Halton Safeguarding Children Board

Annual Report 2011-12

Final Version
October 2012

CONTENTS

1. Foreword

Welcome to the Halton Safeguarding Children Board Annual Report 2011/2012. This report provides a picture of the work all agencies across the partnership have undertaken to safeguard and promote the welfare of vulnerable children and young people in Halton in the last year. It provides information on the achievements and progress of the objectives and priorities set out in the two year Business plan. In addition it identifies areas for future development.

The partnership which makes up the Safeguarding Board is wide ranging with strong representation by all agencies. We are proud that this partnership continues to prioritise safeguarding vulnerable children at a time of financial challenge accompanied by significant changes in organisations. We have recognised the need to continue to focus on the most vulnerable children and young people throughout the last year while meeting these challenges.

There have been changes in membership; this year the Board has had the benefit of two lay members who are local people. They are part of our local community and can advise the Board on how to engage local communities well so that we know what services can best meet needs. Lay members have contributed to this Annual Report which is a welcome development and provides interesting reading.

Early in the year we experienced year a sad loss due to the death of the lead member for children and young people, Councillor John Swain. As a member of the Safeguarding Children Board Councillor Swain made a great contribution to the partnership. He provided constructive challenge and a clear focus on the needs of vulnerable children and his input was of great value.

There have been achievements throughout the year; the development of multi agency audits which helps the Board understand how front line practitioners work with families and therefore identify training that is needed to strengthen this work is one good example. The developing work to understand child sexual exploitation has increasingly become a priority and during the year we have worked to make a strong start in this important area. The major achievement of the partnership, however, has been the continued, steady input and contribution of all those involved in what can be difficult complex work which rightly has a high public profile. This work and commitment is demonstrated by front line practitioners, lay members, managers, elected members and senior officers across all organisations involved with services for children and young people and their families in Halton. This strength will enable us to meet the challenges of the future including the need to work closely with the newly established Clinical Commissioning Groups and the Police and Crime Commissioner who will be elected in 2012.

I would like to thank everyone for all this work and commitment. I am confident that we will continue to work together next year with the same focus on providing good services for children, young people and families in Halton.

Audrey Williamson
Independent Chair
Halton Safeguarding Children Board

2. Introduction

The forming of a coalition government in May 2010 meant that a series of policy developments began to impact on the work of the Board in 2011-12. The final report of the Munro Review of Child Protection was published in May 2011. The Board considered the report and the Government's response at its Development Half Day in November. This included strong emphasis upon the importance of delivering the Early Help offer, with LSCBs being responsible for ensuring the effectiveness of Early Help.

2012-13 will see further implementation of the Munro recommendations including a revised *Working Together to Safeguard Children* guidance, out for consultation in summer 2012; and a revised inspection framework for 2012-13, followed by further revisions and implementation of a multi-inspectorate framework in 2013-14. Future inspections will focus upon the child's journey, the impact and effectiveness of multi-agency service delivery and the outcomes for children and families.

During 2011-12 the provider arm of Halton & St Helens NHS Trust was incorporated in to a new Community Healthcare Trust, Bridgewater CHT (Halton & St Helens Division). The commissioning arrangements were incorporated in to NHS Merseyside. The Board representation remained consistent during this time. Further changes to the commissioning arrangements will take place over the forthcoming year when two Clinical Commissioning Groups (CCGs) will take over commissioning from April 2013. The Board will be responsible for ensuring that effective safeguarding arrangements remain in place. A representative of the CCGs will also be invited to sit on the Board.

Halton's Health & Wellbeing Board has been established. The HSCB Chair sits on the Board. Governance arrangements between the two Boards will be considered as the role of the Health & Wellbeing Board develops.

The Board is well aware of the impact of the current financial climate on partners. Efficiency savings are in place across organisations. In order to consider the impact on staffing and safeguarding, the Board receives biannual workforce capacity reports from Children's Social Care, Community Health and the Police.

3. Accountability Arrangements:

In February 2011 Halton was subject to an inspection of Safeguarding and Looked After Children Services undertaken by Ofsted, in conjunction with the Care Quality Commission (CQC). The outcome of the inspection was that both safeguarding and looked after children services were deemed to be good with a number of outstanding features. The subsequent action plan was overseen jointly by the Board and Children's Trust. The resultant actions included Bridgewater CHT developing a system to identify staff development needs across the Trust, alongside a formal evaluation tool to assess the impact of safeguarding training, supporting a confident and competent workforce. All areas were signed off as having been completed at December's Main Board.

In November 2011 there was an unannounced inspection by Ofsted and HMIC of contact, referral and assessment arrangements. This was only the fourth such joint inspection in the country.

Following the recommendations within the Munro Review of Child Protection the protocol between Halton's Children's Trust and Halton Safeguarding Children Board was reviewed during 2011-12. The revised protocol underlines the responsibility of the Children's Trust to ensure that Early Help is available to children and families, whilst the Board's responsibility is to ensure the effectiveness of Early Help. The protocol also clearly states who represents the Children's Trust and HSCB at the respective Board meetings of each body. The revised protocol continues to ensure clarity about the distinct roles and responsibilities of each strategic body and to ensure effective local challenge of safeguarding arrangements in Halton.

From April 2011 the HSCB has had an Independent Chair, contracted to undertake this work by the Director of Children's Services on behalf of the Board. However, the Board continues to be chaired by Audrey Williamson, under contract to the Board, following her retirement from Halton Borough Council. This means that the Board has benefitted from consistent chairing, as well as the Chair being able to participate more fully in regional and national events for LSCB Chairs by working directly for the Board.

HSCB is a formal consultee of the Trust's Children & Young People's Plan. As such, HSCB ensures that the Plan gives priority to keeping children safe. The Board also provides information for the Joint Strategic Needs Assessment, within which the priorities of both the Safeguarding Children Board and Children's Trust are reported.

The Lead Member for Children's Services attends the HSCB Main Board as a participant observer. In addition, quarterly meetings are held between HBC Chief Executive, the Lead Member, Chair of HSCB and Director of Children's Services. This is so that the Chief Executive and Lead Member can ensure that there is an effective working relationship between the Children's Trust and HSCB, and that the Board is working effectively.

The HSCB Annual Report is formally presented to the Executive Board of Halton Borough Council to ensure that the elected members are informed of the work of the Board and the effectiveness of safeguarding arrangements in the borough. In addition, the Annual Report is also presented to the Safeguarding Adults Board, Health & Wellbeing Board, Clinical Commissioning Group and to the Chief Constable of Cheshire Constabulary.

4. Safeguarding Activity 2011-12

At the end of 2011-12 the level of Children in Need in Halton was 690.8 per 10,000 population. This was calculated on the number of open cases including children subject to Child Protection Plans, Children in Need and Care Leavers. This is a slight increase on the previous year. The rate remains above the national average, but significantly lower than the average for our statistical neighbours.

The Children in Care population has gradually decreased, reducing by approximately 3% since the end of March 2011. Whilst this indicates a slight reduction in the overall Children in Care population, the numbers entering the care system during 2011-12 showed an increase over the previous year from 53 children to 63 respectively.

At 31st March 2012 there were 124 children in care. This compares to 127 at the same point in 2011 and 147 in 2010. There are more males (59%) than females (41%) in care, in line with Halton's general population. The predominant ethnicity is White British, with 6% classed as other than White British. Over 87% are classed as not having a disability.

The average age of those entering care has increased to 7.5 years from 5.36 years. The average length of time in care has decreased to 3.87 years from 5 years, ranging in time from 3 days to 13 years. Analysis of entrants in to the care system indicates that for some children, had they received targeted early help and support then they may not have needed to come in to care. The Board sees scrutiny of the effectiveness of early help and support as a priority in the forthcoming year.

Approximately 69% of children in care are placed within foster care settings, with a further 19% placed in another family setting.

129 Child Protection Plans were commenced in 2011-12. For 12 children this was a second or subsequent Child Protection Plan. This has reduced the percentage below that of all comparators. 52 plans commenced due to emotional abuse or likelihood of emotional abuse; 49 were due to neglect or likelihood of neglect; 18 were due to likelihood of sexual abuse; and 10 were due to physical abuse or likelihood of physical abuse.

125 Child Protection Plans ended during this period, none of which had been in place for 2 years or more. The average time that children were subject to a Child Protection Plan was for 11 months, ranging from under 3 months to 22 months.

29 children moved in to Halton with Child Protection Plans in place from other local authorities and were given a temporary plan in Halton. Of these only 9 became subject of Child Protection Plans in Halton.

The Board receives quarterly information regarding attendance and reports provided to both Initial and Review Child Protection Conferences. Every Initial Child Protection Conference is attended by the Police, which the Board sees as good practice. Where agencies were unable to attend a conference, reports were submitted in most instances; where reports were not submitted this was addressed directly with the setting concerned and the reasons reported to the Board.

Submission of reports to both Initial and Review Conferences by GPs remains a focus of concern for the Board. In order to improve performance the Safeguarding Unit worked with Halton & St Helens PCT to develop a system to alert GP practices to requests for reports via a secure email system. Due to difficulties in setting up secure email accounts, the process did not come in to effect until October 2011. This appeared to improve the number of reports received for Initial Conferences during the final quarter of the year; however, the same quarter saw a reduction in the number of reports to Review Conferences. During 2011-12 GP reports were submitted to 38% of Initial Conferences and 47% of Review Conferences. The target is 100%. Therefore, this will continue to be an area of focus for the Board.

In some instances children may have additional needs which are not child protection related, or which if addressed at an early stage will prevent the need to refer to Children's Social Care at a later point. The child and family may need a range of supportive services to address these additional needs. The Common Assessment Framework (CAF) is a voluntary process, requiring informed consent of the family or young person, dependent upon age and understanding, whereby the child's needs can be assessed holistically, services delivered in a coordinated manner and reviewed regularly.

At the end of 2011-12 there were 233 open CAFs. This compares to 132 open CAFs at the end of March 2011. Over the year there has been an approximate 34% increase in the number of CAFs. However, whilst the number of open CAFs has increased in comparison to the previous year, there has been a reduction in the number of CAFs initiated. Therefore, CAFs are being closed at a lower rate than they are being initiated. The average length of time for a CAF to be open was 8 months, ranging in time from 1 month to 4 years.

Over 50% of all CAFs were initiated by educational settings. School staff made up the highest proportion of Lead Professionals, at 48%. In the final quarter of the year there was an increase in CAFs initiated for children aged 0-4 years which saw a corresponding increase in the number of Health Visitors in the Lead Professional role. However, although there was an increase in the number of health staff undertaking the Lead Professional role

due to the increase in CAFs this has meant a 1% reduction overall by the end of March 2012 to 6%.

A process to regularly audit CAFs is now embedded. The Board receives reports on CAF audits via the Scrutiny & Performance Sub Group.

Additional information can be found in the Board's Performance Report Card 2011-12 at Appendix C of this report.

5. Child Death Overview Panel (CDOP)

All Boards have a statutory requirement to review the circumstances of death of every child under the age of 18 years, who normally reside in the borough. This is in order to identify any issues that, if changed, could help to reduce the risk of deaths under similar circumstances in the future.

Halton's CDOP is a multi-agency group chaired by the Interim Director of Public Health, Dr Dympna Edwards. The core membership of the Panel includes: Public Health, Designated Doctor, Designated Nurse, Midwifery Services, 5 Boroughs Partnership NHS Trust, Cheshire Police, Halton Children's Social Care and Safeguarding Unit. The Board's Lay Members also attended the Panel for the first time this year. Other representatives from relevant agencies are invited to attend Panel meetings as required.

Preventable child deaths are defined as those in which modifiable factors may have contributed to the death. These are factors which, if changed, could reduce the risk of injury or death in other children, although we cannot say that they would have prevented this particular child from dying.

Parental Involvement in the CDOP

Every death is a tragedy for the family concerned, even where everything that could have been done has been done. All bereaved parents receive a letter and additional information explaining the Panel process. A practitioner currently working with the family hand delivers the letter to the parents, which provides an opportunity to answer any immediate questions regarding the process. In addition, parents can arrange to speak to the CDOP Chair should they wish.

Child Deaths

The Panel completed reviews on the deaths of seven children, from April 2011- March 2012. This was a reduction of six in comparison to the previous year. This included 3 deaths which had occurred in the previous year.

Using national guidance, the Panel considered whether any of the following factors may have contributed to children's deaths and whether they could be improved to reduce the risk in future:

- Factors intrinsic to the child - e.g. health issues, life limiting conditions

- Factors related to care or parenting
- Factors in the environment - e.g. hazards, road safety limits
- The delivery of services - e.g. delayed medical response.

The panel determined that modifiable factors which may have contributed to the child's death were present in only one case. The CDOP was satisfied that the learning points identified by the hospital involved in this case had been put in to place.

	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011 – March 2012
Number of Deaths	**14**	**12**	**14**	**4**
	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012
Number of Reviews	**9**	**14**	**13**	**7**

Category of death	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012
Deliberate inflicted injury, abuse or neglect	0	2	0	0
Suicide or Deliberate Self Inflicted Harm	0	0	1	0
Trauma & Other External Factors	1	1	1	0
Malignancy	0	1	0	0
Acute medical & surgical condition	0	0	1	0
Chronic medical condition	4	2	2	2
Chromosomal, Genetic or Congenital Anomalies	1	3	1	2
Perinatal/Neonatal Event	2	4	5	2
Infection	0	0	0	0
Sudden Unexpected, Unexplained Death	1	1	0	1
Total number of deaths reviewed	**9**	**14**	**13**	**7**

Ages of children who died	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012
0 - 27 days	3	4	5	3
28 – 364 days	3	5	3	2
1 year - 4 years	4	4	2	0
5 - 9 years	0	1	1	0
10 - 14 years	0	0	0	2
15 - 17 years	0	0	2	0

The number of child deaths in 2011-12 fell to the lowest number recorded since the CDOP was established in Halton. It is unclear as to the exact reasons for this at present. One possible factor is the reduction in smoking amongst women during pregnancy. However, given the low numbers of child deaths recorded annually, this may be a statistical anomaly rather than a continued downward trend. The CDOP will consider this in more detail during the forthcoming year.

6. Local Authority Designated Officer (LADO):

Each local authority has a Local Authority Designated Officer (LADO). The LADO must be informed of all allegations relating to adults who work with children whether they are a paid member of staff, foster carer or volunteer, where there is concern or an allegation that the person has:

- Behaved in a way that has harmed, or may have harmed, a child.
- Possibly committed a criminal offence against or related to a child; or
- Behave towards a child or children in a way that indicates they are unsuitable to work with children.

The LADO's role includes providing advice and guidance to employers and voluntary agencies; involvement in the management and oversight of individual cases; and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process. This is part of the process of ensuring that safer workforce practices are in place that safeguard children from individuals and practices which may be harmful. This process also safeguards staff by ensuring that malicious or unfounded allegations are thoroughly investigated And resolved in a timely manner.

36 allegations were reported to the LADO during 2011-12. This was a reduction on the previous year's figure of 41 reported cases. Professional misconduct and physical harm were the concerns most frequently reported. Professional misconduct refers to a professional's inappropriate response to young people and can involve behaviour in either their professional or personal lives. Physical harm is usually related to physical restraints

undertaken by professionals most often to prevent a young person from hurting themselves or others and are usually found to be lawful, necessary and proportionate. Occasionally inappropriate restraints are used, these are either inappropriate because the situation could have been managed differently or the method of restraint was inappropriate and may have or has caused an injury to the young person.

The majority of cases were resolved within one to three months. Two cases took 20 months to resolve. This is usually where there is an ongoing police investigation or due to lengthy disciplinary investigations.

LADO briefings to Headteachers are planned for 2012-13 in response to a request from schools due to a number of newly appointed Headteachers having been appointed across the borough. The briefings will also inform Headteachers of the revised guidance for school settings that will come in to practice during 2012.

The LADO has produced leaflets, to be distributed during 2012-13, for young people who have made an allegation, and for parents/carers of a child who has made an allegation, to explain what happens next. Both young people and parents were consulted over the content and presentation of the information. These were approved by the Safer Workforce Sub group. Work is underway on similar leaflets for adults who are the subject of allegations, advising them of the process.

7. Private Fostering:

LSCBs are expected to ensure that effective processes are in place to promote the notification of private fostering arrangements in their local area. This includes raising awareness amongst staff and the public of what constitutes a private fostering arrangement and the requirement to notify Children's Social Care. The local authority is required to provide an annual private fostering report to the Board, which the Board reviews and responds to any findings as necessary.

During 2011-12 one new Private Fostering arrangement was notified to Halton Borough Council. This was acted on appropriately within 7 working days, with visits to children taking place at least 6 weekly in line with Private Fostering regulations 2005. This was a reduction from 5 notifications in the previous year. Low numbers of Private Fostering notifications are in line with the national picture. As of 31st March 2012 there were no arrangements ongoing. The total number of Private Fostering arrangements that ended during 2011-12 was four; all had begun during 2010-11. A steering group oversees the Private Fostering action plan and awareness raising, reporting directly to the Board.

8. Engagement with Children& Young People and Parents/Carers:

Ensuring that the Board has an opportunity to hear the safeguarding concerns of children and young people and their parents and carers is important. It enables the Board to identify areas of work for focus in the future, and to shape the work of the Board over the forthcoming year. The Board also seeks the views of children and young people in the borough to inform responses to national consultations where appropriate in order to give them the opportunity to inform national policy and practice.

Lay Members and HSCB support staff attended a number of public events during the year. Some events were to publicise specific issues such as Safer Internet Day or Private Fostering week; other events were more generic, family events. As well as publicising the work of the Board and safeguarding messages, the events provided an opportunity to seek the views of Halton's parents, carers and children on what their safeguarding concerns were.

Halton Parents Forum worked with the HSCB Safeguarding Development Officer to review the HSCB Parenting Handbook. A range of parents from across the borough took part, with 5 parents conducting focus groups and surveys supported by staff from the Children's Centres. This information, alongside the views gathered from parents and carers attending community events will inform future materials for parents.

Prior to Safer Internet Day the Board undertook surveys of children & young people, parents/carers and practitioners on understanding of e-safety. The results of the survey helped to identify the focus of e-safety messages promoted across the borough. In addition, young people from the Youth Services' IT Crowd group designed an e-safety leaflet for parents/carers, highlighting e-safety messages that they felt carers should be alert to.

A group of care leavers provided their response to Ofsted's young people's survey on inspecting local authority children's services in September 2011.

The Board has worked with the Children's Trust to establish a joint Young People's Participation Group. The Young People's Participation Group comprised of a number of young people from a range of established groups. 15 young people attended a development session in August 2011 from: Ashley School, Bright Sparks/Halton Speak Out, Children in Care Council, Positive Activities Throughout Halton, Young Addaction, Youth Cabinet and Youth Offending Team. The group worked on terms of reference, identifying a name to convey the purpose of the group and key areas of focus.

Unfortunately, following initial impetus development of the group stalled. The Board will continue to seek to involve children and young people and parents/carers in its work. The challenge for the forthcoming year is to establish means for regular consultation with children and young people. Previous experience shows that the best response is when established participation groups are contacted directly by the Board, such as the response

to Ofsted's consultation by care leavers. However, we will also consider use of a variety of media including the use of social media, as we aim to get as broad and diverse an input as possible.

9. Lay Members

We became HSCB Lay Members in November 2010. This was at the time, a new requirement for all LSCB to recruit two Lay Members set out in 'Working Together to Safeguard Children, 2010'. This was an exciting, if somewhat daunting, new role. Since taking up our roles we have been supported by the HSCB support staff and mentors on the Board. After a thorough interview and selection process, we received induction and were invited to attend the Board's development day before attending our first Board meeting, where we were able to meet the Board members in a more informal setting. We were fully involved in all discussions at the development day and our views were listened to, valued and included.

Since becoming Lay Members we have attended meetings of the Board, Executive and all of the Sub groups. This really helped us to understand how the Board works and the range of work it undertakes.

We have also been involved in a variety of public events. This has included Safer Internet Day, where we talked to people who came to the Board's stall in Halton Lea shopping centre about e-safety. We also helped to distribute e-safety CDRoms and questionnaires to parents of pre-school children and had an excellent response. We undertook on the spot surveys with the public about Private Fostering to raise awareness of this issue and the need to notify Children's Social Care of such arrangements.

During the summer we attended public events such as Runcorn Carnival and family days in Children's Centres across the borough. This meant that we were able to speak to a variety of children, young people and parents/carers about any safeguarding concerns and issues they had within their community.

We feel it is important to meet people face to face, but recognise how difficult this can be when there are only two of us. We met with both primary and secondary school Head Teachers representatives on the Board to see how we could contact a wide range of children and parents with support from the schools, to ensure that the message that safeguarding children is everyone's responsibility is promoted amongst the community. The schools were welcoming and the meetings have gone well, we are hoping to plan future meetings and reach a wider audience from Early Years to College as we believe with the support of local educational facilities we will be better placed in promoting the work of the Board across the communities of Halton.

Marjorie Constantine & Yvonne Shelley, HSCB Lay Members

10. HSCB Sub Groups:

Scrutiny & Performance Sub Group

Reflecting the importance of the role of scrutiny in the work of the Board, the Scrutiny & Performance Sub Group established two additional meetings a year to solely focus upon the HSCB Performance Report Card. This provided the opportunity for lead officers to report to the Board on the narrative behind the key performance data, deepening the Board's understanding of the local picture and providing the Sub Group with an opportunity to challenge partners on what was being done to improve areas of poor performance. For example, the Sub Group raised concerns at the number of Early Years settings and registered childminders rated as 'satisfactory' by Ofsted. Lead Officers supporting the sector from the local authority reported to the Sub Group on how this was being addressed, and the Board has been able to support this work in to the forthcoming year by providing advice and guidance on developing safeguarding policies and procedures and training for the sector.

Policy & Procedures Sub Group

The Sub Group continued in its quality assurance role of providing detailed feedback to organisations submitting their safeguarding policies and procedures to the Board for ratification. The Sub Group also up-dated Halton's Practice Guidance which is linked to the Pan-Cheshire Multi-Agency Safeguarding Procedures, Joint Visiting Protocol and CAVA Protocol.

Training Sub Group

The Training Sub Group managed the HSCB multi-agency safeguarding training programme whereby 698 staff attended training. This included joint delivery of a Safeguarding Alerter training course delivered in conjunction with the Safeguarding Adults Board, where participants consider the implications of scenarios enacted by Geese Theatre. The Sub Group also produced a Safeguarding Children Induction Booklet to be used by anyone working with children & young people, parents/carers or the public in Halton.

The Training Sub Group completed a Safeguarding Training Needs Analysis to inform content of the 2012-13 training programme. The Sub Group also began the process of quality assuring safeguarding training courses of its partner agencies. In addition a process for measuring the impact of training on outcomes for children and young people was piloted. This has informed changes to the process of measuring the impact of training on outcomes for children and young people in the future, and to the process being broadened to include a wider range of multi-agency training during 2012-13.

Safer Workforce Sub Group

The Safer Recruitment Sub Group became the Safer Workforce Sub Group to reflect its broader remit. The Sub Group continues to report to both

Safeguarding Boards in Halton. Its terms of reference were also revised and additional members were identified from the Adult Residential and Daycare Provider Forums. Chairing arrangements rotated to the Adult Sector for the year.

The Sub Group approved safer recruitment procedures from a variety of organisations, as well as a Code of Conduct for Transport staff in the Local Authority.

E-Safety Sub Group

The E-Safety Sub Group moved to sit under the remit of the Children's Trust at the end of 2011, reporting directly to the Early Help & Support Strategic Group. Prior to this the Sub Group undertook e-safety surveys of children & young people, parents/carers and practitioners, agreed an Acceptable Use Policy and began planning for Safer Internet Day 2012. The Sub Group continues to report to HSCB on specific issues such as the annual Safer Internet Day which the Board continued to support via funding and providing support staff, including involvement of Lay Members at public events.

Safeguarding Unit Meeting and Safeguarding Children Operational Group (SCOG)

The aim of the Safeguarding Children Operational Group (SCOG) is to provide a multi-agency forum for operational managers to meet to discuss safeguarding practice, identifying areas where improvements in multi-agency working can be made and promoting good safeguarding practice. SCOG reports directly to the Safeguarding Unit meeting, which in turn reports to the HSCB Executive. Both SCOG and the Safeguarding Unit Meeting are chaired by the Divisional Manager for Safeguarding, Quality and Review.

Examples of the work undertaken by SCOG and the Safeguarding Unit meeting over the year include review and subsequent promotion of the Joint Visiting Protocol; reviewing the policy for referral of unborn children to Children's Social Care; and producing a pathway for Child Protection medicals in and out of hours. All of these pieces of work addressed problems encountered by one or more agency in undertaking safeguarding work.

11. Progress against Business Plan 2011-13:

Last year the Board moved to a two yearly rolling business plan model. The existing business plan was up-dated, and the additional priority areas – the effectiveness of Early Help, and the impact of Domestic Abuse on children & young people – were added.

1. Maintain structures for HSCB to enable it to fulfil its statutory functions and respond to local and national change.
Achievements in this area include:

- Review of the Board's structure leading to the E-Safety Sub Group moving to sit under the Children's Trust Early Help & Support Strategic Group, but continuing to report to the Board where appropriate
- Executive undertaking functions of Serious Incident Review Group
- Revised the protocol the Board has in place with the Children's Trust in order to reflect the responsibilities and accountabilities regarding Early Help.
- Continued to be a formal consultee of the Children & Young People's Plan.
- Developed a HSCB Communication & Participation Strategy

Areas for continued development include:

- Working with the Children's Trust and Safeguarding Adults Board to identify opportunities to join up workstreams and address any areas of duplication.

2. Provide comprehensive guidance for agencies and individuals which facilitates partnership working to safeguard children & young people.
Achievements in this area include:

- Revision of Halton's Practice Guidance.
- Ratification of a number of agencies' safeguarding policies.

Areas for continued development include:

- Policy & Procedure Sub Group to hold workshop on writing safeguarding policies & procedures.
- Coordinating review of safeguarding related policies and procedures for schools.

3. Support the development of a safe and informed workforce, including the Voluntary Sector.
Achievements in this area include:

- Dissemination of lessons learnt from Serious Case Reviews and Practice Learning Reviews.
- Completion of a safeguarding children Training Needs Analysis.
- Provision of revised Multi-Agency safeguarding children training programme.
- Piloting an evaluation process for single and multi-agency safeguarding children training that will measure the impact of training upon outcomes for children and young people.
- Developed a training quality assurance process for single agency safeguarding children training.

Areas for continued development include:

- Working with the Children's Trust to ensure that the workforce has the necessary capacity and skills mix to meet the needs of the Early Help offer.

4. Maintain a capability to scrutinise practice and procedure in both single and multi-agency settings.

Achievements in this area include:

- Completion of Section 11 audits of all children's commissioned services; subsequent action plans are monitored by the Children's Commissioning Team and reported to the Scrutiny & Performance Sub Group.
- Development of the Children's Services and Multi-Agency file audits to include the voice of the child.
- Introduction of 6 monthly challenge meetings of the Scrutiny & Performance Sub Group to oversee the HSCB Performance Report Card to ensure a broader multi-agency scrutiny of performance with more focus upon the impact of services on outcomes for children & young people.
- Ethnicity and diversity included in quarterly reports from the Lead Conference & Reviewing Manager .
- Revising the Serious Case Review procedures.
- Development of the Multi-Agency Practice and Learning Review process.

Areas for continued development include:

- Development of performance measures to scrutinise the effectiveness of Early Help.
- Development of performance measures to measure the impact of services on outcomes for children & young people affected by Domestic Abuse.
- Annual report on the impact of auditing within partner agencies.
- Undertaking S175/157 Audits with all schools in Halton.

5. Engage with children and young people, their families and communities in developing and promulgating the Safeguarding agenda.

Achievements in this area include:

- Attendance at community events with Lay Members to engage with children and parents/carers.
- The Children's Trust Parents' Forum leading on consultation on the HSCB Parenting Handbook.
- Developing a joint young people's participation group with the Children's Trust.

Areas for continued development include:

- Developing the role of the Lay Members to raise awareness amongst the community that safeguarding children is everyone's business and what to do if you have concerns about a child.

12. Areas for Future Development:

The following areas have been identified as priorities in 2012-13 to ensure the effective scrutiny of safeguarding arrangements in Halton:

Early Help:

The effectiveness of Early Help has been identified as a priority area for the Board in 2012-13. The Board will develop processes that will enable it to hold the Children's Trust to account on the effectiveness of Early Help in the borough.

The Board currently scrutinises the capacity and skills in the workforce to undertake the core business around child in need and child protection. The Board will work with the Children's Trust to ensure that the Workforce Strategy considers whether there is the necessary capacity and skills mix available to meet the needs of the Early Help offer. Reporting arrangements between the Children's Trust and Board will be strengthened in this area to ensure that the Board is kept appraised of progress against the Workforce Strategy.

Domestic Abuse:

The impact of Domestic Abuse on children and young people has been identified as a Board priority. Accountability arrangements are to be established with Halton Domestic Abuse Forum (HDAF) who are responsible for implementing the Domestic Abuse Strategy. The Board will work with HDAF to ensure that the impact of Domestic Abuse on children and young people is recognised and addressed via the strategy. Performance measures are to be established that will measure the impact of services on outcome for children and young people.

Child Sexual Exploitation:

Child Sexual Exploitation (CSE) has become a focus for government policy. The Board has already responded to the Office of the Children's Commissioner's initial call for evidence on CSE in gangs and groups. During the forthcoming year the Board will focus upon raising awareness amongst practitioners, children & young people, parents, carers and the public of this particular safeguarding issue.

NHS Reforms:

The Board will engage with the Clinical Commissioning Groups and identify how they will be represented on the Board from April 2012. Further work will be undertaken to ensure that GPs have the relevant skills and knowledge to undertake their safeguarding duties. Modular Working Together level 3 safeguarding training will be piloted to help facilitate attendance of GPs.

Effective and Efficient Board:

In recognition of the reduction in resources experienced across partners, the Board will work with the Children's Trust and the Safeguarding Adults Board to identify any duplication of business, and opportunities to bring workstreams

together. This will also include a review of membership. The Board will also consider how it can work more efficiently with the other Pan-Cheshire LSCBs.

Funding:

In order to continue its work the Safeguarding Children Board needs to remain solvent. A significant amount of the financial contributions to the Board comes from NHS Merseyside. However, from 2013 the Clinical Commissioning Group will take over commissioning arrangements from NHS Merseyside. Therefore the Board would seek agreement from the Clinical Commissioning Group to continue with this level of funding in Halton.

The government's policy regarding schools means that more schools will become academies, with others being established as free schools. Currently the Board receives financial contributions from maintained schools in the borough via the Dedicated Schools Grant. However, this contribution has reduced as more schools take on the status of academies, receiving their funding direct from government. Therefore, the Board will be considering proposals to seek similar financial contributions from academies and free schools in the borough in the future.

13. Budget:

Income 2011-12

AGENCY	**CONTRIBUTIONS**
HBC – Children & Enterprise Directorate	45,817
HBC - Schools	37,500
NHS Merseyside	45,817
Greater Merseyside Connexions	-1,359
Cheshire Constabulary	20, 000
Cheshire Probation	3, 230
Cafcass NW	550
Total for all agencies	**151,555**
CWDC (Munro Recommendations Implementation Grant)	13,000
Training Income	10,521
Carry Forward 2010-11	79, 030
Total Budget	**254,106**

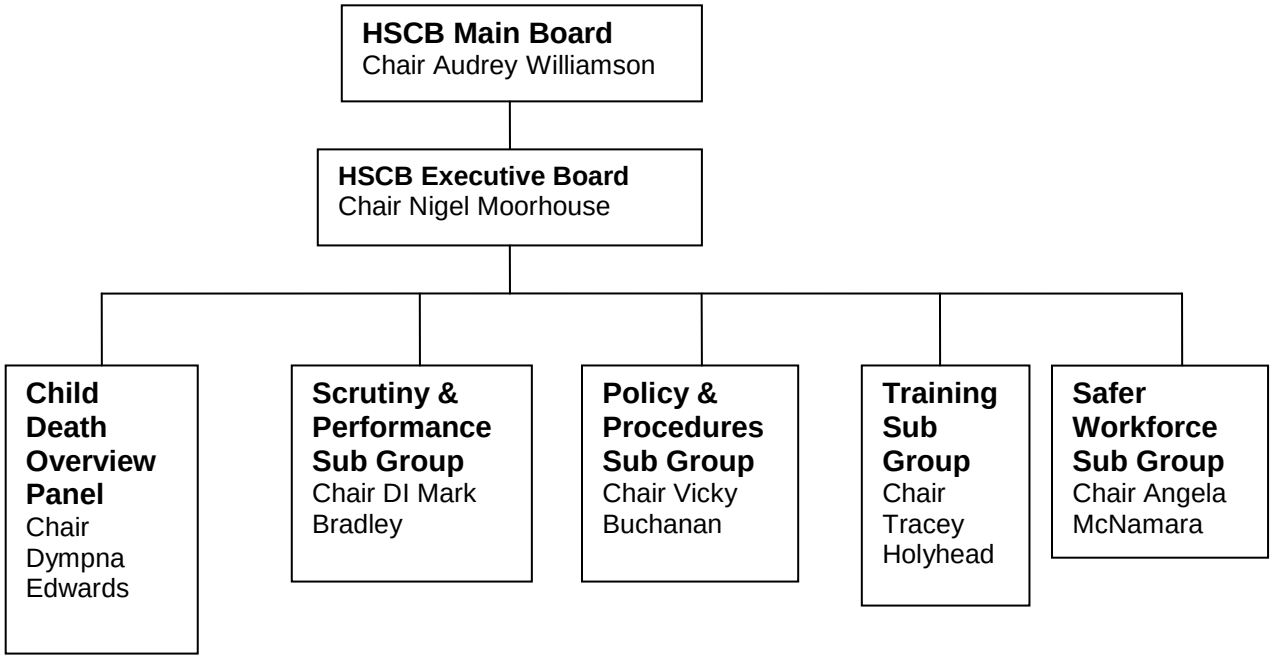
Expenditure 2011-12

Staffing: Chair Business Manager Safeguarding Development Officer	

Administration	81,001
Multi-Agency Training including Crucial Crew	8,069
Training including Travel Expenses	2, 212
Advertising & Marketing	9, 025
CDOP	380
Supplies & Services including: general computer expenditure, refreshments/room hire, postage, mobile phones, fixtures/fittings	2,627
Recharge/Overheads	39,970
TOTAL:	**143,284**
Carry Forward:	110,822

AGENCY	**CONTRIBUTIONS**
HBC – Children & Young People's Directorate	45,140
HBC - Schools	40, 000
Halton & St Helens PCT	45,140
Greater Merseyside Connexions	10, 609
Cheshire Constabulary	25, 000
Cheshire Probation	3, 183
Cafcass NW	550
Total for all agencies	**169, 622**
Child Death Review Grant	5, 667
Training Income	1, 185
Carry Forward 2009-10	73, 003
Total Budget	**249, 477**

Appendix A
HSCB Structure March 2012



Appendix B
HSCB Membership 2011-12:

Membership of all levels of Board as at 31st March 2012

HSCB Main Board

Name	Role	Agency
Audrey Williamson	Independent Chair, HSCB Main Board	
Mike Andrews	Community Safety Coordinator	Community Safety Team, HBC
Sarah Ashcroft	Domestic Abuse & Sexual Violence Coordinator	HBC
Stephen Bailey	Director of Student Services	Riverside College
Suprio Bhattacharyya	Designated Doctor	NHS Merseyside
Sarah Boycott	Superintendent	Cheshire Police
Mark Bradley	DI, Public Protection Unit	Cheshire Police
Michelle Bradshaw	Assistant Director Child & Family Services	Bridgewater CHT
Vicky Buchanan	Divisional Manager	Child & Family Services, HBC
Marj Constantine	Lay Member	
Gill Core	Director of Nursing, Midwifery	St Helens &

	& Governance	Knowsley Teaching Hospital NHS Trust
Steve Eastwood	Coordinator	
Dympna Edwards	Deputy Director of Public Health	NHS Merseyside
Ellis Gordon	Magistrate	
Ruth Gill	Solicitor	Legal, HBC
Tracey Holyhead	Manager	HSCB
Yvonne Yama	Children Services Manager	NSPCC
Catherine Johnson	Principal Improvement Officer	Performance & Improvement, HBC
Gareth Jones	Head of Service	Halton & Warrington YOT
Andrew Keeley	Head Teacher Rep – High Schools	St Chad's
John Kelly	Executive Director	5 Boroughs Partnership NHS Trust
Jane Lunt	Operational Director, Child & Family Commissioning	NHS Merseyside
Rosie Lyden	Safeguarding Training & Development Officer	HSCB
Niall McDonnell	Housing Forum Rep	Liverpool Housing Trust
Gerald Meehan	Strategic Director	C & YP, HBC
David Melia	Director of Nursing	Warrington & Halton Hospitals
Eileen Meredith	Enhanced Services Manager	Cafcass
Nigel Moorhouse	Operational Director	Child & Family Services, HBC
Steve Nyakatawa	Operational Director	Education, HBC
Marie Orrel		Cheshire Probation
Giles Orton	DCI, Strategic PPU	Cheshire Police
Vicky Pierce	Head Teacher Rep – Primary Schools	Fairfield Infants
Peter Richmond	Divisional Manager	Service Improvement, HBC
Yvonne Shelley	Lay Member	HSCB
Lindsay Smith	Divisional Manager	Adults & Community, HBC
Diane Sproson	Assistant Director	Connexions
Paula St Aubyn	Divisional Manager	Safeguarding, Quality & Review, HBC
Frances Stewart	Voluntary Sector Rep	HADWAA

Charlie Whelan	Designated Nurse Child Protection	NHS Merseyside
Dr. David Wilson	LMC Rep	

HSCB Executive Board

Name	Role	Agency
Nigel Moorhouse	Chair, Executive Board Operational Director	Child & Family Services, HBC
Mark Bradley	DI, PPU	Cheshire Police
Michelle Bradshaw	Assistant Director Child & Family Services	Bridgewater CHT
Vicky Buchanan	Divisional Manager	Children in Need, HBC
Gill Core	Director of Nursing, Midwifery & Governance	St Helens & Knowsley Teaching Hospital NHS Trust
Lorraine Crane	Divisional Manager	Integrated Youth Support & Commissioning HBC
Dympna Edwards	Deputy Director of Public Health	NHS Merseyside
David Holmes	Voluntary Sector Rep	ARCHinitiatives
Tracey Holyhead	Board Manager	HSCB
Jane Lunt	Operational Director, Child & Family Commissioning	NHS Merseyside
David Melia	Director of Nursing	Warrington & Halton Hospitals
Andy Smith	DCI	Cheshire Police
Lindsay Smith	Divisional Manager	Adults, HBC
Paula St Aubyn	Divisional Manager	Safeguarding Quality & Review, HBC
Charlie Whelan	Designated Nurse Safeguarding Children (Halton)	NHS Merseyside
Sharon Williams	Lead for Vulnerable Groups & Safeguarding	Education, HBC

Child Death Overview Panel

Name	Role	Agency
Dympna Edwards	Chair, Child Death Overview Panel Sub Group Interim Director of Public Health	NHS Merseyside
Suprio Bhattacharyya	Consultant Paediatrician	NHS Merseyside

Corina Casey – Hardman	Head of Midwifery	Bridgewater CHT
Carol Hill	Lead Independent Reviewing Manager	Safeguarding Unit, HBC
Tracey Holyhead	HSCB Board Manager	HSCB
Linda Kellie	Assistant Operational Director	5 Boroughs Partnership NHS Trust
Nigel Moorhouse	Operational Director	Child & Family Services, HBC
Andy Smith	DCI	Cheshire Police
Charlie Whelan	Designated Nurse	NHS Merseyside
Sharon Williams	Lead for Vulnerable Groups & Safeguarding	Education, HBC

Scrutiny & Performance Sub Group

Name	Role	Agency
Mark Bradley	Chair, Scrutiny & Performance Sub Group DI, PPU	Cheshire Police
Sarah Ashcroft	DASV Coordinator	HBC
Pauline Burke	Manager	YOT
Tom Cheadle	Service Manager	Cafcass
Tania Few	Named Nurse for Safeguarding	5 Boroughs Partnership NHS Trust
Tracey Holyhead	Manager	HSCB
Catherine Johnson	Principal Performance & Improvement Officer	HBC
Helen Moir	Divisional Manager	Adults, HBC
Nigel Moorhouse	Operational Director	Child & Family Services, HBC
Clare Myring	Children & Families Commissioner	Commissioning, HBC
Yvonne Shelley	Lay Member	HSCB
Paula StAubyn	Divisional Manager	Safeguarding, HBC
Sharon Williams	Lead for Vulnerable Groups & Safeguarding	Education, HBC

Policy and Procedures Sub Group

Name	Role	Agency
Charlie Whelan	Chair, Designated Nurse for Child Protection	NHS Merseyside
Jill Evans	Principal Manager, CCT3	C & YP, HBC
Kim Haste		5 Boroughs Partnership NHS

		Trust
Carol Hill	Lead Independent Review Manager	Safeguarding Unit, HBC
Tracey Holyhead	Manager	HSCB
Rosie Lyden	Training & Development Officer	HSCB
Nicola Young	Principal Manager, Think Family	C & YP HBC
Mark Tasker	DI, Strategic PPU	Cheshire Police
Sharon Williams	Lead for Vulnerable Groups & Safeguarding	Learning & Achievement

Training Sub Group

Name	Role	Agency
Tracey Holyhead	Chair	HSCB
Sarah Ashcroft	DASV Coordinator	HBC
Claire Dawes	Head Teacher Rep	Westfield Primary
Karen Dobson	Advanced Nurse Practitioner Safeguarding	5 Boroughs Partnership
Marie Fairbrother	Named Nurse Safeguarding	Bridgewater CHT
Brian Heywood		Cheshire Police
Brian Hilton	Manager	Learning & Development, HBC
Anna Hopwood	Team Leader, Student Welfare	Riverside College
Annie Lawrenson		Halton & St Helens VCA
Rosie Lyden	Safeguarding Development Officer	HSCB
Chris McMahon	Safeguarding Manager	ARCHinitiatives
Wendy Price	Early Years Support Officer	C & YP, HBC
Lynn Rimmer	Professional Development Manager	Connexions

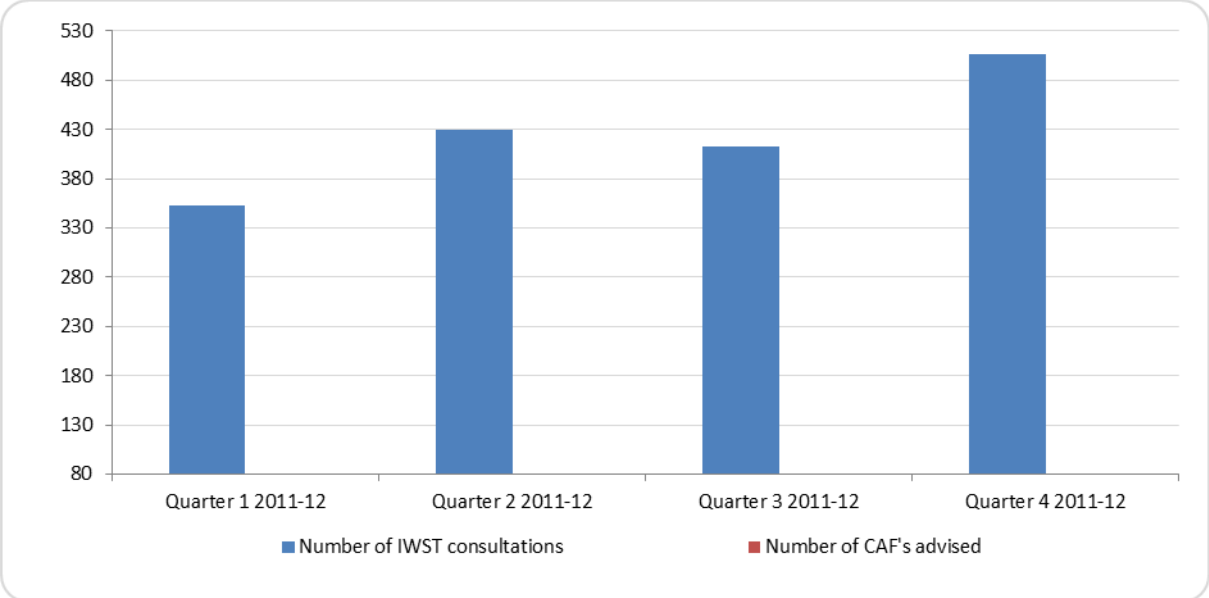
Safer Workforce Sub Group

Name	Role	Agency
Angela McNamara	Chair, Safer Workforce Sub Group Divisional Manager	Adults Commissioning, HBC
Dee Denton	Head Teacher Rep	Lunts Heath Primary School
Tracey Holyhead	Manager	HSCB
Claire Hunter	Principal Manager	C & YP, HBC
Joanne Lowe	Manager, HR	Warrington & Halton Hospitals
Julie McCollom	Employee Services Manager	HR, HBC
Clare Myring	Commissioning Manager	C&YP, HBC
Ann Rimmer	Recruitment	St Helens &

		Knowsley Hospital
Paula St Aubyn	Divisional Manager	Safeguarding, Quality and Review, HBC
Tania Strong	Senior HR Manager	Bridgewater CHT
Mark Tasker	Detective Inspector, Strategic PPU	Cheshire Police
Louise Tierney	Service Manager Cheshire Region, Continuum Group	Independent Providers (Children's)
Julie Weeks		Halton & St Helens

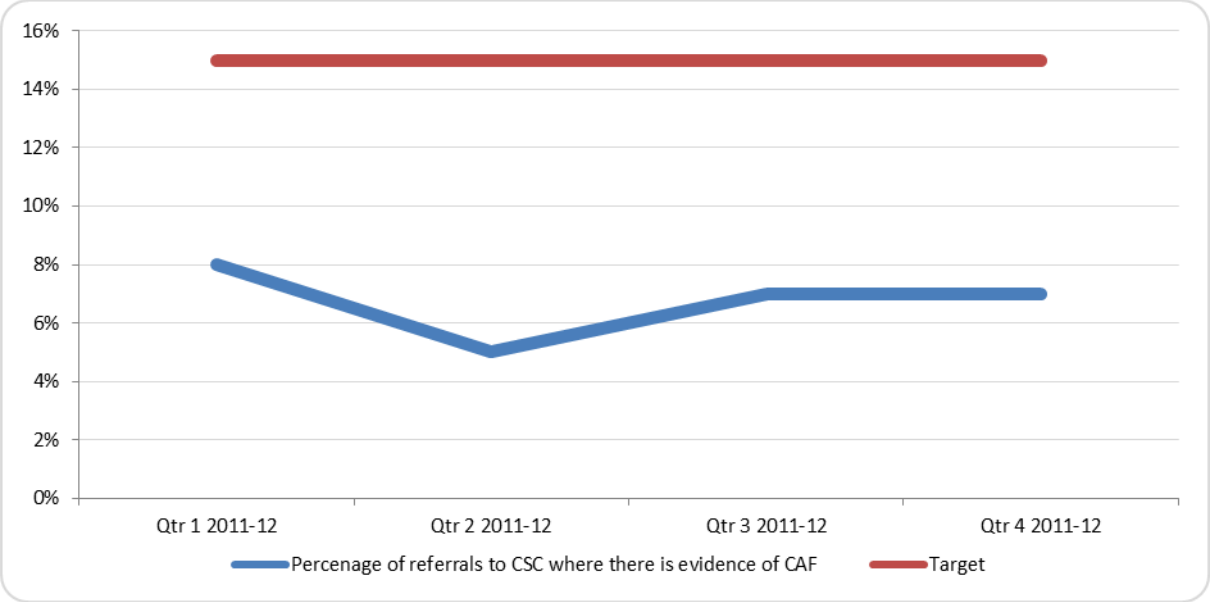
Appendix C
HSCB Performance Report Card 2011-12

Process Measures
Processes measuring the journey of the child, including the work of the Integrated Working Support Team, the escalation and de-escalation of cases to and from Children's Social Care

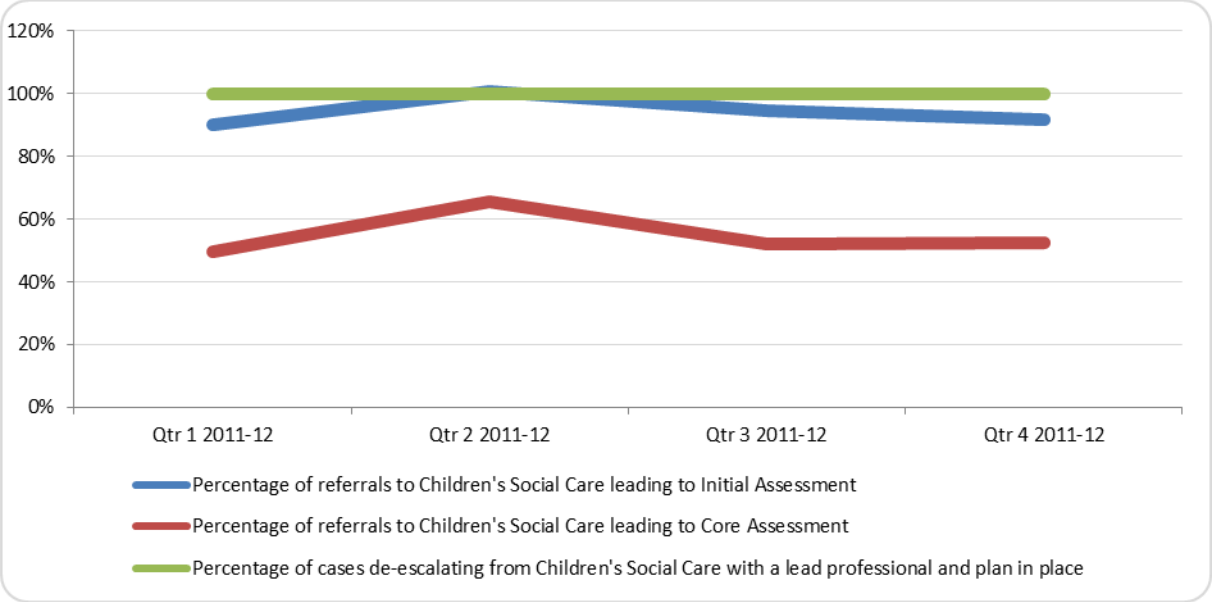


The Integrated Working Support team record consultations with other professionals. From October 2011 recording methods changed. Due to changes in recording there have been difficulties in calculating the number of CAF's advised as a result of the consultation. Work is ongoing to produce another way of accessing this information.

A further measure which could monitor the effectiveness of early help would be the number of CAF's initiated of those advised. Once the issues with data explained above are resolved this will be included above.



The percentage of referrals to Children's Social Care where there is evidence of CAF as a proxy for early help and support, has not met the target set for the year.



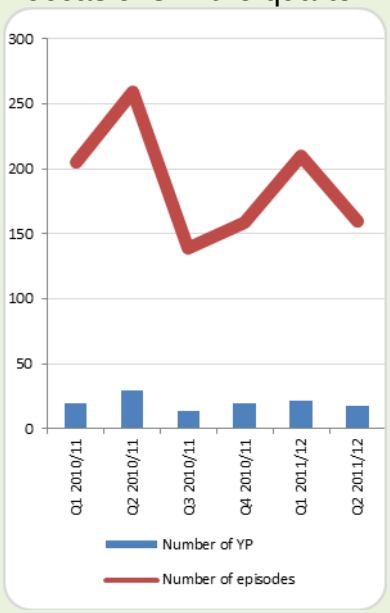
This chart details the percentage of referrals to Children's Social Care which continue to an Initial Assessment (90%+) or Core Assessment (50%+) which is a proxy for those cases where the referral is appropriately identified as at the correct level of need to warrant a thorough assessment of need and support through the statutory service.

The chart also details the percentage of cases de-escalating from social care where there is a requirement to have a lead professional and plan in place who have this. This has consistently been reported at 100% for the whole year through the management of these cases down the level of need by the identification of the lead professional at the final Child In Need Planning meeting.

Outcome Indicators
Indicators which measure the impact on the outcomes chosen as priorities

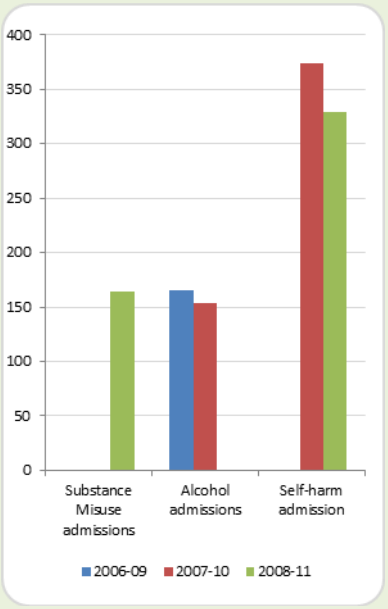
Children and Young People are protected from significant harm

Reduction in the number of children reported missing on more than 3 occasions in the quarter



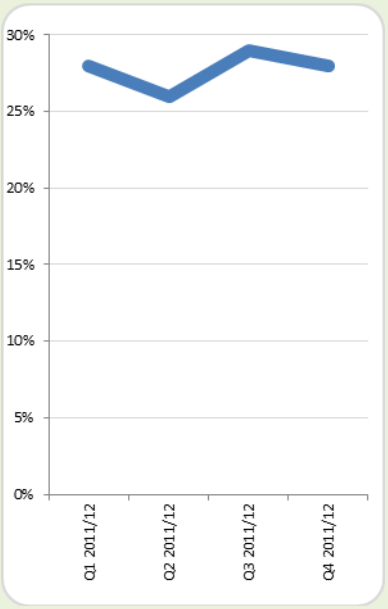
This data is in relation to the previous contract. Data for the new contract will be available in September 2012.

Reduction in hospital admissions related to self-harm, substance misuse or alcohol



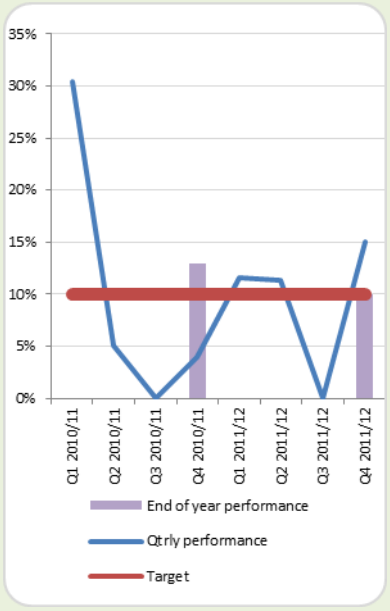
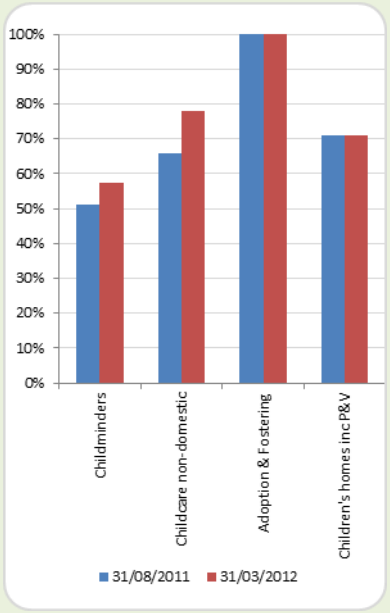
This data is taken from the published CHIMAT profiles. Locally produced and more recent data is currently awaited.

Reduction in the percentage of repeat MARAC



This data shows that performance fluctuated throughout the year and returned to the same level at the end of Q4 as the end of Q1.

Children and Young People who have been subject to significant harm are supported effectively and appropriately to prevent further harm

Reduce the percentage of children subject to a child protection plan for a second or subsequent time	Increase the percentage of all inspected services with good or outstanding overall judgment	Increase the percentage of schools who have completed their Section 175 Safeguarding Audits
		This is a proposed new measure that replaces the measure previously monitoring the schools and other educational establishments Stay Safe / safeguarding judgments which are no longer captured under the new inspection framework.
Whilst Halton's performance can vary across the year given the small numbers in the cohort Halton targets at 10% by the end of the year. This has been achieved for this year with 12 of the 129 children made subject to Child Protection Plans during the year for whom it was their second plan.	Performance is improving across the services in Early Years with a higher percentage of settings achieving good or outstanding for their latest inspections although there is still some progress to be made. Inspection frameworks have recently changed for Children's Homes and the impact of this will be seen in the next reporting period.	n/a

Performance Measures
Measures where performance will impact on the outcomes chosen as priorities

	2010/11	Q1	Q2	Q3	Q4	Target	Alert & DOT
Percentage of Initial Assessments completed within timescales (10 working days)	88.5%	78%	78%	74%	75%	85%	☒ ↘
Percentage of Core Assessments completed within timescales (35 working days)	89.6%	91%	85%	82%	86%	92%	☒ ↘
Percentage of Initial Child Protection Conferences held within 15 working days of S47 enquiry start	96%	90%	75%	50%	81%	100%	☒ ↘
Percentage of Initial Child Protection Conferences held within 15 working days of decision to hold a conference	100%	100%	100%	100%	100%	100%	☑ →
Percentage of Child Protection Plans that have lasted 2 years of more when ceasing	0%	0%	0%	0%	0%	0%	☑ →
Percentage of Child Protection Review Conferences held within timescale	100%	100%	100%	100%	100%	100%	☑ →
Percentage of Child Protection Initial Conferences with reports from GP's	46%	36%	50%	43%	75%	100%	☒ ↗
Percentage of Child Protection Review Conferences with reports from GP's	65%	27%	63%	51%	55%	100%	☒ ↘
Percentage of children and young people participating in the Children in Care process through their statutory reviews (age appropriate)	100%	100%	100%	100%	97%	100%	☒ ↘
Percentage of advocacy interventions where issues are resolved	New measure developed in line with contract for advocacy to measure the impact of advocacy for vulnerable children. This will be measured for future reporting years.						