HERTFORDSHIRE
safeguardingchildren
BOARD

# Annual Report 2016-2017

# Essential Information

Annual Report compiled in July 2017 on behalf of Hertfordshire Safeguarding Children Board by:

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# Forward: Nicky Pace – Chair of Hertfordshire Safeguarding Children Board

As the Independent Chair of the Hertfordshire Safeguarding Children Board (HSCB) I am pleased to present the annual report for the period April 2016 to March 2017. Local Safeguarding Children Boards (LSCBs) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they have intervened they have made a positive difference in children's lives. The HSCB has a really important role in coordinating and ensuring the effectiveness of what is done by each and every person involved in protecting children and it carries statutory responsibilities for safeguarding children in Hertfordshire. It is made up of senior managers within organisations in Hertfordshire who hold responsibility for safeguarding children in their agencies, such as children's social care, police, health, schools and other services including voluntary bodies. The HSCB monitors how they all work together to provide services for children and ensure children are protected.

The national review into LSCBs has been published this year, the recommendations of which were accepted in full by Government. The changes to safeguarding boards and the functions they carry out will form part of the Children and Social Work Bill progressing through parliament. This will make significant changes to the organisation of the safeguarding partnerships and a number of functions that Boards currently fulfil. Our challenge over the next year will be to ensure that replacing LSCBs with something better will need to be done carefully and building on what we know works well. There will be key principles we must still adhere to when deciding the structure and form of local arrangements and agreement on the core functions of multi-agency partnership. The next year will be challenging for all agencies and we will need to ensure the focus and delivery of services to vulnerable children, young people and families is not adversely affected.

Lastly, I would like to thank all the Board staff, for their continued support in the smooth functioning and promotion of the HSCB. I would also like to thank members of the Board, from across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safer in Hertfordshire.

Nicky Pace

HSCB Independent Chair

# 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 260,000 children and young people aged 0-18 in Hertfordshire, representing around 23% of the overall population. 13% of children living in Hertfordshire are classed as living in poverty.

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; Asian and mixed ethnicity are the most common minority groups. Hertfordshire has the third largest traveller population in the Easter Region. There are 53 traveller sites in Hertfordshire. 11 County Council sites, 35 private sites with permission and 3 private sites without permission, the remaining 4 are showman's grounds.

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, underage 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.

# Hertfordshire in Numbers[1]


[1] The format and system for early help assessments changed in the Autumn of 2016. The Families First Assessment replaced Family CAF (eCAF) as part of a wider change in how early help is delivered under the Families First brand. This has made it difficult to make direct comparisons between the data held for 2015-16 and 2016-17; however the figure of 4,863 children supported through some form of early help assessment in 2015-16 will be comparable to the number in 2016-17.

# 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) 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) Ensure the effectiveness of what is done by each such person or body for those purposes."

The HSCB seeks to achieve these functions by:

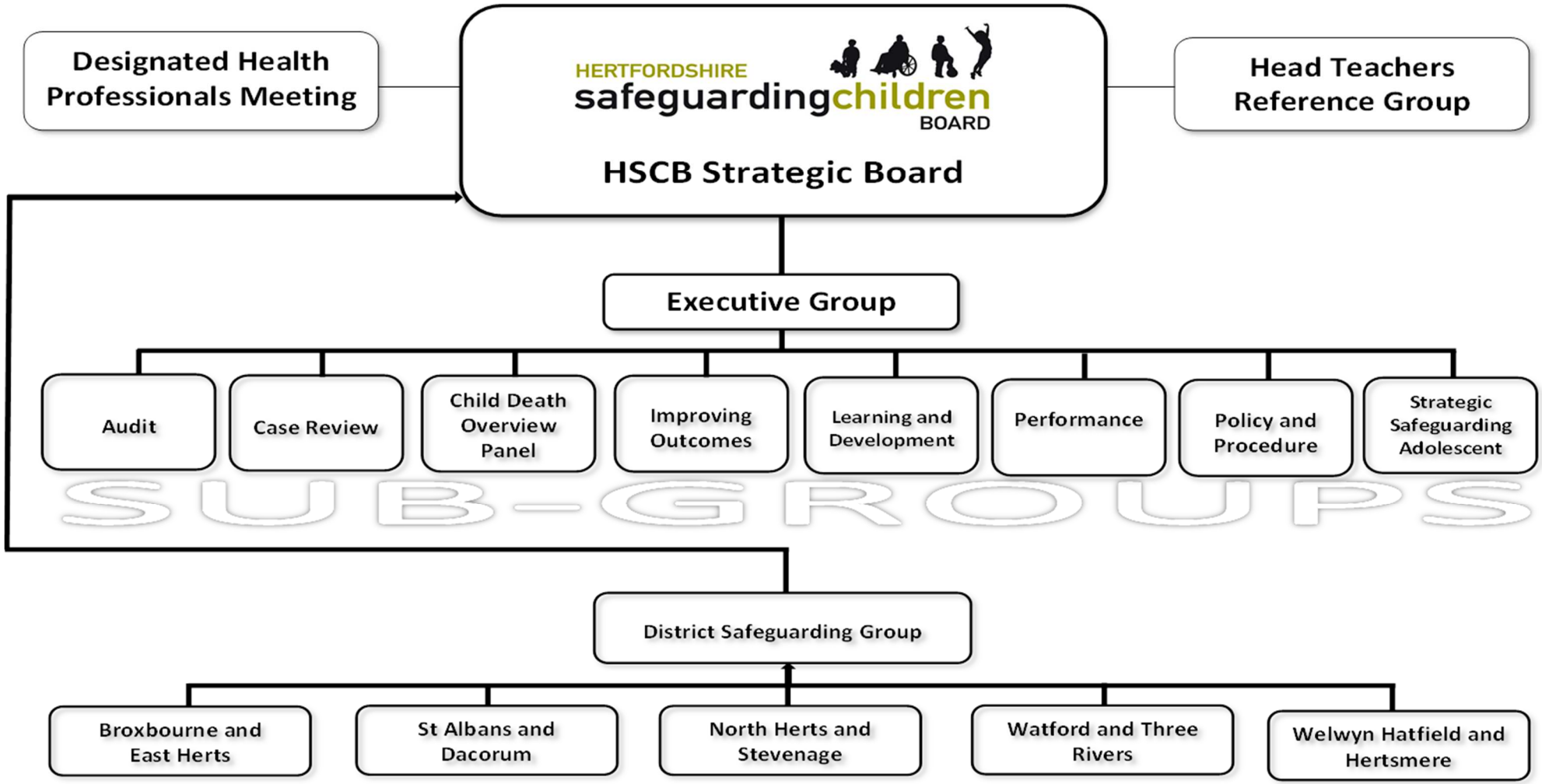
- monitoring the effectiveness of what is done to safeguard and promote the welfare of children
- establishing effective communication and information sharing across agencies undertaking reviews of individual cases, including 'Serious Case Reviews' collecting and analysing information about child deaths, 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 a 'Joint Board' meeting in March 2016 with members of the Adults Safeguarding Board. A Board development day was held in November 2016 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 its work.

In December 2015, the Department for Education (DfE) asked Alan Wood CBE to lead a review of the role and functions of Local Safeguarding Children Boards (LSCBs) in England. As part of the review he also looked at Serious Case Reviews and Child Death Overview Panels. The DfE has published the Wood Review of the Role and Functions of Local Safeguarding Children Boards and the government has agreed the recommendations, which are being incorporated into the Children and Social Work Bill. HSCB partners have continued to work together within our current arrangements whilst revised legislation is awaited.

**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
HERTFORDSHIRE safeguardingchildren BOARD
HSCB Strategic Board
Head Teachers Reference Group
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
North Herts and Stevenage
Watford and Three Rivers
Welwyn Hatfield and Hertsmere
LOCAL MULTI-AGENCY SAFEGUARDING FORUMS

# Highlights of Sub-Group Work 2016-2017

## Improving Outcomes Group

Improving inter-agency working to safeguard vulnerable children

- Received reports on work undertaken to raise awareness of and monitor private fostering arrangements across the county (bi-annual)
- Put into place arrangements to improve triage of domestic abuse incidents between DAISU and MASH, audited effectiveness (completed)
- Initiated multi-agency project to use virtual babies to strengthen pre-birth assessment and support to vulnerable parents to be to try and give baby the best chance of remaining safely within their family (ongoing)
- Developed FGM pathways guidance (completed)
- Received regular updates on DA strategy-escalated concerns about the new IDVA contract (ongoing)
- Overseen implementation of neglect strategy and received regular reports (ongoing)
- Overseen implementation of CiN multi-agency improvement plan, including training on roles, supervision and revision of protocol (ongoing)
- Received reports re self-harm, autism, ADHD and sexually harmful behaviours pathways development work (ongoing)

Scrutiny of operational arrangements

- Received report on peer review of 'front door' Children Services , MASH audit, MASH performance, inter-agency working, reviewed quality of referrals, progressing actions and plans to undertake joint assessments wherever possible with professional referrals, audited strategy discussions and developed action plans, audited quoracy at case conferences and developed action plans (ongoing)
- Received report on Families First Triage (ongoing)
- Organised training for social workers on working with schools (completed)

Protocols

- Review of pre-birth protocol and bruising protocols (ongoing)

Actions commencing in autumn

- Reviewing services to protect children from sexual abuse and sexually harmful behaviour
- Reviewing services for traveller children and young people and assembling a directory
- Reviewing how schools respond to self-harm and support for schools

## Policy and Procedure Group

During 2016 to 2017 the Policy and Procedures sub group has continued to meet bi monthly and has had good representation from all partner agencies. The sub group considers new procedures necessary as a result of new or emerging /changed legislation, recommendations from Serious Case Reviews (SCR) as well as routinely reviewing existing procedures. During the course of the year 2016-2017 thirty five policies and/ or procedures were considered, and of these, twenty- three, were adopted. Examples of new policies adopted are:

- East of England Joint Protocol on Supervision Orders (following the recommendations of a SCR)
- Hertfordshire Safeguarding Trafficking Protocol
- Separate Bruising and Neglect Protocols

Examples of procedures updated are:

- Safeguarding Children Abused through Exploitation
- Disguised Compliance

During the course of 2017-2019 the sub group will continue to work on policies and procedures linked to the 2017-19 strategic priorities (page 45) and will report on these at the end of the 2017-2018 reporting period. The sub group will also be working on the draft of a multi-agency HSCB Children in Need Protocol and Procedures as well as continuing to develop the Bruising Protocol.

## Strategic Safeguarding Adolescents Group (SSAG)

Significant progress has been made over the year to strengthen arrangements for responding to children and young people who go missing from home and local authority care.

The SSAG continues to achieve a high level of contribution and commitment from partner agencies, with responsibility for developing and leading priority areas in the work programme owned and shared by group members. The work programme is organised around the three themes of Prevent, Protect and Pursue.
Below is a list of the main pieces of work SSAG have been engaged in this year:

- Continued development of the Vulnerable Young Persons Dashboard
- Raising awareness at community level through campaigns and workforce development in education establishments
- District Councils engagement in assessing risk of CSE
- Oversight of Missing People service – conducting return home interviews for missing children/young people
- Discussions have taken place with the National Working Group for CSE and the also with the new Regional Prevention Officer for CSE to find any best practice or practical solution on identifying young people who go missing from education during the day. In the interim, the focus will be to continue to raise awareness of school based staff on the importance of identifying signs and patterns early by building this into staff briefings, safeguarding training and designated teacher briefings.

## Case Review Group

The responsibility of the Case Review Group within the HSCB Business Plan 2016-17 is to 'ensure that issues relating to individual Serious Case Reviews and themes across all reviews in Hertfordshire are effectively followed through, that actions are completed and learning is embedded into practice'. The work of the group is largely focused on the conduct of reviews and the responsibility to monitor the implementation of learning is shared with the HSCB Chair, the Executive and the board.

**Monitoring Recommendations**

The Case Review Group monitors in detail the action to implement recommendations of Partnership Case Reviews and the actions required by individual agencies to implement individual actions from management reviews that are prepared as part of SCRs.

The Hertfordshire Safeguarding Children Board takes direct responsibility for the monitoring of recommendations that are agreed by the HSCB as part of the findings of SCR overview reports, and which are therefore, more strategic in their scope and objectives.

**Coordination of the work of Hertfordshire agencies on SCRs, Domestic Homicide Reviews**

Since November 2016 the Case Review Group has received an update at each meeting on the progress with and the learning from Domestic Homicide Reviews, though these are currently led by the 10 local Community Safety Partnerships and coordinated by Hertfordshire Police.

When a decision has been made to conduct a DHR where children are implicated the Case Review group considers the case. The overlapping statutory guidance in relation to SCRs, DHRs and Safeguarding Adult Reviews can mean that a number of circumstances might need to be considered under different guidance.

The Case Review Group has considered a draft protocol that would enable the local partnerships to deal with these potentially complex situations in a way which means that statutory requirements can be met without duplicating effort and activity. A revised protocol has been proposed for consideration by the HSCB executive.

## Child Death Overview Panel

The Hertfordshire Child Death Overview Panel (CDOP) is an inter-agency group that meets to review the death of any child normally resident in Hertfordshire. The CDOP is accountable to the Hertfordshire Safeguarding Children Board and meets six times a year. The membership is made up of representatives from our Community NHS Trust, West Hertfordshire Hospital Trust, Clinical commissioning Groups, East and North Herts NHS Trust, Hertfordshire Constabulary, Public Health and the HSCB business unit. Between April 2016 and March 2017 the Hertfordshire CDOP met 6 times and reviewed 48 cases.

Compared to the England & Wales averages, the infant and child mortality rates in Hertfordshire are lower, and there are also downward trends. But we know that each child death is a tragedy and the CDOP is committed to learning from every death in order to identify whether there are actions that can be taken to reduce the number of child deaths in the future.

Of the 48 deaths reviewed in 2016/17 there was an equal ratio of expected to unexpected deaths.

The largest number of deaths occurred in children aged less than 1 year old. Causes of death in this age group included genetic diseases, congenital anomalies, Sudden Unexpected Death of an Infant (SUDI, previously referred to as cot death) and problems related to prematurity. The largest number of unexpected deaths was also in this age group, which is related to the number of babies being born prematurely. This is consistent with the national picture. Modifiable factors identified in this age group included co-sleeping and smoking in the household.

In the older age groups causes of death included malignancy, chronic diseases, infection, suicide and trauma.

**Recommendations for the coming year**

- CDOP will continue to support the promotion of the 'Safer Sleep for Babies' campaign and smoking cessation for parents
- A subgroup of the CDOP will continue their work to review children who self-harm and attend accident and emergency departments.
- The Wood report (Review of the Role and Functions of Local Safeguarding Children Boards 2016) recommended that the ownership arrangement for supporting CDOPs should move from the Department for Education to the Department of Health. The CDOP will continue in its current form until further guidance is released.

## Performance Sub-Group

Performance management and quality assurance function of the Board includes taking action to ensure outcomes are better than they would otherwise be. Therefore, to know what action to take, performance has to be regularly and robustly monitored and scrutinised. To know how to consistently monitor performance, criteria have to be agreed (aims, objectives, targets and outcomes). To know how to assess performance against criteria, there has to be a method which requires systematic action and coordination.

The Performance sub-group meets quarterly, prior to each Strategic Board meeting to set the agenda. Performance indicators (PI's) represent a useful mechanism for monitoring trends and quantitative information across the partnership. PI's should be viewed as raising questions and issues requiring further interrogation and rarely provide an explanation for what is observed. The Sub group brings to the Board's attention areas for consideration.

The HSCB performance indicators have been selected and developed to underpin the business priorities that the board has selected for the current year.

This year the group has delivered reports on Private Fostering, Child Protection levels, Domestic Abuse incidents, missing children and Early Help. Data reports have also considered locations and demographics in Hertfordshire. The presentations at Board are now planned to coincide with the various themes that are part of each Boards' agenda.

Going forward into 2017-18 the performance sub-group will also be involved in the further development of the HSCB dashboard to incorporate new indicators to support the business plan for the coming two years.

## Audit Sub-Group

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.

The Audit Sub-Group met quarterly from March 2016 to October 2016 increasing to bimonthly thereafter. It 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 2016-17 Business Plan identified the following themed multi-agency audits:

- Children in Need
- Neglect
- Child Sexual Exploitation
- Domestic Abuse

All audits include a proportionate number of disabled children cases.

The recommendations from the Audits are followed through by the development and implementation of an audit follow up action plan. Findings identified from the 2016-17 multi-agency audits are detailed on page 38.

The Board has recognised the need to strengthen the quality assurance functions of the HSCB through audit. The audit process has proved challenging over the past year for the HSCB, with personnel changes and oversight from the audit sub-group has been limited due to poor attendance. Proposed improvements from 2017-18 for the HSCB quality assurance functions are detailed on page 33.

## Learning and Development Sub-Group

The Learning and Development sub group considers training needs against the business priorities, learning from serious case reviews and local requirements.

In early 2016 the NSPCC was commissioned to carry out a training needs analysis with input from key members of the subgroup to inform training requirements for 2017/18. An NSPCC trainer facilitated an event in to identify the multi-agency training requirements for multi-agency professionals working across Hertfordshire. Learning from serious case reviews alongside the HSCB business plan inform the training plan. Multi-agency partners also identify key topics.

Subsequently the L&D group held a planning day to further develop the training plan which was presented to the Board, which agreed to increase funding to facilitate provision of multi-agency training to a wider audience.

Development of Training

A focus group was held in September with the University of Hertfordshire to explore requirements for a course on Avoidant Families. This was well attended and provided the foundation for development of the course which was delivered later in the year with good evaluation. Further work is being carried out to deliver effective training on Child in Need and a course for managers

A Train the Trainers' course was delivered on the Graded Care Profile to increase use of this tool in assessment for Neglect. A number of trainers from Children's Centres attended the training and are now cascading the training to staff.

Training

Training is delivered using a number of methods such as e- learning, face to face events in multiple formats such as Lite Bites, half day to full day courses/conferences. A number of training events addressed the following topics:

- Safeguarding Children with Disabilities
- Familial Sexual Abuse
- Neglect
- Toxic trio (impact of parental mental health and substance misuse and Domestic Abuse)
- Graded care profile

Trainers

There has been a drive to recruit to our training pool -which is currently mostly represented by health colleagues- to provide a more multi agency approach to delivery of training. A meeting was held to discuss requirements with over 10 professionals who responded representing Children's Centres and Children's Social Care.

A commitment was made to provide new trainers with shadowing opportunities, training as required and to observe a training event prior to delivery, to ensure they feel supported. This provides the training pool with a richer source of expertise and experience that should contribute to the learner experience.

Good Practice

Professionals share good practice such as developments/tools '10 points of good practise within safeguarding children Training' and a training passport which other colleagues find useful. A task and finish group is planned to identify how the good practices can be disseminated within partner organisations.

Single agency training audit

An audit is underway to measure compliance with safeguarding children training within each agency. The CCG monitor all Health Providers against the Intercollegiate Document that sets out the levels of training required for each discipline and the competencies to be achieved. Most health Providers are compliant with safeguarding children training and those who are not yet fully compliant have plans to meet

compliance. Most other agencies provide different levels of training and the Board wishes to ensure consistency and quality of this training.

Next Steps

Further training will be delivered against the 2017/19 business priorities to address vulnerable children and young people, neglect, violence against women and girls and will include core facets to address culture, diversity, and supervision and escalation process alongside the subject matter.

Conferences planned for later in the year include a Parents' Conference, Vulnerable Groups Conference and Safeguarding for Housing Providers Conference in conjunction with the Safeguarding Adults Board.

## District Safeguarding Group

The District Safeguarding Group has met on 4 occasions with good representation from most district councils and mixed attendance from the chairs of the Local Multi-Agency Safeguarding Forums.

The group is appreciative of the support provided by the Business Unit and for the attendance and input on a number of occasions of both Phil Picton and latterly Nicky Pace.

**Support provided to Board Processes and Outcomes**

During the last 12 months the District Safeguarding Group has discussed:

- shared safeguarding learning from the Shared Independent Audit Service(SIAS)
- the role and effectiveness of the MASH processes for District Council staff
- the Families First implementation roll out and the impact of Triage processes
- delivery and quality of safeguarding training and the E-learning
- working with BAME and Traveller Communities
- Honour Based Abuse and Forced Marriage
- the Neglect Strategy

**Contributions to the Business Plan, delivering the Board's Priorities**

Child Sexual Exploitation

All 10 district Councils completed CSE self-assessments in 2016 and they will be revisiting the self-assessment in summer 2017.

District Councils have been involved in rollout of the 'Say Something If You See Something' campaign to the public, licensed premises, hotels and taxi drivers. Some innovative initiatives were developed e.g. East Herts DC produced a training video for their night-time economy in conjunction with the Police.

Involvement and Support of Traveller Communities

The district councils completed a self-assessment audit of their involvement and Support of Traveller Communities and this was reported to the Board.

**Contribution to Board Subgroups**

The District Councils provide representation to 4 Board Subgroups; Learning and Development, Supervision Task and Finish Group, Honour BA/FM/FGM and Strategic Safeguarding Adolescent Group. Requests have

been made for representation on the Audit, Neglect and Communications and Engagement groups but at present no nominees have come forward.

Involvement of the district representative on the Learning and Development Sub Group has allowed key partners to be more aware of how districts councils operate and for the group to observe gaps in training e.g. the needs of staff in districts where the council does not manage housing stock. It has also enabled the representative to share relevant information with the district group e.g. training opportunities. The representative also helped audit the SCR Lite-bite session to support the groups' quality assurance work.

The district representative on the Honour BA/FM/FGM group has sought Councils' views by sharing a self-assessment and summarising the district stance at the subgroup meeting. This helped the group to stream-line government guidance to develop a county wide process for FM/HBA (yet to be published). Updates about this group have been shared with the District Safeguarding Group members so that they are familiar with the government guidance.

On the Strategic Safeguarding Adolescent Group the district representation is an active member who has led on a CSE audit of District Council's actions and takes a lead on the development of protocols and interventions.

**Key issues escalated to the Board**

In 2016/17 there have been two related issues sent to the Board for notification and guidance. They relate to families housed in temporary accommodation in Hertfordshire as a result of homelessness by local authorities outside of Hertfordshire and that district councils are not informed of this. This is particularly concerning when these families may have specific social, emotional and or financial needs.

- There needs to be a process in place where District Councils are generally informed about who these children are and what support they may require.
- Where District Councils are made aware it appears these families cannot get access to key services locally.

**Going Forward Issues to be considered by DSG**

- homeless families placed inside of Hertfordshire: access to safeguarding early help services
- case supervision processes for CIN and Families First cases
- clear processes for cases which are stepped up and step down
- autumn 2017 Section II Audit for District Councils outcomes and Action Planning
- Private Fostering: how housing colleagues can be engaged in identification and referral

The District Safeguarding Group will increase focus on Safeguarding adults as generally this is an area which requires further development and embedding in the districts, but hopefully not to the detriment of Safeguarding children work. The District Safeguarding Group will assist the Board with the delivery of the 2017-2019 Business Plan.

# Hertfordshire Safeguarding Children Board Priorities 2016-2017

## Strengthen the safeguarding of children with disabilities

**Why is this priority?**

Disabled children have the same human rights as non-disabled children to be protected from harm and abuse. However, in order to ensure that the welfare of disabled children is safeguarded and promoted, it needs to be recognised that additional action is required. This is because disabled children experience greater and created vulnerability as a result of negative attitudes and unequal access to services and resources and because they may have additional needs relating to physical, sensory, cognitive and/ or communication impairments.

A Serious Case Review in Hertfordshire involving a disabled child highlighted the importance of children with disabilities being a very vulnerable group and therefore the HSCB made this a key priority for 2016-17. The Board required assurances from partners that the safeguarding of disabled children is understood and supported across the local education, health and care partnership.

**What have we done?**

The Serious Case Review has contributed towards the development of new ways of working to ensure systems are better organised and safeguarding matters always take priority. Careful thought and consideration has been placed on the interface between safeguarding children, young people and young adults with disabilities and recognising that some young people will need care and protection throughout their lives. '0-25 Together' is a new specialist service in Hertfordshire that is designed to improve a range of outcomes for these groups.

Children's Services commissioned a single agency audit of Child Protection (s.47) delivered by 0-25 Together that took place during autumn/winter 2016. The audit identified that children were being safeguarded and that most protocols were being adhered to. Some issues remained such as evidence that the Children's voice had been consistently sought and that the perspective of health professionals was included in strategy discussions. The audit offered timely reassurance and reinforces the need for a clear and concise plan that enables continuous organisational learning and development. The Service also maintains a comprehensive data set, originally prepared for OFSTED which tracks performance over a range of themes and issues.

A report that demonstrated that all findings from the Serious Case Review had been followed up with marked progress being made was presented to HSCB on 9 December 2016. Following this report a workshop involving a range of multi-agency partners took place on 31 January 2017. The workshop reflected on the SCR findings, evaluated progress since 2014 and considered what our priorities are, moving forward. The group identified four "Be Safe" outcomes with associated evidence indicators, as follows:

- All professionals know how to communicate with disabled children and young people.

- Staff will have the skills to listen and communicate and will be confident in describing a child's wishes and feelings.
- Case records will reflect the uniqueness and diversity of each child and will capture their wishes and feelings whenever a decision is required or planning is taking place.
- We will be clearly communicating key messages and priorities across SEND workforce, supported by the Disabled Children's Charter and Hertfordshire SEND Professional Charter.
- All professionals know how to identify and label early signs of poor quality care and the meaning of risk to help keep disabled CYP safe.
- The Graded Care Profile will be utilised actively by all partners where there is potential for neglect in a household.
- Professionals will be reflective and aware of their potential to record "uncritical self-report" from parents. Healthy scepticism will be evident in practice across system.
- Staff training and raising awareness will clearly articulate a range of indicators surrounding the health, welfare and development, specific to the lived experience of Disabled Children.
- All plans for disabled CYP are outcome focused and SMART.
- Outcome Bee's will be well understood and will promote a 'one plan approach' to make sure that all partners are sharing responsibility to assist families to meet their outcomes.
- Partnership working with families and multi-disciplinary teams will increase to ensure all information is available when decisions need to be made.
- Staff will be confident in writing SMART targets across all agencies, wherever possible targets must be focussed towards preparation for adulthood outcomes and maximising independence.
- Non-resident parents / carers are identified in assessments and decision making.
- Staff will involve non-resident parent carers in the course of their work which will be described and evaluated in case records.
- Supervision and case direction will clearly address situations where non-resident parents and carers are not included in assessment process.
- All training will include specific examples of where non-resident parents / carers being excluded without healthy scepticism have led to poorer outcomes.

In order to ensure sustained progress the 0-25 service will need to employ a range of activities that remain under review. These activities include:

- Implementation of a 0-25 data set.
- An annual multi-disciplinary audit to take place to include providers of education, and health and care services across the County.
- An annual conference to promote the specific 'Be Safe' outcomes and ensure the 0-25 SEND workforce and leaders are continually reminded of the specialist needs of Disabled Children and Young People.
- A multi-disciplinary professional safeguarding network to be implemented to enable learning and reflection and support continuous improvement.

The HSCB Learning and Development sub-group continued to support the prioritisation of Safeguarding Children with disabilities during 2016-17 and delivered a multi-agency training programme for non-specialist front line staff whose work brings them into contact with children with disabilities, raising awareness of potential safeguarding risk indicators.

The sessions covered:

- Highlighting acceptance of unacceptable events and how to overcome this in practice.
- Approaching the safeguarding of children with disabilities the same as you would those without – not to use lower threshold.
- Recognising Neglect.

Feedback from Participants included:

*"Extremely useful and timely for work. Plenty of opportunity for discussion. The trainer was obviously very experienced and knowledgeable."*

*"Case studies were really interesting."*

*"All of it a brilliant update, but with special reference to disabled children."*

*"Working with other professionals from different backgrounds and the activities."*

*"Recap on Child Protection – realising the barriers for disabled young people and their vulnerabilities."*

The Board conducted a training needs analysis during 2016-17 and identified the continued need to prioritise training on safeguarding disabled children and other vulnerable groups. Further training has been commissioned for 2017-18 in this area.

All HSCB audits during 2016-17 contained a cohort of children with disabilities to ensure that practice in this area is consistent with those children who do not have a disability. Audits did not identify any specific areas of concern around support and intervention across agencies that had not already been picked up by the 0-25 service arrangements. The Board will continue to include children with disabilities in all audits going forward for 2017-18.

The HSCB will continue to monitor and request assurances from all agencies on arrangements for Safeguarding Children with disabilities during 2017-18 to ensure they are being appropriately addressed.

# Strengthen the safeguarding of children who are at risk of or are being sexually exploited or sexually abused

**Why is this 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 people intent on abusing or exploiting children or young people.

**Progress 2016-17**

The Safeguarding Adolescents Group has completed the multi-agency action plan within their sub-group. Performance has been monitored through the 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. Links are established with District Councils to ensure they are engaged with raising awareness around CSE.

The Chelsea's Choice production ran in secondary schools in Hertfordshire which did not have a chance to see it in 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 play has proven highly effective for young people by:

- Raising Awareness of Healthy Relationships.
- Promoting Safe Internet Use.
- Identifying Risky Situations.
- Raising Awareness of Child Sexual Exploitation and the differing forms that it can take.

For adult audiences it also:-

- Raises Awareness of 'The Warning Signs of CSE'.
- Raises Awareness of the journey that young people may have been on that has resulted in them being exploited – a journey that can all too easily make it seem as though they have 'made their own choices' and can leave them not seeing themselves as victims and fighting against any intervention.

There was also a day for professionals to come along and see the show prior to it being seen in schools.

The analysis of the production showed that it was most effective at improving the knowledge of young people on the causes and effects of CSE, the grooming process and the makeup of a healthy relationship. This was due to the way in which the information was presented. This improvement in knowledge was further reinforced with the specific examples used throughout the production alongside the descriptions of the consequences of CSE and grooming along with a discussion about healthy relationships throughout the plenary sessions.

A total of 2595 young people and 200 professionals saw the production in 2016. Over the past two years over 10,000 young people and 300 professionals have had the opportunity to see the production in Hertfordshire.

This year a video resource with supporting materials for schools and settings was made by HALO, YC Herts., young people and the Communications team in HCC. The video is based on real cases in Hertfordshire and tells the story of a 15 year old girl who is befriended on Facebook by someone she has never met and goes on to meet him alone. The video also tackles issues such as sexting and drugs and alcohol. It has been very well received by young people and professionals and is being used in schools. Additional communications activity using the film is planned for the final weeks of term to raise awareness of risks ahead of the long summer holidays.

Multi Agency Training courses continued to be run by the Board around CSE during 2016-17. Three courses were held with 64 participants. Evaluation of these courses noted:

- *The trainers had a wealth of knowledge which they shared which builds confidence with referrals.*
- *Good overview of signs and acknowledging difficulty of going down CP route.*
- *Clear that the professionals can ring MASH line to log concerns.*
- *Facilitators were superb. They were both extremely knowledgeable and delivered the training perfectly.*
- *Case studies are useful as discussion and so learning has a bigger impact. Specific and up-to-date.*

Significant progress has been made over the year to strengthen arrangements for responding to children and young people who go missing from home and local authority care.

The SSAG continues to achieve a high level of contribution and commitment from partner agencies, with responsibility for developing and leading priority areas in the work programme owned and shared by group members. The work programme is organised around the three themes of Prevent, Protect and Pursue.

A focus of the SSAG this year has been on continuing to develop and strengthen the multi-agency response to safeguarding vulnerable adolescents, reducing risks and vulnerability by raising awareness, and ensuring early intervention to help prevent exploitation.

Our understanding of the issues, information sharing across agencies and collation of data is becoming more sophisticated and the partnerships Vulnerable Young People dashboard provides monthly data to all partners to inform service responses and planning. This interactive tool monitors all aspects of missing and recording of CSE and vulnerable young people, in one portal on a monthly basis; the child level reports are also made available for further investigation. The tool continues to develop and will soon include data on care leavers who go missing.

Raising awareness at community level through campaigns, workforce development and through education programmes in schools and other settings on healthy relationships, on-line safety and resilience is ongoing and will remain a priority.

All District Councils have a self-assessment and action plan in place, which are currently being reviewed, one year on, regarding child sexual exploitation. There has been awareness raising, training and testing with hotels, fast food outlets and taxi drivers, which will continue over the coming year.

The latest available data shows that the total number of young people who go missing has reduced. The number of children looked after reported as missing has decreased, as has the number missing from home. A small number of young people who are CLA continue to be responsible for a significant proportion of the missing episodes. Risks are being well managed and the Police recording of CSE risk is being strengthened and the Problem Profile is currently being refreshed.

Discussions have taken place with the National Working Group for CSE and the also with the new Regional Prevention Officer for CSE to find any best practice or practical solution on identifying young people who go missing from education during the day. In the interim, the focus will be to continue to raise awareness of school based staff on the importance of identifying signs and patterns early by building this into staff briefings, safeguarding training and designated teacher briefings.

Funding was secured from Children's Services and the Police and Crime Commissioner to commission the national charity Missing People for an additional 12 months to conduct independent return home interviews for children following a missing episode. The charity has been asked to focus on the top 10 highest risk young people to maximise the impact they are able to have on hard to engage young people. Engagement rates continue to be higher than local authority services are able to achieve.

A new practice forum has been established to identify learning from feedback and casework with victims of CSE. This will be a priority strand of the action plan next year in strengthening the focus on perpetrators of CSE.

**Conclusions and Next Steps**

Additional priorities for SSAG for the coming year will be to continue to strengthen the alignment of the SSAG work programme with the activity taking place through the County Lines and Trafficking and Modern Slavery strands led by the Police Serious and Organised Crime Unit and other partnerships.

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

**Why was this priority?**

Neglect is the most common form of child maltreatment in England. The impact of neglect on children and young people is enormous. Neglect causes great distress to children, leading to poor health, educational and social outcomes and is potentially fatal. Lives are destroyed, children's abilities to make secure attachments are affected and their ability to attend and attain at school is reduced. Their emotional health and wellbeing is often compromised and this impacts on their success in adulthood and their ability to parent in the future. The early recognition of neglect and timely and effective responses to neglect is vital in providing families with the help they need.

Despite the prevalence and persistence of neglect as a form of child maltreatment it remains notoriously difficult to define. We know it often happens alongside other forms of abuse or adversity such as domestic abuse, substance misuse, mental illness and disability. Neglect is often marked by peaks and troughs in care giving which usually correspond with professional advance and retreat and this can make it difficult to take definitive action. As professionals we understand that neglect can be a product of acts of parental omission or commission but whatever the intent the impact on the child is likely to be significant.

Tackling Neglect is a continued priority for Hertfordshire Safeguarding Children Board. At the end of year 2016-2017, a significant proportion (60%) of child protection plans were made under the category of neglect and neglect has featured in serious case reviews.

| No. | On CP Plan | No. due to neglect | % due to neglect |
|---|---|---|---|
| End of March 2013 | 578 | 326 | 56% |
| End of March 2014 | 1140 | 684 | 60% |
| End of March 2015 | 896 | 632 | 70% |
| End of March 2016 | 733 | 443 | 60% |
| End of March 2017 | 520 | 310 | 60% |

The number of children subject to child protection plans under the category of neglect has decreased during 2016-17, as have the number of children protection plans.

**What have we done?**

In October 2016 the Neglect strategy was launched which sets out how the Hertfordshire Safeguarding Children Board will make a difference to children living with neglectful care giving. This strategy is ever evolving, in order to take into consideration and respond to any matter that may relate to other safeguarding concerns such as child sexual exploitation and radicalisation, where neglect could be a contributing factor.

At the event senior strategic staff were asked to make a pledge on behalf of their organisation, please see below. The pledge will be reviewed during the coming year to assure the Board that agencies are prioritising Neglect.

**HERTFORDSHIRE PARTNERSHIP FOUNDATION TRUST**

- Include shadowing Families First in the local induction for new staff
- Highlight 'Neglect' in the Safeguarding / Care Act Training
- The Neglect Strategy to be included as regular feature on monthly business meetings as an agenda item
- Neglect awareness/understanding to be checked in regular staff supervision
- Continued regular attendance at A&I meetings
- Ensure Trust wide communications link to Families First

**HERTFORDSHIRE COMMUNITY NHS TRUST**

- To share the Neglect Strategy with the HCT Board
- To scope who has not undertaken Graded Care Profile training and increase attendance to 100%
- Consider making HSCB Neglect training mandatory
- Continue to audit referrals to Children's Services when Neglect is a concern and where Graded Care Profiles should have been undertaken
- Reminders about Neglect in Team Meetings and Notice Boards
- Standard Operational Procedures on early detection of Potential signs of neglect.

**HERTFORDSHIRE COUNTY COUNCIL**

- Develop a practical common language with GP's and clarify referral pathways
- Work to successfully deliver the Families First Strategy including the establishment of local hubs and improve local needs data collection around neglect
- Raise awareness with schools through training / Head Teachers briefings/publications.
- Advise and support schools through the consultation service.
- Staff to access training – eLearning, Graded Care Profile, Face to Face
- Ensure training about the identification of Neglect is taken up by Early Years Providers e.g. day nurseries, pre-schools, childminders
- Children's Centres – ensure all providers have staff training for the identification of neglect and the use of the Graded Care Profile
- Set up peer support networks for Children Centre practitioners who are using Graded Care Profiles
- Monitor Children Centre involvement in Graded Care Profile's and any action resulting from them

**EAST AND NORTH HERTS HOSPITAL NHS TRUST**

'Neglect Clinic' to identify and initiate management of health concerns in neglected children (including development problems). This will need funding and commissioning

# PLEDGE TO REDUCE NEGLECT

**CLINICAL COMMISSIONING GROUPS**

- Support provider partners to embed the Neglect Strategy into practice
- Ensure the strategy is reflected in care planning / services
- Support the utilization of the Graded Care Profile / Neglect assessment tool, ensuring appropriate use across services

**HERTFORDSHIRE CONSTABULARY**

- Wider roll out of training and awareness for front line officers on Neglect e.g. Scenes of Crimes Officers who are in and out of houses
- Find a way to convey the messages from the Neglect Strategy into something simple and useful for front line officers

**WEST HERTS HOSPITAL NHS TRUST**

- Continue to develop the 'Lavender Team' - specialist midwives who provide intensive targeted support to women with complex needs (mental health, alcohol, drugs, domestic abuse and teen mothers)
- Share the Neglect Strategy at Trust Safeguarding Panel to raise awareness with all clinical divisions in the hospital

**PUBLIC HEALTH**

- Ensure that some of our smaller commissioned services are fully briefed on 'neglect' and receive appropriate training to enable them to identify neglect, know how to support where appropriate and how to refer on not only to Children's Services but to the new Families First hubs
- Support Health Visitors and School Nurses in their role dealing with Neglect
- Brief Public Health Children and Young People's team on the Neglect Strategy

**HERTFORDSHIRE SAFEGUARDING CHILDREN BOARD BUSINESS UNIT**

- To ensure Neglect training is prioritised by the Board – particularly around Early Help
- To create a Neglect leaflet for practitioners to support the Neglect Strategy and Protocol
- To Drive the Neglect Strategy delivery plan forward

The Improving Outcomes Sub-group set up a working party which concentrated in the first instance in reviewing the old Neglect protocol and updating it to provide practitioners with clear guidance on what to look for – the early signs of neglect – how early help services can impact neglect cases and of course where cases reach threshold for statutory intervention. The Neglect delivery plan has several strands, one of which was the review of documentation.

During the year the group also spent time designing a front line practitioner leaflet for all partners giving an outline of what constitutes neglect, where to go for help i.e. access to early help or the Graded Care Profile assessment tool. The intention is to ensure all staff has access to this document and it can be used as an aide memoire.

The introduction of the Graded Care Profile(GCP) in Hertfordshire has been slow over the past few years. During 2016-17 the HSCB decided that it was important that such a comprehensive tool be fully embraced by partners. To this end the GCP was re-launched as part of the neglect strategy and in order to ensure more staff were trained, the Learning and Development Group ran a 'Train the Trainer' course for agencies so that the GCP could be cascaded quickly among organisations.

The numbers of GCP being instigated is increasing across Hertfordshire and many more staff have been trained due to the train the trainer programme. Numbers for 2016-17 stand at 89.

As part of a Training Needs analysis undertaken by the Board, Neglect remained a high priority among agencies. The Board commissioned Neglect courses training during 2016-17 and in November 2016 ran a full day conference on Tackling Neglect. The Conference was headlined by Professor David Shemmings, and workshops were held on domestic abuse, early help and think family, parents with drug and alcohol problems and neglect and sexual abuse.

The Learning and Development sub-group also developed a new course during 2016-17 on the Toxic Trio. This involved partners from domestic abuse, drugs and alcohol and mental health services coming together to deliver a course around the impact of these issues on children. This tied in with the priority of Neglect. The course is being further developed in 2017-18 with a greater emphasis on case study work. Work was also undertaken with the development of a course on disguised compliance with input from Hertfordshire University. The course was successfully piloted late in February 2017 and will run again in the new financial year. Both the Toxic Trio and Disguised Compliance courses have neglect as a key element of their learning.

In order to develop this further for 2017-18 the Learning and Development sub-group have re-commissioned further Neglect training with an emphasis on early help and spotting the signs. Graded Care Profile training also remains a priority for the coming year with courses being delivered across the partnership and by the HSCB.

A multi-agency audit into Neglect focusing on identification and agency intervention was conducted in 2016. The audit has shown evidence of good practice and positive outcomes for children who have been suffering from neglect. Joined up working, linking emerging themes around missed appointments, poor school attendance, hygiene issues etc., have improved because of the work conducted by professionals in Hertfordshire from all agencies across the spectrum (Early Help through to Safeguarding).

Further work needs to be done to embed the Graded Care Profile with staff and to raise awareness of the importance of the Voice of the Child in recordings, particularly for children with disabilities. Members of the early help workforce would benefit in some guidance from the partnership around this. The following recommendations were approved by the Board:

- HSCB to facilitate a forum for cascading the Graded Care Profile Training to partners.
- The use of the Graded Care Profile to be monitored via HSCB Improving Outcomes Group and updates provided as assurance to the Board.
- A promotion campaign to be coordinated by the HSCB for staff around the 'Voice of the Child – what is the child's lived experience' making particular reference to vulnerable groups.
- All partners to review training packages on children with disabilities to ensure that the 'Voice of the Child' is adequately covered.
- The Early Help Partnership to provide a guide to supervision for members of the early help workforce.

Work has already commenced on these recommendations which are being overseen by the HSCB Executive.

The HSCB will continue to deliver training on Neglect, with a focus on early help for 2017-18 and will manage the Neglect Work Stream, which these recommendations will complement.

The successful implementation of the Family Safeguarding model within Hertfordshire, which has developed multi-disciplinary safeguarding teams, using a unified model of practice and group supervision with a shared evaluation of risk, has contributed to an improved understanding and addressing of neglect within families.

Child protection plan numbers have reduced significantly as have care proceedings. The Ofsted inspectorate made particular reference to the model which has gone on to be piloted in other areas of the Country. The 'Think Family' approach adopted by Hertfordshire in the Family Safeguarding Model has been cited by the Department of Education as being extremely positive, in its evaluation report it states:

*"The creation of multidisciplinary teams seems a very promising way of moving to better practice. Indeed, it may lead one to ask why child protection and family support should not be provided by multidisciplinary teams, when the issues dealt with involve complex adult, child and family elements."*

The report goes on to state that the review has implications nationally:

*"all local authorities should consider the potential that multidisciplinary working has for improving practice and outcomes in Children's Services. In Hertfordshire adult specialists have played a central part in creating more family focused assessment and intervention, and this has helped reduce the need for children to enter care, and contributed to other positive outcomes"*

**Conclusions and Next Steps**

*"Neglect can have serious and long-lasting effects. It can be anything from leaving a child home alone to the very worst cases where a child dies from malnutrition or being denied the care they need. In some cases it can cause permanent disabilities.*

*Neglect can be really difficult to identify, making it hard for professionals to take early action to protect a child."* NSPCC

The HSCB have continued to keep Neglect as a priority for the coming two years. The Board will continue to seek assurances from all partners with regard to identifying and working with children and young people suffering from neglect. The Improving Outcomes group will lead this work on behalf of the Board and will focus additionally on older children, recognising neglect of adolescents, this year.

The HSCB will continue to monitor and commission training for Neglect, including the Graded Care Profile and ensure issues of neglect are identified and debated at other multi-agency courses such as Disguised Compliance and Toxic Trio. The Board will also take into account any learning from Serious Case Reviews/Domestic Homicide Reviews or Safeguarding Adults Reviews as appropriate and ensure learning is cascaded throughout the partnership.

The Board will continue to monitor the prevalence of neglect in Hertfordshire via the multi-agency data set and will oversee any recommendations from audits or case reviews.

# Responses to specific safeguarding issues in Hertfordshire

Four specific local issues for 2016-17 detailed below were identified which were informed by:

- Feedback received from HSCB extended members during the planning day in November 2016.
- HSCB quality assurance activity and analysis of performance data.
- Learning from local and national Serious Case Reviews.
- The local needs identified in the Joint Strategic Needs Assessment.
- Review of 2015-16 Business Plan.

Learning from Serious Case Reviews

Hertfordshire Safeguarding Children Board takes direct responsibility for the monitoring of recommendations that are agreed by the HSCB as part of the findings of SCR overview reports, and which are therefore more strategic in their scope and objectives. Recent examples from the SCR 2014 G case include the implementation of the neglect strategy and the development of work with Traveller children.

The Case Review Group chair presented 2 hour briefing sessions on 'findings from recent SCRs' to 115 members of staff. Feedback and evaluation has been provided to the Learning and Development Subgroup. The presentation and discussion focused on 'recurring themes in SCRs' as follows: Assessment of risk and need; Responses to neglect; Supervision and management oversight; Plans and services for children in need; Safeguarding of disabled children; Working across adult and children's services; and Children of Traveller families.

The Case Review Group has considered the recently published triennial review of SCRs and will look at the equivalent Scottish report at a future meeting. Any new important learning from these documents will be incorporated into future training.

Safe and effective services for children within its traveller communities to further enhance services to other minority communities within Hertfordshire.

A scoping exercise took place led by the District Safeguarding Group. A questionnaire was formulated and distributed to all District Councils to provide the Board with an overview of what links and strategies had been developed in each district in their work with traveller communities. Further work is required by member agencies in order to determine what knowledge is held about the outcomes being achieved by Traveller children and this area is to be taken forward as a priority for the 2017-19 Business Plan. Training around cultural difficulties is being prioritised by the Learning and Development sub-group for the coming year and will be woven into current courses. A new course including traveller communities entitled 'Safeguarding Vulnerable Groups' has been scoped for commencement in 2017-18.

Recognition and early intervention and support for the management of self-harm behaviour in children and young people are improved

The national need to address the gaps in children's and young people's mental health and wellbeing provision and the whole system review of Hertfordshire's Children and Adolescent Mental Health Service (CAMHS) have provided the driving forces for the development of the CAMHS Transformation plan in Hertfordshire.

The CAMHS Transformation plan was presented to the HSCB which proposed a new approach to supporting the emotional and mental health of children, young people and families in Hertfordshire that moves away from the historical tiered model of interventions. The new approach places an emphasis on prevention and early intervention and the delivery of services and interventions that offer swift, evidence-based and flexible support that looks holistically at the needs of the child or young person rather than focusing on a diagnosis or thresholds. The aim of the plan is to empower the system, increase capacity across it and skill up children, young people, their families and professionals to be resilient, to be informed about support available and the choices they have and to understand what they can do to help themselves. The key priorities to improve services over the next five years are:

1. Focus on prevention and early intervention.
2. Improve access to psychological therapies.
3. Bring together education and mental health services with joint training.
4. Develop community eating disorder services.
5. Improve perinatal care, particularly for mums-to-be and new mother.

The Hertfordshire Safeguarding Children's Board has raised concerns regarding the commissioning arrangements and provision of inpatient beds for children and young people with complex and acute mental health needs to NHS England. The Board continues to monitor the situation.

Additional funds have been secured to provide the 'Spot The signs' campaign for Children and Young People. A multi-agency workshop was held to develop a suicide reduction plan for Hertfordshire. This will continue to be a priority in 2017-19. Work is continuing to ensure robust information is available to the HSCB for monitoring.

Early identification of and the response for children and young people at risk of radicalisation are in place.

Hertfordshire's PREVENT strategy aims to reduce the threat to the UK from extremism and terrorism by stopping people becoming terrorists or supporting terrorism / extremism. The most significant threats are currently those associated with organisations such as IS in Syria and Iraq, and Al Qaida associated groups. However, extremism associated with the far right also poses a continued threat with 'National Action' becoming the first far right group to be proscribed by the Government.

The multi-agency PREVENT Board, has an internal Board with representatives from all Directorates. This has resulted in the sharing of best practice and the championing of the safeguarding culture of the initiative.

Channel is part of the local PREVENT strategy and is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism or extremism. WRAP training has been

delivered and an online training package developed which has resulted in a number of cases referred to Channel.

# 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

Four areas were identified to increase the effectiveness of the HSCB:

1. Strengthen the voice and impact of children and young people.
2. Respond to issues identified in the training Needs Analysis, including consideration to ensure an appropriate level of training on:
   - Children with disabilities
   - Child Sexual Exploitation
   - Neglect
   - Toxic Trio
   - Cultural Diversity
3. Further strengthen the quality assurance arrangements.
4. Respond positively to any recommendations from the National Review of LSCB's.

Strengthen the voice and impact of children and young people

The HSCB Annual Conference was held during Takeover Day 2016. The conference was opened by a young person and young people attended the workshop with their named professional chaperones and participated in discussions. All audits include 'Voice of Child' analysis. Audit findings have informed HSCB plans for 2017-18 which includes a professional's campaign on the 'Voice of the Child'.

A Communication and Engagement Subgroup will be launched in 2017-18 which aims to deliver activities to ensure that the HSCB engages with and seeks the views of children, young people and their families in the delivery of its functions and activities. The Communication and Engagement Subgroup aims to positively promote and raise awareness of activities, campaigns and local work to ensure children and young people are safe in Hertfordshire.

Respond to issues identified in the training Needs Analysis

The training needs analysis report conducted by the NSPCC identified several areas that the Board needs to consider for the needs of staff training across the partnership and beyond. These included looking at current oversubscribed courses to see if they could be increased in number, looking at online options and considering different mediums for delivering learning and training. The HSCB has agreed to double the number of courses for 2017-18, which will be funded out of the HSCB's underspend.

Further training will be delivered against the 2017-19 business priorities to address vulnerable children and young people, neglect, violence against women and girls and will include core facets to address culture, diversity, supervision, disguised compliance and escalation process alongside the subject matter.

Further strengthen the quality assurance arrangements

There has been an identified need to strengthen the quality assurance functions of the HSCB. The audit process has proved somewhat challenging over the past year for the HSCB, with personnel changes; oversight from the audit sub-group has been limited due to poor attendance. Performance analysis has seen considerable development and improvements, however more detailed analysis of performance indicators at the Board meetings with an emphasis on addressing the 'so what?' question is to be developed.

The audit and performance analysis function was performed by a specific post hosted within the HSCB Business Unit. The HSCB has identified that there is a greater need for quality multi-agency audits, therefore the Data and Performance Analyst Post has been removed and the cost for this post will fund future multi-agency audits for the HSCB. External auditors will be commissioned from 2017-18 to undertake multi-agency audits for the HSCB, giving the audit independence, strong practice base and the recommendations more strength.

A meeting with key staff around the HSCB audit function going forward for 2017-18 has taken place identifying key individuals. A move away from process based audits has been agreed. The HSCB will undertake two annual 'deep dive' audits. The approach will be based on members of the audit sub-group completing a joint case audit together as a group considering specific cases and identifying any practice issues and themes. This will then result in multi-agency recommendations for the Board. The outcomes of the audit will be presented to the Board by the Board sponsor for the audit. All agreed recommendations from Audits will be monitored at the Audit Sub-group which will provide a quarterly update to the HSCB Executive meeting.

Performance analysis has and will continue to develop over time. Further detailed analysis of performance indicators at the Board meetings with an emphasis on addressing the 'so what?' question is to be developed. The themes arising from the audit function will be linked into the regular reports to Board.

The S11 audit process for 2017-18 will be reviewed and a new process put in place which would include a questionnaire to be completed by as many staff in each organisation as possible through a tool such as Survey Monkey. This would move the S11 process to a more focussed frontline -evidenced based process rather than self-assessment. It is proposed that following this, each agency would carry out a self-assessment of the results of the questionnaire. Leading on from this, each agency which, as a result of the self-assessment, had identified areas for learning and improvement would be required to complete an action plan and audit analysis. The final part of the process would involve a peer review process of a sample of self-assessments with the view to identify gaps, strengths and areas for improvement in safeguarding. The agencies action plans would be scrutinised and monitored 6 months into the year with requests for updates. An overarching report will be produced following the analysis of results including an action plan. Repeating the process on an annual or biennial basis, will form provide a baseline and template to measure progress.

As part of the Board's learning and development function, the dissemination of learnings from Serious Cases and other reviews and audits requires more co-ordination along with cross board learning. As part of

the learning cycle the communication of HSCB findings and action plans requires more consistency. From 2017-18, the HSCB Business Managers will co-ordinate and oversee the communication plan for HSCB/HSAB publications. This will include newsletters, additions to the website, audit findings, review publication dates and any other campaigns and national priorities. It will also include an overarching Action plan bringing all the plans together in one document to aid monitoring.

Respond positively to any recommendations from the National Review of LSCB's

In December 2015, the Department for Education (DfE) asked Alan Wood CBE to lead a review of the role and functions of Local Safeguarding Children Boards (LSCBs) in England. As part of the review he also looked at serious case reviews and Child Death Overview Panels. The DfE has published the Wood Review of the Role and Functions of Local Safeguarding Children Boards and the government has agreed the recommendations , which are being incorporated into the Children and Social Work Bill. HSCB partners have continued to work together within our current arrangements whilst revised legislation has been awaited.

# Statutory Functions

## Learning and Improvement

The statutory guidance Working Together to Safeguard Children (HM Government 2015) requires the Local Safeguarding Children Board (LSCB) to have a local learning and improvement framework within which reviews and audits are carried out.

The Hertfordshire framework is set out in the Hertfordshire Safeguarding Procedures. Its aim is to identify improvements which are needed and to consolidate good practice through programmes of action which produce improvements and the prevention of death, serious injury or harm to children.

The framework covers the full range of single and multi-agency reviews and audits which aim to drive improvements to safeguard and promote the welfare of children.

Types of Reviews

The different types of review commissioned by the HSCB include:
• Serious Case Review for every case where abuse or neglect is known or suspected and either a child dies, or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.
• Child death review; a review of all unexpected child deaths.
• Review of child protection incidents that fall below the threshold for an SCR (referred to in Hertfordshire as a partnership case review (PCR).
• Review or audit of practice or theme in one or more agencies.

Individual cases which may require a review are considered by the HSCB Case Review Group which is chaired by an independent person with experience in conducting reviews. This group makes recommendations to the independent chair of the HSCB. However, the decision on whether to conduct a serious case review rests with the independent chair of the HSCB. The HSCB oversees implementation of actions resulting from these reviews and reflects on progress.

Multi-agency audits are determined by the Business Plan or recommendations from case reviews.

Reviews in progress, published or commissioned in 2016-17

Child A – a disabled child who was injured by his mother's partner in 2013. The SCR was completed in September 2014 but publication was delayed due to the delays in the criminal trial. The review identified 7 areas of learning, which were in relation to ensuring the voice of the child is heard with children with different 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.

SCR 2014 relates to a baby whose 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, and working with minority communities. The recommendations led 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 was commissioned in 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 Board is in the final stages of a review in relation to services provided to a young child who is alleged to have committed serious sexual offences.

Learning from SCRs and themes that have been repeated in more than one review

Reviews always provide learning which is specific to the case in question. Reviews often demonstrate that there have been a series of small errors which in combination and in the specific circumstances of the case have led to a child being seriously harmed. This can lead to changes in procedures and training in order to ensure that the same mistake is not repeated.

Often reviews highlight weaknesses in areas which are already the focus of activity by the Board and by individual agencies. The very nature of the activity to safeguard children – which must address unpredictable and complex aspects of behaviour – means that not all errors and risks can be eliminated completely. Reviews repeatedly return to the more difficult aspects of safeguarding services where there is a need for vigilance and alertness to the possibility of different errors occurring.

In Hertfordshire these have included:

*Neglect*

It is understood that '*Neglect can be difficult to define because most definitions are based on personal perceptions of neglect. These include what constitutes 'good enough' care and what a child's needs are'*.

It is difficult to estimate the prevalence of child neglect in Hertfordshire. However, we know that children suffering from neglect form the largest cohort of children on child protection plans and child in need plans. Almost 60% of children who are at the highest level of risk in the County are as a result of Neglect. It is important to highlight that to truly understand neglect we need to understand the basics of child development.

We found in one SCR that the focus was made on the poor home conditions and practical issues rather than improving parenting skills and outcomes for children. In the same case, it was only the Social Worker who named neglect.

*Assessment of Risk and Need*

Our SCRs found that male carers and fathers were not included in the assessment. In one case the mother's partner caused the injuries to the child.

In another case the foster carers raised concerns about the impact contact with father was having on the child. There was also an allegation that father had hit the child which resulted in no further action. There was a lack of multi-agency strategy discussion and the child proceeded to move to live with father and tragically three months later he murdered her. This case highlighted a number of shortcomings in the assessment, which was focused on the father and not taking into account a full understanding of the child's needs.

SCRs also found the lack of weight given to what the child was saying and child observations.

SCRs also found an over reliance on self-reporting and the lack of professional scepticism.

*Identifying and responding to abuse of disabled children*

Case reviews identified that where the primary focus for intervention remains the child's disability or health needs, indicators of abuse may be misinterpreted and the risk of significant harm go unrecognised. Also the significance of a parent or carer not taking a child to health appointments, particularly where the child is additionally vulnerable, should be an indicator that the child may be at risk. There was a pattern of uncritical acceptance of parental self-report by professionals.

There was an identified failure to use expertise within the professional network to hear the voice of child and a professional unwillingness to label the early signs of poor quality care provided to disabled children as Neglect.

*Supervision of staff in all agencies*

The SCRs highlighted that despite the differing processes in agencies, supervision must ensure that the rights of children are discussed, supervision is challenging and testing, focused on improvement and impact and not just focused on the completion of tasks and the effectiveness of supervision of less experienced staff and students.

*Escalation of concerns within agencies*

SCRs identified a need for the development of challenge between agencies when there are concerns about children or disagreements about how cases are being addressed.

*Children in Need*

It has been noted that it is more difficult to provide high levels of scrutiny and coordination when children are the subject of Child in Need Plans, rather than being children who need a Protection Plan. The judgements that lead to a child being treated as a Child in Need and the coordination of a plan for a Child in Need are therefore of particular importance.

Every review is completed by the development of a detailed Board response and action plan. The implementation of actions is overseen by the Safeguarding Board itself (for SCRs) and the Serious Case Review Group (for partnership reviews and other reviews). Each action is subject to immediate action and monitoring of practice to demonstrate that the action taken is having a positive effect on outcomes for children.

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.

Multi-Agency Audits

*Neglect*

The aim of the audit was to ensure Neglect was being identified and addressed across cases in Early Help, Children in Need and Children on a Child Protection Plan.

Findings:

The audit has provided evidence of good practice and positive outcomes for children who have been suffering from Neglect. Joined up working, linking emerging themes around missed appointments, poor school attendance, hygiene issues etc., have improved because of the work conducted by professionals in Hertfordshire from all agencies across the spectrum (Early Help through to Safeguarding).

Improvements have been identified to embed the Graded Care Profile with staff and to raise awareness of the importance of the Voice of the Child in recordings, particularly for children with disabilities.

The HSCB continue to deliver training on Neglect, with a focus on early help for 2017-18 onwards and will continue to progress the Neglect Strategy Delivery Plan launched in October 2016.

*Child in Need Plans*

The aim was to assure the Board that appropriate multi-agency Children in Need Plans are in place and all agencies are engaged in the Plan. The audit looked at whether appropriate agencies have been involved in individual children's cases and what their contributions were and whether this has made a difference.

Findings:

The audit highlighted the need for plans to be multi-agency and SMART which is key to documenting progress in cases, evidencing the desired outcome for the child and avoiding drift. There was clear evidence that reviews of cases were clearly taking place, however, it is not evident that the plan and work was shared by all relevant agencies.

The recommendations outlined the importance of shared ownership and that individuals should be proactively promoting services and interventions for children and young people.

*Child Sexual Exploitation*

The aim was to assure the Board that multi-agency work on cases of CSE is effective and young people are adequately safeguarded.

Findings:

The audit revealed as with other audit findings, case management and supervision was inconsistent amongst the multi-agency partnership, information sharing requires strengthening and capturing the voice of the child varied across the partnership.

*Domestic Abuse*

The HSCB multi-agency audit was de-commissioned as a peer review was undertaken in November 2016, which was targeted towards supporting the wider domestic abuse partnership to assess progress made against this vision, to date, and to make any recommendations that will help the partners in Hertfordshire to achieve their ambition for the children and vulnerable adults of the county. The review focused on the following key lines of enquiry:

- Overall Domestic Abuse strategy, partnerships and impact of improvement programme.
- Commissioning arrangements.
- Strategic responsibilities of partner agencies to support multi-agency working.
- Procedures and service pathways for responding to Domestic Abuse.
- Performance Management & Quality Assurance.
- Evidence of effectiveness of casework outcomes.

<u>Section 11 Assessments</u>

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 2016-17 the below partners were asked to carry out an audit:

1. All Hertfordshire County Council Directorates – including Herts for Learning and Herts Catering
2. National Probation Service
3. BENCH

The results, which were discussed at the Audit Group showed good compliance overall across the Partners with some recommendations about raising awareness around Early Help.

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.

# Allegations against Staff

Local Authority Designated Officer (LADO Working Together March 2015) states:

"Local authorities should put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process."

The scope of the role defines the framework for managing cases when it has been alleged that a person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

The procedures apply to situations when:

- There are suspicions or allegations of abuse by a person who works with children in either a paid or unpaid capacity - as a permanent, temporary or agency staff member, contract worker, consultant, volunteer, approved foster carer, child minder or approved adopter;
- It is discovered that an individual known to have been involved previously in child abuse, is or has been working with children.

Referrals

| Year | July 2014 - June 2015 | July 2015 – June 2016 | July 2016-June 2017 |
|---|---|---|---|
| Total Recorded Allegations | 804 | 804 | 630 |
| Allegations that reached child protection threshold | 60 | 67 | 68 |

The number of allegations (630) received by the service was 12% lower than the previous year but the number of allegations reaching threshold (68) rose by 15%. This resulted in 83 Strategy/Joint Evaluation Meetings being held (a rise of 4%). All those allegations that do not reach child protection threshold are dealt with as a consultation, which means that the LADO still advises and supports the employer with the process. LADO involvement in these cases can range from a single contact and one-off provision of advice, to a significant number of contacts and meetings for more complex pieces of work.

Allegations (%) that reached threshold specific to agency:

**July 2016 - June 2017**

| | |
|---|---|
| Education | 58% |
| Social Care | 7% |
| Health | 1% |
| Police | 2% |
| Private and Voluntary Sector | 32% |

Referrals from education establishments remain the largest percentage, those from Social care generally relate to either foster carers or residential settings (HCC and independent). The suitability of foster carers who are the subject of a substantiated allegation is independently reviewed by an Independent Reviewing Officer and their registration will be reviewed by the Fostering Panel. Substantiated allegations received from the private and voluntary sector primarily relate to early years settings and sporting organisations.

## Private Fostering

We started the financial year 2016-2017 with one designated Private Fostering worker within the Family and Friends team but a further half time worker has been assigned from within the team. The current half time worker has however, been on maternity leave since December 2016.

In addition to the statutory visits and assessments, the private fostering worker has continued to undertake a programme of awareness raising activities throughout the year both internally within the Service and with partner agencies. These have included attendance at the Local Safeguarding forums, talks within various team meetings, contribution to safeguarding training to school DSPs and early years' settings, stands at the Multi Faith Forum Conference and the Early Years Conference, presentations to the Academy cohorts and University Social work students.

Quarterly meetings of the Private Fostering Development and Action Group have continued with the aim of knowledge/ideas being shared and for respective agencies who attend to contribute to the task of maintaining its profile within their services. The Group provides an overview of actions relating to Private Fostering development work and to review the effectiveness of the actions.

Notifications of Private Fostering arrangements remain low both nationally and locally and awareness of the meaning of Private Fostering and the requirement to notify the Local Authority remains variable. The task of raising awareness, especially amongst the general public is relentless and is hampered by the lack of a national campaign, a specified budget assigned for this purpose and often the limitations of resources to undertake this task. Maintaining the profile of Private Fostering and its significance to the safeguarding of children is a huge task and we are reliant on partner agencies to assist us in the identification and notification of these arrangements.

During the period April 16-March 2017, there were a total of 35 new Private Fostering Notifications, a total of 32 Private Fostering Assessments were completed, and we had 42 arrangements. Three notifications did not progress to Private Fostering arrangements. We continued to monitor enquiries and we had a total of 47 general enquiries, of which 27 were not Private Fostering arrangements, and 4 were referred onto other Local Authorities.

# What's Next?

HSCB Strategic Priorities 2017-2019

In addition to the statutory requirement set out in Working Together to Safeguard Children 2015, Hertfordshire Safeguarding Children Board has identified four local strategic priorities over 2017-2019.

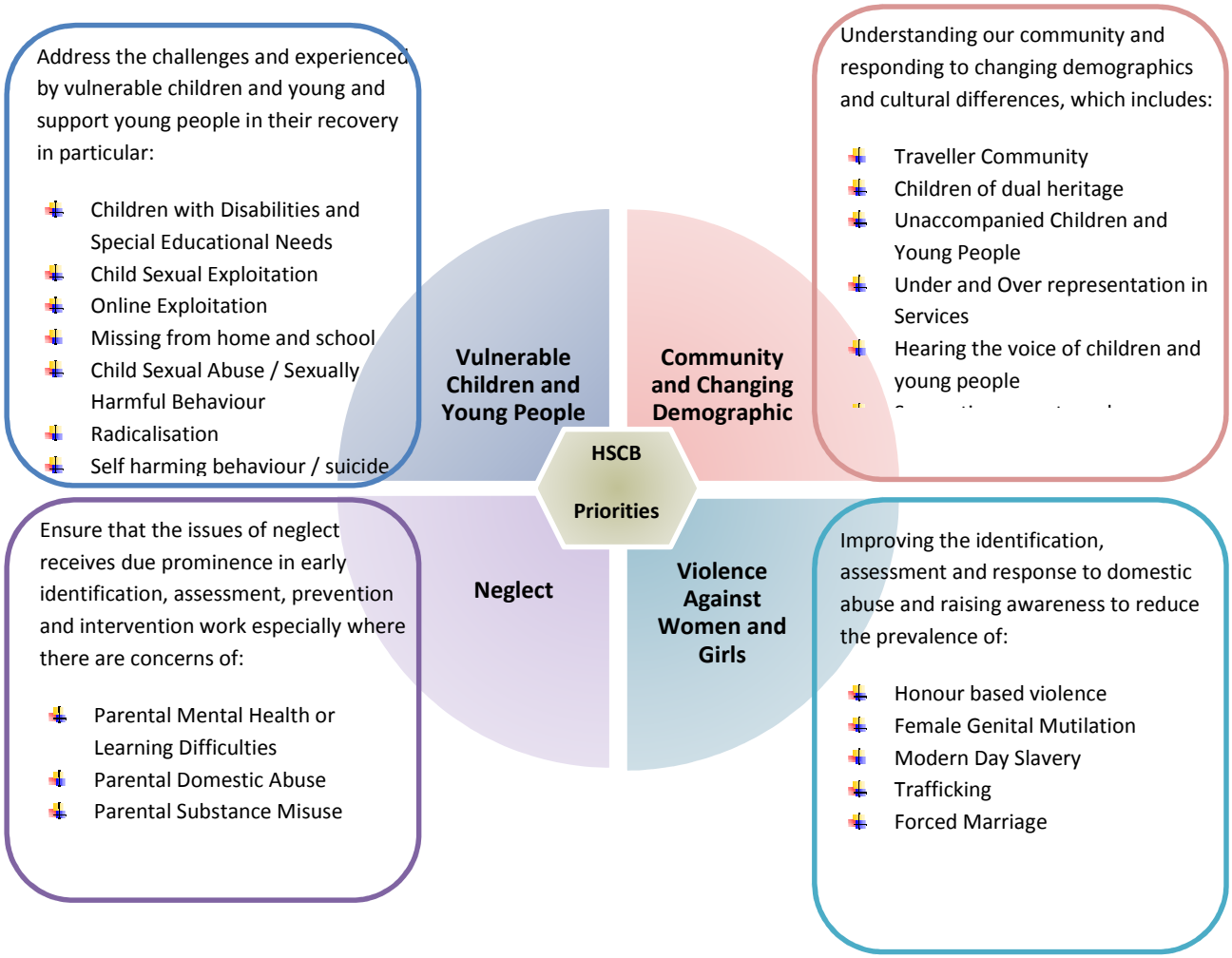
The priorities were informed by:

- Feedback received from HSCB extended members during the planning day in November 2016.
- HSCB quality assurance activity and analysis of performance data.
- Learning from local and national Serious Case Reviews.
- The local needs identifies in the Joint Strategic Needs Assessment.
- Review of 2016-17 Business Plan.

In deciding our priorities, the HSCB acknowledges that our core business of safeguarding children is ongoing which includes the early identification, assessment and provision of services and help to those children who need protection. In deciding the Board's improvement priorities, the HSCB considered how well priorities from the previous year were delivered and whether further work was needed. The HSCB has recognised that the priorities identified for the Board would require a two year work plan at least to make the necessary improvements.

Safeguarding children and young people is a key overarching priority for all partners working together in Hertfordshire. The HSCB brings together senior leaders to promote partnership working and co-operation, identify and promote a learning and development culture, whilst overseeing efforts to improve safeguarding services for children through active challenge and scrutiny.

# HSCB Strategic Priorities 2017-2019



# Hertfordshire Safeguarding Children Board Budget 2016-2017

2016-17 Partners contributions

| | |
|---|---|
| Hertfordshire County Council | 198,919 |
| Herts PCC | 16,800 |
| Herts Valleys CCG | 52,150 |
| East &North Herts CCG | 52,150 |
| Community Rehabilitation Service | 4,032 |
| Herts Probation | 2,688 |
| **TOTAL** | 326,736 |

The outturn for 2016/17 is £344,010, against a budget of £326,739.

£14,310 received from non-attendance at training courses and training fees for agencies who do not contribute to the HSCB budget.

Current carry forward to 2017-18 £121,394

**Expenditure Budget 2017-18**

| Expenditure | 2017-18 |
|---|---|
| Staffing and Staffing Related | 189,796 |
| Board Services and Supplies | 11,785 |
| Case Reviews | 30,000 |
| Multi-Agency Audits | 40,000 |
| Independent Chair | 35,700 |
| Training | 30,000 |
| Annual Conference | 6,095 |
| Communication and Procedures | 7,389 |
| Launch of practitioner forums<br><br>Trial of webinars<br><br>Parent Conference | 14,310 |

# 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 – 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
- 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

# Appendix 2 Attendance at Strategic Board meetings 2016-2017

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

| | |
|---|---|
| Director of Family Safeguarding, HCC | 2/4 |
| Representatives of Primary, Secondary and Special Schools | 4/4 |
| Deputy Principal, Further Education | 0/4 |
| Chief Executive, District Councils (or nominated representative) | 3/4 |
| Lay Member #1 | 0/4 |
| Lay Member #2 | 2/4 |
| Executive Member, Children's Services | 2/4 |
| Head of Hertfordshire National Probation Service – National Probation Service | 3/4 |
| Head of Service, Children & Young People, Public Health | 3/4 |
| Operational Director, Herts BeNCH CRC | 3/4 |
| HSCB Business Manager | 4/4 |
| HSCB Development Manager | 4/4 |
| HSCB Data Analyst | 3/4 |

# Appendix 3 Training Course 2016-2017 – 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 | 52 |
| Children's centre | 140 |
| Children's Services | 351 |
| Colleges | 12 |
| District Council | 26 |
| Drug and Alcohol Service | 21 |
| Education | 3 |
| Family Support Services | 46 |
| Health - East and North Herts NHS Trust | 30 |
| Health - Hertfordshire Community NHS Trust | 160 |
| Health - Herts NHS Foundation Trust | 13 |
| Health - NHS Hertfordshire | 35 |
| Health - West Herts Hospitals Trusts | 24 |
| Health - Other | 14 |
| Herts Constabulary | 9 |
| Hertfordshire County Council | 22 |
| Housing Provider | 9 |
| HSCB | 1 |
| Nursery | 4 |
| Other | 14 |
| Pre-school | 14 |
| Probation | 3 |
| School | 2 |
| Schools - designated senior person | 108 |
| Schools - non designated senior person | 48 |
| South West Partnership | 7 |
| Voluntary Sector | 49 |
| **Total** | **1,217** |

**Total number of attendees by course Apr 16 - Mar 17**

| Course Title | Total number of attendees | How many times the course ran |
|---|---|---|
| Safeguarding Disabled Children | 48 | 3 |
| Bruising Lite Bite | 86 | 4 |
| Child Sexual Exploitation Prevention, Protection and Investigation | 65 | 3 |
| Self-Harm Awareness Lite Bite | 63 | 4 |
| Understanding Neglect - a half day refresher | 39 | 2 |
| Safeguarding and Child Protection Multi-Agency course | 254 | 11 |
| FGM: Tackling Female Genital Mutilation Together | 105 | 6 |
| The Toxic Trio | 107 | 4 |
| Serious and Partnership Case Reviews and Audits Lite Bite | 21 | 2 |
| Graded Care Profile Lite Bite | 62 | 3 |
| Learning and Action from Recent Hertfordshire Serious Case Reviews | 115 | 3 |
| HSCB Annual Conference 2016 - Neglect | 162 | 1 |
| Disguised Compliance and Avoidant Families | 20 | 1 |
| FGM Learning Seminar and Workshop | 52 | 2 |
| Graded Care Profile - Train the Trainer | 18 | 1 |
| **Total** | **1,217** | |

# Appendix 4 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 |
| 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 |
| FFA | Families First Assessment |
| 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 |
| HSAB | Hertfordshire Safeguarding Adults Board |
| 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 | West Hertfordshire Hospitals NHS Trust |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| **Priority 1** | **Strengthen the safeguarding of children with disabilities** | | | | | |
| 1.1 | Deliver a multi-agency training programme for non-specialist front line staff whose work brings them into contact with children with disabilities, raising awareness of potential safeguarding risk indicators (including Child Sexual Exploitation) | Mary Emson<br><br>Sheilagh Reavey | 3 training events to be held by 31.03.2017 | Feedback received from those attending and evaluation confirms effectiveness of the multi-agency training<br><br>Audit confirms impact on practice<br><br>Increased percentage of appropriate referrals to Children's Social Care<br><br>Increase CAF activity for children with disabilities<br><br>Number of attendees receiving training | Increase knowledge of staff<br><br>Improved awareness of potential safeguarding risk indications to ensure the protection and support for children with disabilities | |
| 1.2 | Evaluation report to be presented to the HSCB Strategic Board on the quality of support and intervention across agencies for disabled children and the impact on protecting disabled children. | Marion Ingram<br><br>Jenny Coles | Evaluation Report to be presented to the HSCB Strategic Board – March 2017 | Evaluation report to include a clear identification of areas for improvement to improve outcomes for children, young people and families. | Multi-Agency Action Plan developed for areas of improvement identified. | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| | | | | | Assurance for strategic leaders that safeguarding issues for children with disabilities are being appropriately addressed | |
| **Priority 2** | **Strengthen the safeguarding of children who are at risk of or are being sexually exploited or sexually abused** | | | | | |
| 2.1 | Full delivery of the revised Child Sexual Exploitation Action Plan | Lindsay Edwards<br><br>William Jephson | Implementation as set out in the action plan<br><br>Progress Report to be presented to the HSCB Strategic Board – December 2016 | | Improved identification and support for young people subject to sexual exploitation<br><br>Increased awareness on the part of the public, professionals and young people of the risks of sexual exploitation and how to combat it | |
| 2.2 | HSCB Strategic Board to receive an annual report evaluating the intervention and prevalence of missing children in Hertfordshire. | Lindsay Edwards<br><br>Jenny Coles | Annual report to be presented to the HSCB Strategic Board in September 2017. | Number of missing children<br><br>Number of children with repeat missing episodes | Reduction in the numbers and frequency of missing children<br><br>Understanding from | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| | | | The report to include findings of audits conducted on return interview and risk assessments for children who go missing from home, care and school.<br><br>The report to include an evaluation of early help services to reduce the risk of young people going missing go missing from home, care or school | | professionals and agencies in the causes of missing children and their experience<br><br>Assurance for strategic leaders that action to address safeguarding issues for missing children (and the risks of factors such as CSE etc) are being appropriately addressed | |
| 2.3 | Develop a plan for maintaining young people, parent and professional awareness of Child Sexual Exploitation | Lindsay Edwards<br><br>William Jephson | Say Something if You See Something Campaign to be launched by September 2016<br><br>Say Something if You See Something Campaign to include raising awareness with local pharmacies | Referrals to the HALO Team<br><br>Referrals to SEARCH Panel<br><br>Referrals to Children's Services | Increased awareness on the part of the parents and young people of the risks and signs of sexual exploitation and how to combat it<br><br>Increase of referrals to the HALO Team<br><br>Increase of referrals to the SEARCH Panel | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| | | | | | Increase of referrals to Children's Services<br><br>Improved identification and support for young people subject to sexual exploitation<br><br>Increased awareness on the part of the public, professionals and young people of the risks of sexual exploitation and how to combat it | |
| 2.4 | HSCB dataset to include data on children missing from school. | Lindsay Edwards<br><br>Jenny Coles | Communicate clearly with schools about the safeguarding issues relating to children who are missing or absent from schools;<br>i) through Safeguarding Board – ensuring that school staff are receiving training,<br>ii) schools to | Data on children missing from school included in the vulnerable young people dashboard | Reduction in missing episodes<br><br>Improved targeting of actions and interventions to children missing from school.<br><br>Data to be collated and | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| | | | communicate risks to parents,<br>iii) head teachers briefings 3 x a year.<br><br>Promote the use of intelligence available on school attendance to be included in case planning for all relevant children's services teams.<br><br>Work with existing Missing Children Task & Finish group to review information feeds and consolidate information into a single accessible place and coordinate the information (missing from home, education and care) to identify patterns and act appropriately. | | analysed to inform risk management and service planning, both for individual children and also strategically to inform disruption activities and service planning.<br><br>Appropriate monitoring by SSAG of the level of 'missing from education' so that action to manage and reduce CSE can be appropriately planned | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| | | | Need to co-ordinate and define missing from education in order to get any useful data:<br>Some authorities have compared: EWO caseloads with police missing data, persistent absentees (more than 15% absence), excluded, home educated children, PRU students, CIN. Cambridgeshire have been successful in pulling this together. | | | |
| 2.5 | HSCB to be assured that current arrangements in relation to the recognition, early intervention and support are in place to safeguard children from familial sexual abuse. | Mary Emson<br><br>Sheilagh Reavey | Raise multi-agency awareness through the delivery of training and learning materials. | Feedback received from those attending and evaluation confirms effectiveness of the multi-agency training<br><br>Survey confirms impact on practice | Professionals are confident in the identification, risk indicators and protections of children from familial sexual abuse. | |
| | | | | | | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| **Priority 3** | **Strengthen our work in preventing, identifying and protecting children from neglect including the protection and support of children living with domestic abuse, substance abuse and adult mental health issues** | | | | | |
| 3.1 | Complete and implement the delivery plan for the HSCB Neglect Strategy | Sue Williams<br><br>Jenny Coles | HSCB Neglect Strategy Delivery Plan to be agreed April 2016, date for progress report to be decided at the April 2016 Executive Group Meeting<br><br>Implementation as set out in the delivery plan<br><br>HSCB Annual Conference to be held on Neglect | Increased use of the graded care profile<br><br>Numbers of children subject to child protection plans due to neglect<br><br>Levels of awareness of neglect strategy | Improved analysis of neglect cases leading to better outcomes and services to young people and their families<br><br>Better coordinated and targeted response to neglected children by the Children's Workforce across Hertfordshire | |
| 3.2 | Ensure targeted multi-agency training for front line professionals on the recognition of neglect, its impact on children and strategies for effective assessment and intervention | Mary Emson<br><br>Sheilagh Reavey | 2 training events to be held by 31.03.2017 | Increased use of the graded care profile<br><br>Numbers of children subject to child protection plans due to neglect<br><br>Feedback received from those attending and evaluation | Improved awareness of potential safeguarding risk indications to ensure the protection and support for children from Neglect<br><br>Better coordinated and targeted response to | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| | | | | confirms effectiveness of the multi-agency training<br><br>Audit confirms impact on practice | neglected children by the Children's Workforce across Hertfordshire | |
| 3.3 | Ensure targeted multi-agency training for front line professionals on the recognition of the toxic trio and the impact on children. | Mary Emson<br><br>Sheilagh Reavey | 4 full day training events to be held by 31.03.2017 | Feedback received from those attending and evaluation confirms effectiveness of the multi-agency training<br><br>Number of attendees receiving training<br><br>Survey confirms impact on practice<br><br>Increased percentage of appropriate referrals to Children's Social Care<br><br>Increase CAF activity for children<br><br>Increased use of the graded care profile | Improved awareness of potential safeguarding risk indications to ensure the protection and support for children from Neglect and the links to the toxic trio.<br><br>Awareness of Children's workforce on the impact of individual aspects of the 'Toxic Trio' and the complexity of issues for children, family members and professionals when more than one 'Toxic' factor is present | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
|---|---|---|---|---|---|---|
| 3.4 | Partner agencies to assure the board in relation to the use of the think family model in interventions to safeguard children. | Sue Williams<br><br>Jenny Coles | Board event to be held in September 2016 on the Think Family Approach | Analysis and scrutiny of how the think family approach is adopted in agencies.<br><br>Evidence of the use of the 'Think Family' model in audits and evaluation work – (including within the University of Bedfordshire evaluation of the Family Safeguarding project)<br><br>Reduction of the number of children looked after (150 in the next three years) | Improved outcomes and services for children who are living in households where two or more of the toxic trio issues are present.<br><br>Children are safeguarded where appropriate by addressing issues across the whole family – with the outcome that children are more able to remain safely within their community and family | |
| **Priority 4** | **Responses to specific safeguarding issues in Hertfordshire** | | | | | |
| 4.1 | Ensure that recommendations from Serious Case Reviews, other reviews and themes across all reviews in Hertfordshire are effectively followed through, that actions are completed and learning is | Keith Ibbetson<br><br>Phil Picton | Implementation as set out in the audit and case review action plans | All HSCB Multi-Agency audits to include the evaluation of the voice of the child in case work, supervision and management oversight. Think | Professionals are increasingly aware of critical factors in improving safeguarding in Hertfordshire | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
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| | embedded into practice.<br><br>In 2015-16 themes identified were voice of the child, supervision and management oversight of case work. | | | family approach and themes from case reviews<br><br>Learning from reviews disseminated | | |
| 4.2 | Partner agencies need to assure the Board that they are equipping their workforce to deliver safe and effective services for children within its traveller communities and to use the learning from the SCR on Child G (and the Children Services Audit on BME cases) to further enhance services to other minority communities within Hertfordshire. | Graeme Buck<br><br>Steven Halls | Scoping exercise with all district community safety?, the local authority and health provider trust teams to ascertain what links and strategies have been developed in their work with traveller communities<br><br>LMASF to support the partnership working with cultural based groups, raise awareness of local resources and identify service gaps within their local areas | Analysis of services specific to traveller communities<br><br>Actions taken forward from discussions at LMASF<br><br>Dissemination of work to address issues within traveller communities in a way which encourages learning more widely across the Children's workforce dealing with minority groups | Professionals are confident in working with families from minority ethnic groups.<br><br>Children in traveller communities are better safeguarded<br><br>Learning about improving safeguarding in traveller communities is used to address issues in other communities | |
| 4.3 | HSCB to be assured that the current arrangements in relation to recognition and early intervention and support for the management of self-harm behaviour in children and young people are improved. | Oliver Shanley | Action plan developed and monitored for areas for improvement identified in the multi-agency audit | Number of self-harm admissions at Accident and Emergency | Improved targeting of actions and interventions for young people who engage in self-harm behaviour. | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
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| | | | Update report on the CAMHS review approach to self-harm to be presented to the HSCB Strategic Board<br><br>4 training events to be held by 31.03.2017 | Feedback received from those attending and evaluation confirms effectiveness of the multi-agency training<br><br>Survey of those receiving training confirms impact on practice | Improved awareness of potential safeguarding risk indications to ensure the protection and support for children who self-harm.<br><br>Strategic leaders are assured that services to support children at risk of self-harm (both in early stages and in serious cases) are effective | |
| 4.4 | HSCB to be assured that the current arrangements for the early identification of and the response for children and young people at risk of radicalisation are in place. | Andrew Simmons<br><br>William Jephson | Evaluation Report to be presented to the HSCB Strategic Board – March 2017 | Evaluation report to include clear identification of areas for improvement to improve outcomes for children, young people and families.<br><br>Number of referrals to Chanel panel | Improved awareness and understanding of radicalisation and referral pathways | |
| **Progress:** | | | | | | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
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| **Priority 5** | **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** | | | | | |
| 5.1 | Strengthen the voice and impact of children and young people in every aspect of the work of the HSCB. | Caroline Aitken<br><br>Phil Picton | All reports presented to the HSCB Strategic Board to include evidence of communication, consultation and engagement with children and young people. | Reports prepared and presented to the HSCB Strategic Board and Subgroups to include evidence of communication, consultation and engagement with children and young people. | Young People consulted and involved in the delivery and evaluation of services.<br><br>Strategic leaders will be assured that services to protect children are more fully taking into account the views and needs of children | |
| **Progress:** | | | | | | |
| 5.2 | Respond to issues identified in the training Needs Analysis, including consideration to ensure an appropriate level of training on:<br>- Children with disabilities<br>- Child Sexual Exploitation<br>- Neglect<br>- Toxic Trio<br>- Cultural Diversity | Mary Emson<br><br>Sheilagh Reavey | Report on the findings of the Training Needs Analysis to be presented to the HSCB Strategic Board in June 2016 | Comprehensive training needs analysis in place regarding multi-agency training provision<br><br>Report completed and presented to the HSCB Strategic Board in June 2016 to discuss recommendations. | Analysis of the multi-agency training needs of safeguarding processionals in Hertfordshire.<br><br>Safeguarding training will be provided to meet the needs of the | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
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| | | | | | partners and their workforce in an increasingly efficient and cost effective way | |
| **Progress:** | | | | | | |
| 5.3 | Further strengthen the quality assurance arrangements through the continued development of the multi-agency audit programme, scrutiny of individual agency performance and the robust scrutiny and challenge of performance data | John Hughes<br><br>Phil Picton | Three themed multi-agency audits to be completed by 31.03.2017 covering:<br>- Child in Need Plans<br>- Neglect<br>- Child Sexual Exploitation<br>- Domestic Abuse<br>All audits to include a proportionate number of disabled children cases and the board sponsor will be decided at the HSCB Executive Group<br><br>Multi-Agency audits to include the evaluation of supervision and management oversight, themes from case reviews | Audit confirms areas of effective practice and clearly identifies areas and plans for improvement<br><br>All HSCB Multi-Agency audits to include the evaluation of the voice of the child in case work, supervision and management oversight and themes from case reviews<br><br>Learning from audits disseminated | Professionals are increasingly aware of critical factors in improving safeguarding in Hertfordshire<br><br>Safeguarding of children will continually improve and respond appropriately to new issues<br><br>Strategic leaders are assured of the standard of safeguarding children min Hertfordshire and action needed to achieve improvement | |

# Appendix 5 Business Plan 2016-2017

Business Plan 2016-17

| | Action | Lead Person Responsible and Board Lead | Target Timescale and Milestones | Measures | Outcomes | RAG |
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| | | | and voice of the child<br><br>Section 11 audits to be completed by Hertfordshire County Council Directorates, Herts for Learning and Herts Catering<br><br>Review and progress against action plans in response to external scrutiny. | | | |
| 5.4 | Respond positively to any recommendations from the National Review of LSCB's (which reports in March 2016) and the planned central commissioning of some SCRs. The board and member agencies should continue to learn through different types of reviews | Caroline Aitken<br><br>Phil Picton | Plan developed in response to the recommendations from the National Review. | To be decided once the result of the review has been announced | HSCB and its partners will be at least compliant with national requirements for safeguarding children. | |