidents where a health professional has missed FGM. Further training may slightly increase numbers identified in the future. In general the demography in Hertfordshire does not lend to the identification of large numbers of women with FGM. FGM awareness is covered in the basic Level 2 Safeguarding courses.

Development of Board and Partner Capacity

The assurance of safeguarding standards with the district and borough councils, through section 11 audit

So why is this a priority?

Safeguarding Standards in the District/Borough Councils - a rolling three year section 11 audit program provides assurances of safeguarding standards within the county. The section 11 audit 2015-16 involved the 10 district/borough councils.



Progress and Outcomes

All 10 borough/district councils undertook the section 11 self-assessment. A detailed report was presented to the Audit Subgroup. The section 11 audit identified the need for an update in policy and procedures; staff training in relation to the use of CAFs; review of job descriptions and safe recruitment procedures, working with commissioned services to ensure safeguarding responsibilities are fully understood. The Section 11 District Audit showed clearly that District Councils with Hertfordshire have been involved in ensuring that their staff are clear about the early help process and the use of CAF's. A substantial amount of training has taken place during the year and most councils now have 'CAF champions' to assist in this area. All areas for improvement are monitored by the Audit Subgroup. Section 11's for 2016-17 will focus on Hertfordshire County Council Directorates plus Bench and Probation.

Evaluation of the impact of the Multi-Agency Safeguarding Hub (MASH)

So Why is this a priority?

In September 2014, a report was presented to the HSCB proposing the introduction of a multi-agency safeguarding hub (MASH) in Hertfordshire. Discussions took place to decide whether a Multi Agency Safeguarding Hub should be introduced in Hertfordshire and how it would be implemented. Members unanimously agreed in principle to the establishment of the recommended MASH approach. The MASH brings together Police, Probation, Health Visiting and Children's Services staff, working together as a team to share information and decision making about the best way to safeguard and meet the needs of vulnerable children in Hertfordshire.



Progress and Outcomes

MASH went live on 28th July 2015. The MASH has introduced specific timescales for information gathering by agencies. All member partner agencies represented at the HSCB have agreed to adhere to these timescales. As a partnership the HSCB is committed to joining up information sharing, decision making and support for Hertfordshire's vulnerable families across the Early Help and Safeguarding spectrum as much as possible. An evaluation report was requested to assure the HSCB of the effectiveness of the MASH. A task and finish group overseen by IOG is evaluating the impact of MASH. **The task and finish group involves representatives from probation, schools and the CCG.** The report will be discussed by IOG and the Strategic HSCB Board in 2016-17.

Improved effectiveness of business process and focused outcomes and Risk Register

So why is this a priority?

Improved effectiveness of business process and focused outcomes - A peer review in October 2014, identified that the Board Governance could be clarified in terms of the systems and methods needed to keep the HSCB focused on the Herts picture and the actions necessary to improve safeguarding and minimise risks to children and young people. The pace of work would be assisted by clearer business processes.

Risk Register - A peer review of the Board in 2014 recommended that the Board needs a better overall analysis of safeguarding, a clearer performance management framework and more confidence that it can delegate tasks and get the right reports back in respect of the impact of this work on practice.



The HSCB performance data set has been further strengthened; this year saw the enhancement of missing children data and additional scrutiny and challenge in the performance report presented to board. Tailored data reports are provided for all Local Multi-Agency Safeguarding Forums, District Safeguarding Group and Strategic Safeguarding Adolescent Group. An updated JSNA was not achieved, this is currently being progressed for 2016-17. Performance measures have been identified as a means to measure progress within the Business Plan and the performance report is always the first issue at Board meetings.

All reports presented to the HSCB require a covering report which ensures focus on recommendations and any associated risks.

The focus of the HSCB Executive Group was agreed which is to ensure it focus to 'effectively manage the operational business of the board'. The Executive is a group of key directors from the partnership and is accountable for proactively driving forward the LSCB Board Agenda, commissioning work required for meetings and ensuring that clear solutions and or proposals have been formulated for items taken to the Board. The executive has strategic oversight of the functions of the HSCB Sub Groups, providing advice, guidance and scrutiny including holding sub group chairs to account. It is also responsible for the implementation and monitoring of the HSCB Business Plan and agrees priority actions against core business.

Cabinet executive monitoring the Business Plan and Risk Register (first met May 2015), a form has been piloted for sub-groups to report risks to Executive. 2015-16 saw the responsibility of Risk Register transferring from the Audit sub group to the Executive Group. Two risks were mitigated and removed in 2015-16. The Risk Register is focused on risks to children in Hertfordshire rather than reputational risks. There is now a review of 1 or 2 sub-Group's effectiveness and impact at each Executive meeting, also a stronger monitoring of sub-group progress to Executive again in a new format.

Impact of Learning from Case Reviews

Impact of Learning from Case Reviews

So why was this a Priority?

To ensure that recommendations from case reviews in Hertfordshire are effectively followed through, actions are completed and learning is embedded into practice to ensure the safeguarding of children in Hertfordshire. Two Serious Case Reviews and one Partnership Review have been commissioned in 2013 and 2014. The reviews have been completed and agreed by the board. These Serious Case Reviews are awaiting publication.



SCR 2013 relates to a disabled child who was non accidentally injured by a step parent. The review which is yet to be published identified 7 areas of learning, which were in relation ensuring the voice of the child is heard with children with difference or complex communication needs; focused Child in Need Plans and clarity around child in need processes; defining neglect; importance of understanding the risk of non-attendance at health appointments; over reliance on self-reporting; common language; exclusion of non-resident parents. This SCR 2013 prompted a letter from the Chair to the Director of Children's Services on performance in relation to children in need, including children with a disability. A review was initiated by Children's Services of a sample of children's cases and reported to the board. The board has commissioned a multi-agency audit of Child in Need cases for 2016-17. A lot of work has been undertaken in response to the findings of case reviews, through single agency audits, evaluation reports, dissemination of practice guidance notes commissioning of multi-agency training courses, restructure of services (introduction of the family safeguarding service) and an agreed multi-agency approach to neglect.

SCR 2014 relates to a baby who's cause of death is unknown however the post mortem showed several non-accidental style fractures to the body. The review which is yet to be published identified 4 recommendations; strategic approach to neglect; assessments of children in need; supervision and management oversight; working with minority communities. The recommendations lead to the development and launch of a new Neglect Strategy for Hertfordshire and the further development work around use of the Graded Care Profile. An audit of the effectiveness of Children in Need Plans has been commissioned for 2016-17 which includes management oversight and voice of the child. The Learning and Development sub-group as part of their ongoing training plan are including working with minority communities as a priority for the coming year.

The recent Ofsted inspection highlighted '*The board drives action plans to disseminate learning from case reviews well. Partner agencies provide good support to ensure that key messages are conveyed to front line workers and their managers through training, bulletins and practitioner events. Social workers who were interviewed by inspectors were clearly aware of recent serious case reviews and their implications for their practice. The LSCB is proactive in taking forward learning as lessons emerge from case reviews, rather than waiting for reports to be signed off and published. For example, it has put training in place to address a concern emerging from review findings about a risk of uncritical acceptance of parental self-report by professionals, which can leave children's needs and circumstances unassessed.*

PCR 2014 relates to an adult care leaver who died whilst living outside Hertfordshire. The review which is not for publication identified 5 recommendations. In response to this, the HSCB independent Chair requested that the Director of Nursing from East & North Hertfordshire CCG, convene a senior manager review to consider the findings and recommendations for which a task and finish group was set up which included commissioners and provider services from health and children's services. The aim of this group was to discuss the shared learning within organisations and agree recommendations to develop future pathways and improve practice within all agencies involved. The lessons learnt from this review has been a source of discussion at a range of Hertfordshire's multi-agency meetings about the need for improvements in services which support children into adulthood. This review has been particularly influential, as planning for children leaving care is now up to the age of 25. The recent Ofsted inspection commented on the work undertaken in commissioning the PCR stating that *'The board works collaboratively with the Hertfordshire Safeguarding Adults Board and with other safeguarding boards across local authority boundaries. For example, the LSCB is currently leading a joint serious case review regarding a care leaver who was 19 at the time of his death in a neighbouring authority area. The board is already acting on the emerging findings from this case review, with changes being made to patient databases to ensure that mental health service users who are care leavers are identified as such on patient databases. This will improve information sharing and strengthen the help that young people with mental health needs receive.'*

Child Death Overview Panel

In line with its statutory duty, Hertfordshire Safeguarding Children's Board has a Child Death Overview Panel (CDOP) whose purpose is to review child deaths in a multi-disciplinary effort to inform essential learning and to take appropriate and timely actions to prevent future deaths. The CDOP panel considers whether the deaths might have been preventable, and what were the factors that may have contributed to the death (these are called "modifiable factors"). This group meets six times a year.

During 2015-2016 a total of 56 cases were reviewed. Modifiable factors were identified in 14 of these cases. The most frequent modifiable factors were co-sleeping and parental smoking. As a result of these findings, CDOP has supported the development and promotion of the 'Safer Sleep for Babies' leaflet and also supported the work of midwives, health visitors and children's centres in providing help to parents to stop smoking.

What's Next?

Early Intervention

The delivery of the multi-agency workforce analysis (commissioned by Families First) will ensure that any skill or competency gaps amongst the Families First workforce can be addressed via relevant training/development opportunities. In addition to this the Board training needs analysis being commissioned via the NSPCC will assist in identifying partnership needs for training including early intervention.

The launch of the Continuum of Need across the partnership should establish the thresholds for services and will clearly show early help services input to emerging, targeted and intensive needs below the threshold for safeguarding.

The impact on children performance reporting will be further developed to demonstrate the impact across the wide breadth of early help.

To embed the Families First Quality Assurance framework with all staff providing services as part of the Early Help continuum through the induction process.

The recommendations from the Early Help and Self Harm Audit were formally agreed by the HSCB and will be monitored via the audit sub-group. The lead and Board member for CAMHS was in agreement with the recommendations.

CAHMS transformation programme will continue to develop the priorities identified which will include the spot the signs, Save a Life suicide prevention campaign – a young people's version. Early help will continue to be a key theme for 2016-17 and will be included in audits for neglect, CSE and Domestic Abuse.

Risk to Children and Young People - Child Sexual Exploitation, Domestic Abuse and FGM

Chelsea's Choice was commissioned to run in Hertfordshire Schools again in 2016-17 funded by HCC and HSCB. Those schools which had not been able to see the performance in 2015 being targeted. The Say Something if You See Anything campaign is due to run again in 2016-17 and will target taxi-drivers and pharmacists.

The CSE action plan has been refreshed for 2016-17, which will further develop the data set around the SEARCH panel data, develop a self-assessment tool to ensure consistency in tackling CSE in the county. It will also further develop a CSE module to be delivered as part of SRE (Sex and Relationships Education) content within PSHE. Work will also continue around the identifying suspected perpetrators, support for victims throughout the investigation, prosecution and post court phases.

To publish a final Domestic Abuse (partnership) strategy and to re-tender the Independent Domestic Violence Advisor service. To re-model the provision of accommodation for domestic abuse victims and perpetrators and develop a clear action plan for housing providers

To fully identify clear referral routes and pathways for service users and to determine how various elements of the improvement programme should be mainstreamed into existing services and structures such as Safeguarding

Training to take place in 2016-17 for FGM awareness and specific Health staff courses and to scope requirement for further training across Health

A multi-agency FGM pathway with risk assessment required for Hertfordshire

Commissioners to identify service requirements for women who have had FGM i.e. psychological/surgical Health professional to record FGM in the Parent-held Child Health Records (red book) of female infants whose mother has had FGM.

Development of Board and Partner Capacity

The Needs assessment will be updated

Completion of the evaluation of MASH

Section 11 Audit on HCC directorates, Probation and Bench

Continued strengthening of the HSCB performance data and multi-agency audit programme

Respond to the recommendations of the National Review of Local Safeguarding Children Boards

Impact of Learning from Case Reviews

The Neglect Strategy Implementation Plan will be delivered

All multi-agency audits commissioned by the board include themes identified in reviews. Themes identified were voice of the child in case work, supervision and management oversight. Multi-Agency audits also include a proportionate number of disabled children cases

All learning has been taken forward into 2016-17

HSCB Business Plan and Priorities for 2016-2017

The HSCB will continue to monitor the outcomes and impact from the priorities for 2015-2016, several of which feed into 16-17 priorities also. The identified priorities for the coming year (16-17) are:

To strengthen the safeguarding of children with disabilities

To strengthen the safeguarding of children who are at risk of or are being sexually exploited or sexually abused

To strengthen our work in preventing, identifying the protection children from neglect including the protection and support of children living with domestic abuse, substance misuse and adult mental health issues

To respond to specific safeguarding issues within Hertfordshire

Increase the effectiveness of the HSCB in co-ordinating and ensuring the effectiveness of the work of all agencies to safeguard and promote the welfare of children and young people



Hertfordshire Safeguarding Children Board Budget 2015-2016

Total Partner Contributions 2015-16 £331,724

Carry Forward 2015-16 £100,595

	Budget Set at the start of 2015/16	Total Spend 2015/16	Variance
Independent Chair, HSCB Business Unit Salary and Salary Related	291,465	268,191	-23,274
Services, Supplies, Communications, Training and Annual Conference	34,580	48,311	13,731
Case Reviews	Funded from previous underspend	40,239	
Chelsea's Choice	Funded from previous underspend	17,010	
	12,000 contribution from Targeted Youth Service		
	331,724	373,751	42,027

The carry forward to 2016-17 is £124,356, this includes the remaining carry forward from previous years, additional £64,000 from East and North Herts CCG to fund future SCRs (£49k) and the Training Needs Analysis (£15k).

Appendix 1 – Members of the Hertfordshire Safeguarding Children Board Partnership

District and Borough Councils

Cafcass

The two Hertfordshire Clinical Commissioning Groups

NHS England

NHS Trusts and Foundation Trusts –

- o East & North Herts Hospitals

- o Hertfordshire Community NHS Trust

- o West Herts Hospitals NHS Trust

- o 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

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

Please see attendance overleaf

Attendance at Strategic Board meetings 2015-2016

Member / Agency / Organisation	Meetings attended
Independent Chair	4/4
Assistant Chief Constable, Hertfordshire Constabulary	3/4
Assistant Chief Legal Officer, Adult & Children's Law, HCC	3/4
Executive Director Quality & Safety, Hertfordshire Partnership NHS Foundation Trust (or representative)	4/4
Service Manager, CAFCASS	2/4
Designated Doctor for Child Protection & Consultant Paediatricians, NHS	2/4
Designated Nurse, Safeguarding Children & Children Looked After, E & N Herts CCG (or representative)	3/4
Director of Children's Services, HCC (or representative)	4/4
Director of Quality & Governance, Hertfordshire Community NHS Trust	3/4
Director of Quality & Patient Experience/Nursing, Hertfordshire & South Midlands NHS England* *No longer attending Board since May 2015 and are now represented by the CCG.	1/4
Director of Nursing & Quality, Herts Valley CCG	4/4

Attendance at Strategic Board meetings 2015-2016

Director of Nursing & Quality East & North Herts CCG	4/4
Chief Nurse & DIPC, West Hertfordshire NHS Trust	3/4
Director of Family Safeguarding, HCC	4/4
Representatives of Primary, Secondary and Special Schools	4/4
Deputy Principal, Further Education	1/4
Chief Executive, District Councils (or representative)	4/4
Lay Member #1	0/4
Lay Member #2 (from September 2015)	2/4
Executive Member, Children's Services	4/4
Detective Chief Superintendent– Herts Constabulary	2/4
Head of Hertfordshire National Probation Service– National Probation Service	3/4
Head of Service, Children & Young People, Public Health (from September 2015). Was previously Deputy Director of Public Health	4/4
Children's Nursing Services Manager, East & North Herts NHS Trust (from December 2015)	1/4
Head of Social Care and Safeguarding HPFT (from December 2015)	2/4
Operational Director, Herts BeNCH CRC(from December 2015)	1/4

Attendance at Strategic Board meetings 2015-2016

HSCB Business Manager	4/4
HSCB Development Manager	4/4
HSCB Data Analyst	3/4

Training Course 2015-2016 - Attendance

Total number of attendees by course Apr 15 - Mar 16

Name of course	Total number of attendees	How many times the course ran
Safeguarding children - the impact of parental learning difficulties	35	2
Safeguarding children - the impact of parental mental health	35	2
Safeguarding disabled children	51	3
What to do if you identify a baby/child with bruises lite bite	86	4
Child sexual exploitation prevention, protection and investigation	61	3
Serious and partnership case reviews and audits lite bite	53	3
Graded Care Profile lite bite	103	6
Self Harm Awareness lite bite	43	2
Substance misuse lite bite	31	2
Safeguarding and Child Protection Multi-agency course	171	8
Safeguarding children - understanding the impact of neglect	24	1
Total	693	

Training Course 2015-2016 - Attendance

The numbers of attendees below relate to Hertfordshire Safeguarding Children Board Multi-Agency courses only. All organisations have their own responsibility for providing other safeguarding training.

Agency	Total number of attendees per agency
Adult Care Services	3
Children's centre	57
Children's Services	279
Colleges	8
District Council	6
Drug and Alcohol Service	3
Education	5
Health & Community Services (was ACS)	18
Health - East and North Herts NHS Trust	7
Health - Hertfordshire Community NHS Trust	107
Health - Herts NHS Foundation Trust	11
Health - NHS Hertfordshire	14
Health - West Herts Hospitals Trusts	3
Health - Other	6
Herts Constabulary	2
Housing Provider	6
HSCB	1
Nursery/Pre School	30
Other	24
School	4
Schools - designated senior person	54
Schools - non designated senior person	10
Schools Family Support	1
South West Partnership	9
Voluntary Sector	19

Glossary

BeNCH	Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company
CAF	Common Assessment Framework
CAFCASS	Child and Family Court Advisory Support Service
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CiN	Child in Need
CP	Child Protection
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CYP	Child and Young People
DA	Domestic Abuse
DBS	Disclosure and Barring Service
DHR	Domestic Homicide Review
ENHT	East & North Hertfordshire Hospitals NHS Trust
FGM	Female Genital Mutilation
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
LADO	Local Authority Designated Officer
LMASF	Local Multi-Agency Safeguarding Forum
MASH	Multi-Agency Safeguarding Hub
NPS	National Probation Service
PCR	Partnership case review
SCR	Serious case review
WHHT Trust	West Hertfordshire Hospitals NHS Trust