Halton Safeguarding Children Board

Annual Report 2012-13

October 2013

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Halton Local Safeguarding Children Board (LSCB)
Safeguarding children is everyone's responsibility

Our priorities are:
To identify and prevent children suffering harm.
To protect children who are suffering, or are at risk of suffering harm.

1. Foreword

Welcome to Halton Local Safeguarding Children Board Annual Report. I hope you will find it useful in understanding the way all services in Halton work together to safeguard children who may be at risk of harm. This annual report is intended to provide information for a wide ranging audience including Halton residents and staff in all agencies responsible for safeguarding children and promoting their welfare.

The report sets out how the LSCB works; the structure and resources that support its work and the specific areas of work it must cover. These are important as all the professionals need to work together to make sure we have a skilled workforce supported by strong and effective working arrangements. It recognises the challenges faced by organisations in the current financial climate but which continue to make keeping children in Halton safe a priority.

The report provides information on how many children in Halton need protecting and require additional support, and how agencies have worked together to provide this support. The report highlights the achievements of the LSCB and identifies priorities for future work. It shows how we continue to scrutinise and challenge the work of partner agencies and promote a culture of openness and learning. By doing this we seek to improve the safety and well being of the children of Halton.

Finally I would like to take this opportunity to thank the small team which supports the LSCB for all its work this year and all those staff across Halton who work so hard in this difficult and complex area; they are central to keeping children and young people safe in Halton.

Audrey Williamson
Independent Chair
Halton Local Safeguarding Children Board

2. Chair's Executive Summary

Halton is a largely urban area of 125,700 people. Its two biggest settlements are Widnes and Runcorn that face each other across the River Mersey, 10

miles upstream from Liverpool. The population of Halton was in decline for over a decade, but has recently started to increase, projected to grow to 129,300 in 2021. Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. Deprivation has stayed relatively level in the Borough over recent years.

There are 24,900 children and young people living in Halton. This is 20% of the population. The LSCB is responsible for coordinating and ensuring the effectiveness of services in Halton in safeguarding and promoting the welfare of children and young people.

The LSCB has strong governance arrangements and is well positioned to influence partnerships across Halton. The Chair has a seat on both the Health and Wellbeing Board and the Children's Trust Board. Last year's LSCB Annual Report was presented at both of these partnerships and was well received. There is a good understanding of the role and responsibilities of the LSCB.

There have been significant NHS reforms; Halton's Clinical Commissioning Group (CCG) is now in place and the accountability and assurance framework outlining arrangements to secure children's and adult safeguarding in the future NHS has been published. Shadow arrangements during 2012-2013 ensured that this year the new CCG could play a strong role in the LSCB which has been welcomed.

Responsibility for Public Health services has transferred to the Local Authority. This offers opportunities to focus on specific services, for example commissioning School Health provision to better focus on services for vulnerable children. Increasingly Public Health will play a strong role in the work of the LSCB and inform the Joint Strategic Needs Assessment on the needs of vulnerable children.

The government continues to implement policy changes which may affect children, the full impact of the Welfare Reforms will be felt in 2013-14. The LSCB and its partners are concerned at the potential impact this will have on families in the borough, and how this could lead to an increase in demand for services. The government continues to progress with significant welfare reform and the LSCB expects all agencies to monitor and consider the impact of the reforms and the possible impact in its reporting.

The government published the revised version of Working Together guidance at the end of March 2013. This guidance sets out clear expectations of the role and functions of the LSCB and re-emphasises the importance of the role of multi-agency work to protect children, the importance of the LSCB's role in monitoring the effectiveness of that work and the development of a single assessment to replace the current initial and core assessment. The LSCB has instigated plans to ensure that it fulfils these requirements throughout 2013/14.

The LSCB will continue to constructively scrutinise the capacity of agencies to deliver high quality services that meet the needs of vulnerable children. The LSCB regularly receives reports from key agencies detailing capacity and potential gaps in service. One particular area of focus has been the capacity of Children's Social Care services to recruit permanent managers for operational teams. The LSCB recognises there is a plan in place to address this and will continue to monitor to assure itself that social workers are receiving the appropriate quality supervision with manageable caseloads.

One of the primary roles of the LSCB is to scrutinise and assess the performance and effectiveness of local services in safeguarding children. This is undertaken in a range of ways, for example it receives regular and detailed reports on the outcomes of multi-agency audits of cases. There is strong participation from practitioners across all agencies in undertaking this work increasing the learning and identification of both good practice and areas for development. This year there was increased involvement of families to ensure that managers and practitioners hear directly the experiences of families receiving services. The audit tool used by Children & Families Services to undertake their audits has been well designed and has been recognised by Ofsted as an effective way of scrutinising complex work.

Through audits the LSCB noted a consistent theme regarding difficulties of timely distribution of notes by Children's Social Care from a range of safeguarding meetings, following challenge to Children's Social Care they responded with additional administrative resources. This positively impacts on supporting families and partners to have written clarity on reasons for involvement and measurable plans.

LSCB members met practitioners across the partnership at the annual LSCB and Children's Trust Frontline Event. In 2012/13 we learned how thresholds and levels of need were used in everyday practice. It was identified that more work was needed to increase understanding across the partnership and as a result the Levels of Need guidance was revised and strengthened.

The LSCB recognises the importance of early help to meet the needs of children and preventing the need for intervention at a later stage. Early help for young children is developing well; the challenge now is to ensure this extends to meet the needs of older children at an early stage. The LSCB has recognised that there are growing numbers of older children requiring care who may have benefitted from earlier intervention and support. The LSCB will scrutinise services for children who do not yet meet the threshold for services from Children's Social Care. It will also increase its scrutiny of outcomes for older Children in Care and those who leave the care system.

The expected multi-agency inspection framework has been put on hold and the government is consulting on a revised inspection framework for children in need of help and protection, children looked after and care leavers. This will include reviewing the effectiveness of the LSCB. The LSCB has recognised the need to strengthen its understanding of its impact and effectiveness in

improving safeguarding services for vulnerable children in Halton. As a result the LSCB has:

- Undertaken frontline visits to staff, with the objective of developing an understanding of each other's roles and responsibilities.
- Tested out the understanding of the Escalation Policy to ensure agencies can challenge and resolve differences in order that children receive the right services at the right time.
- Established an action plan to address the findings from this exercise and to strengthen links between frontline staff and LSCB members
- Started to strengthen the performance framework to increase its scrutiny function
- Recognised the need to increase learning from case reviews. While the Executive group has led on this area increased capacity to enhance learning and reflective practice across the partnership is required and will be put in place this year

Finally the LSCB looks at outcomes for particular groups of children, ensuring that gaps in services are identified and addressed. These include:

- Children at risk of sexual exploitation. The LSCB has established an Operational Group as a forum for multi-agency information sharing on potential victims, perpetrators and community areas of activity to help its understanding of the scope and profile of child sexual exploitation.
- Children who experience domestic abuse in the home. The LSCB has identified the lack of service for this group of children and welcomed the response by the Children's Trust in commissioning services. A perpetrator programme is being piloted in the autumn of 2013 and a service to support children and parents directly affected by the impact of domestic abuse will also begin then.
- Children in Care both those who live in Halton and those placed by other Local Authorities. The LSCB recognises that these children may be particularly vulnerable and have a range of needs including health needs which must be met. The LSCB will increase its focus on services for those groups in addition to services for care leavers in the coming year.

During this last year the LSCB has experienced a significant change in organisations; this has meant a change in LSCB representation and the need to form new partnerships. Despite the change in personnel attending the LSCB, partners have continued to engage in its work enabling the LSCB to continue to offer strong leadership across the partnership to carry out its role in ensuring a coordinated approach in delivering services to children in need of safeguarding.

3. Accountability Arrangements:

The LSCB continues to have an Independent Chair, who has been a consistent presence, chairing the LSCB since 2006. The Chair is an active participant in the LSCB Chairs' network meetings at a Cheshire & Merseyside, North West and national level. This benefits the LSCB in that we are able to

share good practice with other LSCBs and enter into collaborative working arrangements. For example, a planned event for the Cheshire & Merseyside LSCBs to launch the joint Child Sexual Exploitation Strategy; a joint arrangement to have a CSE data post across the four Cheshire LSCBs.

The Chair also ensures that she visits the Social Work Duty Service to observe practice and enable staff to raise any operational concerns. This provides an opportunity to understand the pressures at the frontline first hand. For example, social workers raised concerns about additional support services for families where domestic abuse is identified which the Chair raised at the LSCB. As a result, the Halton Domestic Abuse Forum is leading on the commissioning of services for children and adult victims, and a programme for non-statutory perpetrators.

During 2012-13 reporting arrangements between the Children's Trust and the LSCB were revised to ensure greater challenge between the two. The LSCB presents a report to the Trust on areas of challenge which the Trust formally responds to. Examples of the areas identified through this challenge reporting include commissioning Domestic Abuse services; the potential duplication of scrutiny of commissioning; and Workforce Strategy.

The LSCB is a formal consultee of the Trust's Children & Young People's Plan. As such, the LSCB ensures that the Plan gives priority to keeping children safe. The LSCB 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 LSCB Main Board as a participant observer. In addition, quarterly meetings are held between the Local Authority's Chief Executive, the Lead Member, Chair of the LSCB 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 LSCB, and that the LSCB is working effectively.

The LSCB Annual Report is formally presented to the Executive Board of the Local Authority to ensure that the elected members are informed of the work of the LSCB 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 and Police & Crime Commissioner of Cheshire Constabulary.

4. Safeguarding Activity 2012-13

How Safe are our Children & Young People in Halton?

All services and the community in Halton need to be vigilant in reporting concerns where they think that a child may be at risk of harm. We also need to ensure that children are provided with opportunities to speak out when they are at risk, or are being harmed. Specialist services such as Children's Social

Care and the Police can only intervene to protect children if they are alerted to concerns. The following information regards children and young people in Halton who have been identified by the Local Authority and partner agencies as being in need of safeguarding.

During 2012-13 the level of Children in Need in Halton was 566.7 per 10,000 population. This was calculated on the number of open cases including children subject to Child Protection Plans, Children in Need, Care Leavers and those receiving an assessment. This is a slight reduction on the previous year (646). The rate is below the national average (652 2011/12), and significantly lower than the average for similar and statistical neighbours (726 2011/12).

The LSCB scrutinises the impact and effectiveness of early help and the contacts and referrals received by Children's Social Care to ensure that thresholds are being applied appropriately. In order to address the low rates of Child Protection Plans and Children in Need Children's Social Care will be reporting upon a range of activity and its impact over the forthcoming year to the LSCB as a priority area for improvement. This includes an audit of contacts and referrals, revision of the Contact and Referral process and implementation of a single frontdoor to ensure appropriate management of contacts and referrals at that point. Work will also be undertaken between Children's Social Care managers and the police to review how s47 enquiries and strategy discussions are recorded to raise the profile of risk assessment and analysis.

Additional information can be found in the Board's Performance Report Card 2012-13 at Appendix C of this report. An addendum to the Annual Report will be published in January 2014 following the publication of national comparator data; this will provide a picture of how Halton compares both nationally and with similar authorities.

Children with a Child Protection Plan

Children become subject of a Child Protection Plan when it has been identified that they are in need of protection from either neglect, physical, sexual or emotional abuse. Only children who are the most vulnerable have child protection plans.

114 Child Protection Plans were commenced in 2012-13. For 2 children this was a second or subsequent Child Protection Plan. The numbers of Plans are amongst the lowest proportion nationally, and are lower than those of comparator local authorities. The LSCB continues to receive quantative and qualitative data in order to challenge Children's Social Care on this. The LSCB has noted that the number of children subject to Child Protection Plans and Children in Care are now increasing.

Category of Abuse for Child Protection Plans:

	2010-11	2011-12	2012-13
Neglect	44%	38%	38%
Sexual	3%	10%	10%
Physical	22%	13%	9%
Emotional	31%	39%	43%
Mixed			4%

NB Children may change category of abuse during the course of the plan and therefore may appear in more than one category:

The data regarding category of abuse in Child Protection Plans open at the end of the year shows a reduction in the percentage of Plans under the category of neglect. As this reduction has been sustained, it indicates the impact of early help and support in Halton. The increase in Plans due to emotional abuse reflects the need to protect children living in households where they are at risk of harm due to domestic abuse. This informed the LSCB's decision to identify the impact of domestic abuse on children and young people in the borough as a priority and challenging the Children's Trust on the lack of service provision for children and families.

41 children moved in to Halton with Child Protection Plans in place from other local authorities and were given a temporary plan in Halton. The majority return to the area they came from. For all those children who remained resident in Halton a transfer conference was convened within the national timescale.

The LSCB receives quarterly information regarding agencies' attendance at and reports provided to Initial and Review Child Protection Conferences in line with the required standards. Further work needs to be progressed with all agencies to ensure that these standards are recognised and adhered to. 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 agency concerned by the Safeguarding Unit.

In recognition of the need to improve in this area, a focus group has been working across Halton, Cheshire West & Chester and Warrington to consider ways to better support greater involvement of GPs at conference; this will now include the Lead GP for Safeguarding within NHS Halton CCG. Current statistics evidence that GP's submitted reports to 51% of Initial Conferences and 49% of Review Conferences: these figures represent an upward trend but are not at the level required by the LSCB. This will continue to be an area of scrutiny for the LSCB, overseen by the Scrutiny & Performance Sub Group, with quarterly reporting from the Safeguarding Unit.

Children in Care

At 31st March 2013 there were 145 Children in Care. This was an increase of 17% from April 2012 to March 2013. In particular there has been a significant

increase in the numbers of older children being admitted to care, aged 11 years or over.

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 LSCB sees scrutiny of the effectiveness of early help and support as a priority in the forthcoming year, and has directed the Children's Trust to examine how multi-agency early help is coordinated for older children.

The average length of time in care has decreased to 3.4 years from 3.8 years, ranging in time from 2 days to 17 years. This indicates that good permanency planning is in place for these children.

Approximately 70% of Children in Care are placed within foster care settings, with a further 13% placed in another family setting. At 31st March 2013 14 young people were placed with external residential care providers. Of those 1 young person was placed within an independent children's home in Halton; 7 were placed within 20 miles of the borough and 6 were placed over 20 miles from the borough. Of those, 1 young person was placed within a secure welfare placement; 1 in a Young Offenders Institution; and the remaining 4 were living in placements to meet their specific needs. This is good performance and recognises the need for Halton children to remain close to their communities.

The LSCB receives regular reports on Children in Care to ensure the effectiveness of safeguarding arrangements for this particularly vulnerable group. The LSCB has asked the Children's Trust to focus upon this group of children and young people as a priority area. The Trust is currently revising its structures to ensure robust oversight of this group of children and young people via the Children in Care Partnership Board.

Children in Care of Other Local Authorities (CiCOLA)

Some children living in Halton are Children in Care of other local authorities; this means that they live in foster care placements, independent children's homes or within a Leaving Care / Semi Independent placement where the placement has been arranged by another local authority.

At the end of the year there were 138 such children living in Halton. It is notable that the number of children living in Halton from boroughs in other parts of the country has reduced significantly. This is due to a number of factors including the impact of the sufficiency duty that requires local authorities to place children within 20 miles of their home unless there are specific circumstances that mean this is not an option. In addition Halton's Integrated Commissioning Manager has worked with the Planning Department to confirm that providers have appropriate permissions to operate; shared information with local providers regarding Halton's requirements; and liaised

with the Missing from Care Service, Police, Youth Offending Service and shared qualitative information on placements with placing local authorities.

This has led to a reduction in independent children's homes in the borough of 20% - from 15 homes to 12 – and a reduction in the number of placements (beds) of 29% - from 37 to 26. Planning permission for a new four-bedded children's home in Halton has also been refused. The reduction in children's homes in Halton is the opposite of the national trend that indicates a 10% increase in the number of independent children's homes.

This is beneficial in that fewer children are being placed in the borough more than 20 miles from their own homes. Also, the needs of these children can have a significant impact upon local provision as these children often have specific needs and vulnerabilities that impact on services such as the Police, Child & Adolescent Mental Health Service, Education, Housing and Youth Offending Service.

Children Missing from Home & Care

Missing children are vulnerable to a number of risks, including sexual exploitation. Identification and access to appropriate services for missing children is important. The Pan-Cheshire Missing from Home & Care Protocol has improved identification and service response to children, ensuring clear definitions of missing and absence are understood by agencies. This has meant that the Police no longer receive inappropriate referrals such as where a Child in Care is late coming home, but their whereabouts are known.

Halton leads on behalf of the Pan-Cheshire local authorities on commissioning of the Missing from Home Service provided by Catch 22. In previous years there had been a high number of missing incidents relating to CiCOLAs who were going missing on multiple occasions. Targeted work has reduced this and in 2012-13 the majority of children reported as missing in Halton were missing from home (58%).

Catch 22 undertake return interviews following missing incidents. From this we can identify the reasons children state for going missing and the areas where they go to. The most frequent reasons for going missing were reported as family conflict, boredom & socialising, to see family and peer pressure.

Halton accounted for 30% of total missing incidents reported to Catch 22 which was the highest percentage across Cheshire. However, this appeared to be due to appropriate identification and referral to the service in comparison with other areas within Cheshire. Early reporting during 2013-14 appears to reflect this with other areas showing an increase in referrals compared to Halton.

The LSCB has requested that Catch 22 undertake further analysis of the age of children referred to the service as it appears to be lower than the Pan-Cheshire average. End of year reporting in Halton stated that the average age was 13 -14 years.

Children who are Adopted

The government has identified adoption as an area of focus nationally in order to increase the number of children adopted, whilst also reducing the length of time for an adoption to take place. Stringent levels of performance have been set for local authorities resulting in a number failing to reach standards. This has not been the case in Halton. The number of adoptions from care during the reporting period was 35. The average time between a child entering care and moving in with their adoptive family was 567 days which is better than the England average of 636 days and is shorter than the threshold set by government.

Early Help and Support in Halton

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 2012-13 there were 315 open CAFs in Halton. This compares to 233 open CAFs at the end of March 2012 and 132 at the end of March 2011. Over the year there has been an approximate 26% increase in the number of CAFs.

This has been helped by the development and launch of Halton Children's Trust's Early Help Strategy. The impact has been that all partners are aware of Halton's priorities, which facilitates working more effectively across the workforce, as well as reinforcing the Common Assessment Framework and the importance of the Lead Professional. The introduction of the revised Halton Levels of Need Framework developed with the support and involvement of all relevant stakeholders across the partnership has meant clearer direction for the workforce to reach decisions about the level of a safeguarding need a child may require in a single or multi agency context. At times where further support is required in more complex cases the Early Help Panel has been developed to provide a forum where staff can receive support and share information to be more effective in helping families they are involved with and creating seamless services for them.

The continued development of co-location arrangements for multi-agency practitioners has been a priority for Halton. Successful co-location at Warrington Road Children's Centre working within the Early Help & Support model has allowed for testing out improved ways of working towards better outcomes for families, evidenced by increased cooperation and communication between teams at case and service level. This has prompted

further co-location by developing a similar model at Kingsway Learning Centre.

A process to regularly audit CAFs is now embedded, and CAFs are also included in the multi-agency practice audits. The LSCB receives reports on CAF audits via the Scrutiny & Performance Sub Group. Findings from audit activity are reported in the next section: Learning from Practice.

4. Learning from Practice

LSCBs are required to consider holding a Serious Case Review when abuse or neglect is known or suspected to be a factor in a child's death, life threatening injury or serious sexual abuse, and there are concerns about how professionals may have worked together. The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result; and
- As a consequence, improve multi-agency working when it comes to protecting children.

In some cases, the criteria for holding a Serious Case Review may not have been met but a review of the case may provide an opportunity to identify learning. Under such circumstances the LSCB will consider undertaking a Practice Learning Review.

During the year there were no Serious Case Reviews either commissioned or ongoing from previous years. Two Practice Learning Reviews were concluded, and the LSCB will scrutinise how learning has been embedded in practice from these during 2013-14.

Learning from Halton's Practice Learning Reviews:

The Practice Learning Reviews identified learning as:

- Missed opportunities to analyse the significance of an increasing number of domestic abuse incidents
- Missed opportunity to initiate a Core Assessment where a detailed analysis of the children's needs could have taken place
- Missed opportunities for agencies to use the LSCB Escalation Policy
- Improvements to be made in the frequency of supervision and management oversight of social workers
- The need to review agency procedures on risk management and escalation
- Good communication was identified in one case both between Children's Social Care, Midwifery and Health Visiting Services in Halton and across borders with another area

Child Death Overview Panel:

The LSCB's Child Death Overview Panel reviews all cases where a child died before their 18th birthday. The death may have been expected, such as where the child had a life limiting condition; or may have been unexpected or accidental, for instance sudden infant death or suicide. In 2012-13 there were five child deaths of Halton children; this was an increase of one compared with 2011-12 but continues to be lower than previous years. A full report from the Child Death Overview Panel is at Appendix D.

Audit Activity:

The LSCB also receives reports on audit activity which supports its objective to scrutinise the effectiveness of the work of partners to safeguard and promote the welfare of children. Audits of practice also provide an opportunity to assess how well the lessons from learning and improvement activity including Serious Case Reviews, Practice Learning Reviews and the Child Death Review process have been embedded into frontline practice.

During 2012-13 the LSCB received reports on audit activity in relation to the Common Assessment Framework (CAF), Children & Family Services cases, Children & Family Services supervision practice, in addition to the three Multi-Agency practice audits undertaken by the LSCB.

No of cases audited per cohort

Category of audit case	Grand Total	Cohort population	% of cohort audited
Adopters	4	17	24
Child in Care	27	130	21
Child in Need	52	624	8
Child Protection	12	95	13
Contact	48	972	5
Family Support	35	305	11
Fosterer	4	78	5
Private Fostering	1	1	100
CAF	39	292	13
Supervision Audits	19	123	15

Findings from audit activity led to:

- Workshops for staff in the Children & Families Service on communication and use of direct work tools with children, with auditors subsequently finding that individual practitioners were able to readily discuss the daily lived experience of individual children they were working with.
- Revisions to the School Health Service safeguarding assessment tool to include the requirement to record the child's views and wishes.
- The Midwifery Service revising their risk assessment tool to include a focus on social needs.

- No children were identified as having been left at risk of significant harm.

The focus for audit activity in 2013-14 will be:

- To increase the number of contributions from the child and family in the audit processes.
- To increase the multi-agency audit activity, including practitioner focus groups.
- To receive more information from partner agencies about their auditing activity, its impact and effectiveness.
- To revisit previous practice or process recommendations in order to evidence that improvements have been embedded.
- To disseminate identified good practice widely across the workforce.
- To ensure that the recommendations and themes identified from any Practice Learning Reviews are fed into the auditing process.

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 may pose a risk of harm to children.

The LADO's role includes providing advice and guidance to employers and voluntary agencies; management and oversight of individual cases; 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.

39 allegations were reported to the LADO during 2012-13, compared with 36 in the previous year.

The LADO noted an increasing number of consultations and allegations made against professionals who are using Facebook and other social media sites to make contact with young people. This has highlighted that a number of organisations do not require staff to sign a code of conduct regarding contact with children and young people outside the work setting, including via social media. The LSCB will therefore be advising all agencies to ensure that staff, including volunteers, are made aware of expectations of behaviour at the point of induction and regularly thereafter.

The LADO undertook briefings to Head Teachers in 2012-13 in response to a request from schools. This was coordinated by the primary school Headteacher representative on the Board. 40 Head Teachers attended. The LADO also undertook briefing sessions with school governors and the Children's Independent Provider Forum.

The LADO made a number of recommendations to the LSCB in their annual report which will be actioned during the forthcoming year. These are:

i. To amend the consultation form and re launch across all agencies.
ii. To revise the procedures for LADO.
iii. To advise all agencies of good practice to be included in standards/expectations at the point of induction for all staff regarding contact and communication with children and young people
iv. To continue to forge links with faith and voluntary groups.
v. To record all consultations and include in LADO reports to HSCB.

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 LSCB, which the LSCB reviews and responds to any findings as necessary.

During 2012-13 six private fostering notifications were received by the Local Authority. This was an increase of five on the previous year, and in line with the number received in 2010-11. Of these four were deemed suitable for Private Fostering arrangements. All were acted upon appropriately within 7 working days, with visits to children taking place at least 6 weekly in line with Private Fostering regulations 2005. Two of these arrangements ended in the year, and two were still open at 31st March 2013. A steering group oversees the Private Fostering action plan and awareness raising, reporting directly to the LSCB.

8. The Voice of Children & Families:

The LSCB has consulted with groups of young people to identify how they would like to find out about its work and how they can influence this work. The LSCB Business Manager met with young people involved in a variety of youth provision in Halton to raise awareness of the LSCB, explore safeguarding messages and identify communication methods that the young people felt would be most effective. The young people preferred communication via social media and visits to them at the places they were already attending as part of the youth provision, such as C-Rmz. They did not want to attend meetings specifically held for participation. As a result of this feedback the LSCB is visiting community settings to engage young people in awareness raising on issues such as child sexual exploitation; and reviewing its use of social media.

LSCB members also undertook visits to frontline practitioners across a range of services, where they asked staff to provide evidence of how the voice of the child was influencing their service. Staff were able to give examples of how they had changed their own practice as a result, clearly demonstrating how they were listening to children & young people in their work.

The LSCB is currently involved in a project with Professor Jan Horwath, Sheffield University, in collaboration with Cheshire West & Chester and Telford & Wrekin LSCBs. The aim of the project is to develop working practices, models and training to help staff understand what life is like in terms of the daily lived experience for children subject to Child Protection Plans. The aim is to create meaningful Child Protection Plans which will provide a way to measure the impact of interventions on outcomes for the child and family. The pilot will begin in September 2013.

A researcher from Gloucester University is also working with the LSCB on a project to elicit the views of children and young people on their experiences of the child protection system. The aim of the research is to identify ways to improve their experiences. The LSCB will be receiving progress reports during the forthcoming year.

Partners have also engaged in activity to ensure that the voice of children and families influences practice and service delivery.

The Safeguarding Unit has:

- Introduced personalised letters to children featuring a photograph of the Independent Reviewing Manager (IRM).
- Introduced business cards so that the IRMs can write down the dates of future meetings and ensure that the young person has their contact details, supporting the young person to make independent contact.
- Introduced tracker cards designed by young people to be completed by young people at Children in Care reviews to monitor the progress of recommendations made by the IRM. There are plans to introduce this in to Child Protection conferences in future to track recommendations in Child Protection Plans.
- Young people routinely advise the IRMs as to where they want their reviews to take place and who they would like invited.
- Following requests from parents, all parents are contacted prior to a child protection conference offering an opportunity to meet with the Chair before. There has also been an increase in advocates attending conference to ensure that parents are fully aware and understand what is being discussed, and that their views are considered as part of the Plan.

Cheshire Police has:

- Made significant improvements in how they deal with young people who are arrested in connection with criminal investigations, reducing the number of young people brought into police custody.
- Ensured rigorous risk assessments and support for all those arrested.

- Continually monitored all arrests and will be reporting to the LSCB for scrutiny.

Children's Social Care has:

- Delivered workshops to social workers on the use of practical tools for effectively communicating with children and young people.
- Provided all social workers with resources to undertake direct work with children and young people.

Cheshire Probation has:

- Trained staff to develop risk management plans and sentence plans to clearly put the child at the centre when safeguarding is an issue.
- Introduced specific, personal objectives that provide evidence of the impact they are seeking to achieve for the child/family and the outcomes.

Bridgewater Community Healthcare Trust has:

- Developed the School Health Service to ensure that the child's voice is heard, for example via holistic health assessments for all children subject to a Child Protection Plan which identify any health needs which are of concern to the child.

5 Boroughs Partnership has:

- Transformed services to improve waiting times for assessment and intervention following feedback from children and families, meaning that the first assessment is within 10 days.
- Ensured better engagement with the CAF model by the Child & Adolescent Mental Health Service following challenge from the LSCB.

St Helens & Knowsley Teaching Hospitals NHS Trust has:

- Applied the Laming Compliance Audit on a quarterly basis within Paediatrics which includes the voice of the child as a criteria and measure.
- Embedded into assessment detailed analysis of the child's perspective on the nature of the problem and their preferred outcomes from interventions, particularly amongst 10 – 16 year olds, often with a mental health focus.
- All children and young people over the age of 12 years who are admitted to the Trust have the opportunity to complete an 'Adolescent Screening Tool' covering general health issues but also open questions around domestic abuse, drug and alcohol use, smoking and sexual health; completion and analysis has led to specific interventions being generated with individual children and young people.

Warrington & Halton Hospitals NHS Trust has:

- Obtained children's views to develop care and services offered. For example, via focus groups for children with epilepsy, diabetes and visual impairment; and a monthly coffee morning for hearing impaired children.

- Captured the views of children and families at discharge meetings, extracting any themes to inform practice.
- Ensured that CAFs completed by the hospital staff on young people always record the views of the young person.
- Used in-house training to stress the importance of asking children about their injury / life / seeking their views. There has been increasing evidence in notes of practitioners documenting information such as the history from the child as a result.

Public Health has:

- Held focus groups with children on the Fit4Life Programme to understand the high drop out rate, leading to the programme being opened up to the whole class so that children do not feel singled out by attending. The programme now runs across all primary schools in Halton and the excess weight rate for all children has fallen significantly.

Future plans for 2013-14:

Cheshire Police will:

- Focus on 'the voice of the child' at the heart of policing activity.
- Develop a new IT referral process that ensures officers understand and capture the child's voice to inform risk assessments and decision making.

NHS Halton Clinical Commissioning Group will:

- Ensure that commissioned health services have a systematic and on-going engagement process in place which demonstrates changes made to service delivery through the influence of children and young people's voices.
- Require all health providers to submit evidence of compliance on an annual basis.
- Ensure that challenge and scrutiny is applied through performance and contractual management.

Halton Borough Council – Children & Enterprise Directorate will:

- Review all Children in Need cases, including the degree to which the voice of the child is demonstrated in the planning process.
- Emphasise the centrality of the child in assessment and provision.

5 Boroughs Partnership NHS Trust will:

- Strengthen the therapeutic services offered to children and their carers in Halton in response to feedback received.
- Implement a service user participation plan to build on its work to elicit the views of children and carers, and adapt services accordingly.

St Helens & Knowsley Teaching Hospitals NHS Trust will:

- Complete an annual audit to assess the Trust's position and compliance in listening to the voice of the child.

- The new post of Patient Experience Manager will develop more appropriate and robust ways of understanding and responding to the voice of the child.

9. Lay Members

As Lay Members we contribute to the LSCB's work by supporting stronger public engagement in local child safety issues, raising awareness and contributing to an improved understanding of the LSCB's safeguarding work in the community. We gather local information, for instance via questionnaires on topics such as Private Fostering, to inform LSCB discussions and bring an independent view to the LSCB enabling members to focus on the concerns, needs and feelings of children & young people and their families living in Halton.

We have spent the day with the Local Authority Child in Need Teams in Widnes and Runcorn where we met managers and staff, observed their practice and asked them about their work. We provided a written report to the LSCB following our visits. Staff spoke about how they felt they are the best agency to capture the voice of the child and of how important it is to listen and get the child's point of view. Managers and staff work well together; they carry out frequent audits of their practice; they look at and scrutinise others' file work to see what they have done well or if there is anything missing; and have regular briefings looking at tasks, timescales and assessments, what's working well, or if there are any areas of development needed. The teams are aware of the role of the LSCB and access information via the LSCB website and training.

Staff were concerned about a rise in Domestic Abuse cases, and the need for specialist services to support their work. The LSCB has challenged the Children's Trust on this and specialist support services are now being commissioned.

As Lay Members it is clear that we need to work together in partnership to ensure that the children of Halton have the best opportunities in life to develop to their full potential. This can only be achieved if we work together in partnership with schools, settings and other services and organisations with a shared understanding helping us to develop our role, enabling us to establish links, share information and raise an awareness to get the message out there, that together we can make a difference to the children and families of our local and surrounding communities.

Marjorie Constantine & Yvonne Shelley, Halton LSCB Lay Members

10. Training Activity:

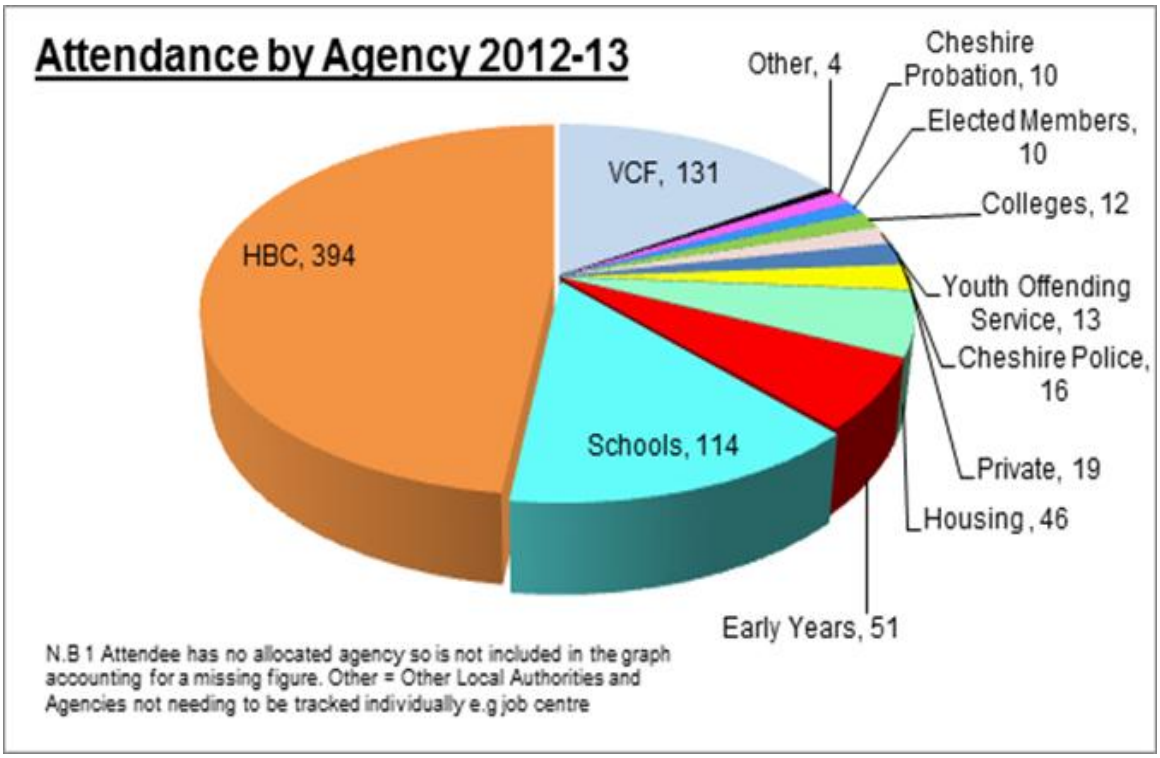
The LSCB has a responsibility to ensure that appropriate safeguarding training is available to the workforce across the borough. It does this by undertaking an annual Training Needs Analysis; quality assuring single

agency safeguarding training packages; and delivering multi-agency training. This work is led by the Learning & Development Sub Group.

The 2012-13 training programme saw 36 courses delivered with 1092 places accessed. This was a considerable increase of 64% on the previous year. The training programme included new courses on Child Sexual Exploitation, Multi-Agency Public Protection Arrangements (MAPPA), Safeguarding Children with Disabilities and Understanding Sexual Abuse. Lessons from national, regional and local Serious Case Reviews (SCRs) and Practice Learning Reviews were disseminated via SCR workshops.

The LSCB also promoted national e-learning packages via its website on both child trafficking and forced marriage as staff need to ensure they keep up to date on all areas of safeguarding, and should be alert to issues which they may be less likely to encounter.

Overall Agency Attendance on HSCB Courses 2012-13



The LSCB also hosted a session on the Duty to Refer facilitated by the Disclosure and Barring Service which focussed upon changes to recruitment practices following implementation of the Protection of Freedoms Act 2012.

In order to measure the impact of training the LSCB measures knowledge outcomes immediately after the training. This is followed up 3 months later by measuring the impact of training against improved outcomes for children. All courses showed an increase in knowledge with the most marked increases related to the Domestic Abuse for Practitioners, Sexual Abuse and Working Together Refresher courses.

Improved outcomes for children included young people safeguarded and supported with regards to sexual exploitation; identification of a potential perpetrator of sexual exploitation; identification of physical harm leading to the young person being safeguarded; and the implementation of direct work with young people on recognising healthy relationships.

Partner agencies are required to submit their level 2 Basic Awareness safeguarding courses for quality assurance. This included an e-learning package from 5 Boroughs Partnership, and face to face courses delivered to schools, Riverside College and Bridgewater Community Healthcare Trust.

Priorities for the 2013-14 training programme include:

- Revising all courses to ensure they reflect the changes included in Working Together to Safeguard Children 2013.
- Developing Domestic Abuse training to focus upon the impact on children.
- Further developing Child Sexual Exploitation training across agencies and the LSCB.
- Delivering Lessons from Practice training as part of the Learning & Improvement Framework.
- Delivering training on working with resistant families in response to national learning from SCRs.
- Delivering more courses jointly with neighbouring LSCBs across Cheshire and Merseyside.

11. HSCB Sub Groups:

Scrutiny & Performance Sub Group

The role of this Sub Group is central to the monitoring and evaluation function of the LSCB. The child's journey performance report card, based upon recommendations in the Munro Review, provides the data behind the detailed commentary reports, from early help through to adoption. This has enabled the Sub Group to challenge more effectively, for example addressing the lack of engagement by Tier 3 Child & Adolescent Mental Health Services (CAMHS) in the CAF process. The outcome of which has been that CAMHS practitioners have since initiated CAFs and been identified to undertake the Lead Professional role, ensuring that children and young people already engaged with specialist mental health provision are accessing appropriate early help and support services under Halton's Levels of Need Framework.

Section 11 Audits are undertaken to ascertain how effective organisations are in meeting their duties to safeguard children and young people under the Children Act 2004. This includes having up to date safeguarding procedures that staff know how to access; having an identified Safeguarding Lead; adhering to safer recruitment practices. The Sub Group has overseen Section 11 Audits of commissioned services undertaken by the Children's Commissioning Team. This identified a number of services where

safeguarding procedures needed to be revised and safer recruitment practices needed to be embedded. These areas were addressed with providers via the Children's Commissioning Team, supported by the LSCB. Providers undertaking the Section 11 audits included youth provision, contact centre, counselling services and play services.

Section 175/157 Audits of schools were also completed. These relate to the safeguarding duties of schools under the Education Act 2002. As a high proportion of children in the borough are of school age and attend an educational setting it is important that schools are clear of their safeguarding duties and can identify areas of strengths and weakness. The Primary Head Teacher representative on the LSCB reported positively on the audits as they were a means of improving safeguarding awareness and practice within the schools. There was an excellent return rate of 97%.

The audits identified themes apparent across a number of schools in the borough including:

i. Safeguarding training needs for Senior/Deputy Designated Persons – this is being addressed by LSCB increasing the number of level 3 Working Together and Refresher sessions and targeting places.
ii. The need for a consistent approach to retention and secure destruction of Child Protection records at transition – this is being addressed by LSCB agreeing the standard and including in a template Safeguarding Policy for schools.
iii. Safeguarding training needs for Governors – this is being addressed by ensuring a variety of approaches to safeguarding training are available to governors, including induction booklets, e-learning and modular training packages.
iv. Support needed to produce Allegations Management procedures – this is being addressed by working with schools on template procedures and developing awareness of the LADO role with schools.

Action plans have been sent to schools and outcomes will be reported when the next annual audits take place.

The Sub Group has also benefitted from the appointment of a Quality Assurance Officer, who has improved communication with performance leads in partner agencies and has provided additional capacity to the audit work undertaken by the LSCB.

Priorities for 2013-14 include:

- Identifying key performance indicators from partner agencies and including within the LSCB's performance reporting.
- Developing an audit schedule whereby partners will report their safeguarding audit activity to the Sub Group.

Policy & Procedures Sub Group

The Sub Group ensures that the Pan-Cheshire Multi-Agency Safeguarding Procedures and local Practice Guidance are reviewed and fit for purpose. Revisions have been made to the Pan-Cheshire Procedures to reflect a Rule

43 decision from Cheshire's Coroner. This is made when a Coroner feels that evidence at an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur and that action should be taken to prevent or eliminate or reduce such risks. The procedures were also amended to reflect an increased focus upon recognition of the potential of Child Sexual Exploitation. The Sub Group has also been working on a Pan-Cheshire Forced Marriage Protocol, in collaboration with the Merseyside LSCBs.

The Sub Group has quality assured a number of safeguarding policies and procedures from a diverse section of organisations working in Halton. This supports effective safeguarding practice.

Priorities for 2013-14 include:

- Reviewing the Pan-Cheshire Multi-Agency Safeguarding Children Procedures to ensure compliance with Working Together 2013.
- Progressing a Pan-Cheshire Policy & Procedures Sub Group meeting.

Child Sexual Exploitation (CSE) Sub Group

The Sub Group has made progress against its action plan developed in line with the national CSE action plan, and informed by a range of reports and nationally identified areas of learning. This Group reports to the Pan-Cheshire Strategic Group chaired by the DI form the Police strategic Public Protection Unit who is also a member of the LSCB. The Strategic Group has worked with Merseyside Police and LSCBs to launch a joint CSE Strategy which will improve joint working across neighbouring local authorities and police forces, safeguarding victims and disrupting and prosecuting perpetrators.

Both the LSCB and partner agencies have delivered training to frontline staff, which has resulted in staff recognising children at risk of CSE, thereby acting to safeguard children and identify potential perpetrators. Cheshire and Merseyside police and LSCBs have jointly delivered CSE events to promote their joint strategy and working.

Cheshire Police has made improvements to how information and intelligence regarding sexual exploitation is obtained and recorded, to support the LSCB's awareness of understanding of this issue. This has been supported by extensive training and awareness across the constabulary's workforce and the appointment of a dedicated Detective Sergeant in the role of CSE/Missing Person Coordinator.

A multi-agency Operational Group has been developed, that has been meeting monthly since February. The focus of the group is to identify children at risk of CSE, ensure referrals to agencies are made, identify potential perpetrators and local areas of concern referred to as 'hotspots'. The work of this group is developing as more cases are referred in line with the level of awareness.

Priorities for 2013-14 include:

- Expand remit of the Sub Group to include children missing from home, care and education in recognition of the increased vulnerability of such children to sexual exploitation.
- Engage with the Pan-Cheshire Communications Sub Group on awareness and education.
- Improving data collection and sharing of information between partners regarding potential victims, perpetrators and hotspots.
- Raising awareness amongst young people and the public.
- Developing Practice Guidance for staff
- Ensuring the systems are embedded relating to CSE

Learning & Development Sub Group

A joint Learning & Development Sub Group was established in November 2012, reporting to both Safeguarding Boards in Halton. The joint Sub Group has overseen a joint Safeguarding Training Needs Analysis, and opportunities to jointly deliver training. This has included the Alerter Workshop and the Duty to Refer event delivered by the Disclosure & Barring Service.

The Sub Group oversees the LSCB Training Programme which has responded to requests from partners to amend content and delivery to meet the needs of the workforce. In total 1092 training places were taken up during 2012-13 compared with 698 in the previous year. This reflects revisions to the training programme, with new courses becoming available, and the impact of targeting some sectors to improve attendance.

The Sub Group has further developed how it measures the impact of training in terms of improved outcomes for service users. Examples of staff identifying safeguarding concerns and going on to protect children and young people are detailed in the Training Activity section of this report.

Priorities for 2013-14 include:

- Ensuring that the workforce responsible for CSE awareness raising with children and parents/carers has the appropriate level of knowledge and skills.
- Developing engagement with the Voluntary, Community & Faith Sector.
- Developing a joint Learning & Development Strategy.
- Delivering joint safeguarding training to elected members.
- Continuing to evaluate the impact of training on outcomes for service users.

Safer Workforce Sub Group

The Safer Workforce Sub Group continues to report to both Safeguarding Boards in Halton. The Sub Group has focussed its attention on the changes that have been taking place following the implementation of the Protection of Freedoms Act 2012. It has also approved a Safer Recruitment training course

for the Adults Sector that puts the training of recruitment panel members on a similar footing to that across the Children's Sector.

In recognition of the need to strengthen the Sub Group a review of membership, terms of reference and work plan is underway.

Priorities for 2013-14 include:

- Reviewing membership and terms of reference.
- Monitoring Safer Recruitment practices across partners.
- Developing a process to oversee audit of supervision practices across partners.

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. It is solution focussed with SCOG reporting directly to the Safeguarding Unit meeting, which in turn reports to the LSCB 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 include the introduction of a system to flag children subject to Child Protection Plans with acute Healthcare settings; review of Practice Guidance on police checks; and improving telephone contact with Children's Social Care following implementation of a new system across the Local Authority.

12. Priority Areas 2012-13:

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

Early Help:

During the year the LSCB ratified the revised Levels of Need Framework that were developed by the Children's Trust. The LSCB planned and delivered a launch event with the Trust at the joint Frontline Event in April 2013.

The Trust plans to undertake a training and skills analysis which will be reported to the LSCB's Learning & Development Sub Group. A representative from the Children's Trust Workforce Strategy Group now attends the LSCB's Learning & Development Sub Group, reporting formally on a six monthly basis, and the LSCB's Training Officer continues to attend the Workforce Strategy Group to ensure good communication and strengthen reporting on this area of business between the two.

The Children's Trust has piloted its multi-agency Induction Programme, which facilitates the workforce learning together and understanding the range of roles and agencies operational in the borough. This has helped to ensure that staff receive consistent messages and information on Halton's priorities. The LSCB will receive reports from the Children's Trust on the impact of the Induction Programme.

Domestic Abuse:

The gaps in Domestic Abuse services were highlighted by the LSCB. This was formally raised at the LSCB Chair's quarterly meetings with the Local Authority's Chief Executive and Lead Member. In addition the LSCB funded a development session for Halton Domestic Abuse Forum (HDAF) to strengthen the Forum's work. A Senior Director from Children's Services now chairs HDAF, strengthening the links between Children's and Adult Services.

The LSCB welcomes the commissioning of additional Domestic Abuse services during the forthcoming year that will improve outcomes for children and families. Performance measures will be established to measure the impact of these services on outcomes for children and young people.

Child Sexual Exploitation:

The LSCB has established a Child Sexual Exploitation (CSE) Sub Group in recognition of the work that needed to be undertaken. There is a strong Pan-Cheshire CSE & Missing From Home Strategic Group which the LSCB contributes to and locally the LSCB's CSE Action Plan is informed by the Pan-Cheshire and national action plans.

Progress this year has included:

- Ratifying the Pan-Cheshire CSE Strategy and Protocol.
- Delivering training and awareness sessions to staff.
- Identifying CSE champions across partners.
- Providing evidence to the Office of the Children's Commissioner's enquiry into CSE in gangs and groups.

There are strong plans for the year including:

- Funding a CSE post to support information sharing and collation across partners, helping the LSCB to understand further the scale of the problem across the borough.
- Development of an Operational Group to share information and identify potential victims, perpetrators and community areas of concern.
- Further awareness raising amongst children & young people, parents and the public.
- Training for staff working in licensed settings such as the hospitality industry and taxi companies.

13. Progress against Business Plan 2011-13:

1. Maintain Structures for Halton Safeguarding Children Board to be enable it to fulfil its statutory functions and respond to local and national change

	Action required	Intended Impact	Achievements
1.1	Review the structure and current HSCB activity in the context of other strategic partnerships in order to ensure that the Board is effective and efficient.	Board continues to undertake its objectives and functions effectively.	Established joint Learning & Development Sub Group with Safeguarding Adults Board. Established CSE Sub Group. Established Pan-Cheshire Child Death Overview Panel.
1.2	Establish clear links and governance arrangements with key strategic partnerships in Halton.	Strategic partnerships are accountable for safeguarding children in their work.	Protocol agreed between LSCB and Safeguarding Adults Board.
1.3	Revise the protocol in place with the Children's Trust to ensure effective governance arrangements are in place that help the Board meet the requirements of the Munro recommendations.	The Board and Children's Trust are clear on how their roles differ and hold each other to account, providing robust challenge as appropriate.	Protocol revised.
1.4	To ensure that HSCB contributes effectively to the Children and Young People's Plan, and that the	Safeguarding children is embedded in the CYPP.	LSCB continued to be formal consultee of Children & Young People's Plan.

	safeguarding dimension in the planned delivery of services is effective, by influencing other strategic partnerships.		

2. Provide comprehensive guidance for Agencies and Individuals which facilitates partnership working to Safeguarding Children and Young People

	Action required	Intended Impact	Achievements
2.1	Maintain HSCB Safeguarding procedures in a current and easily accessible format ensuring amendments are made to reflect changing guidance & legislation	The workforce, including volunteers, have access to up-to-date procedures to support them in safeguarding children.	Amendments made to Pan-Cheshire procedures to reflect Rule 43 letter issued by Coroner. Amendments made to reflect priority of CSE.
2.2	Provide a supportive and Quality Assurance role for all agencies, organisations and the voluntary sector in their development of Safeguarding related policies and procedures	The workforce, including volunteers, have access to up-to-date procedures to support them in safeguarding children.	Ratification of a number of agencies' safeguarding policies & procedures.

3. Support the development of a safe and informed workforce including voluntary sector

	Action required	Intended Impact	Achievements
3.1	Training Needs Analysis is	Workforce has necessary skills and	Training Needs Analysis completed with

	conducted and reported to the Children's Trust to ensure Safeguarding training is provided to Children's Workforce	knowledge to effectively safeguard children.	Safeguarding Adults Board.
3.2	Quality assure level 1 and 2 safeguarding training delivered by stakeholders.	Workforce has necessary skills and knowledge to effectively safeguard children.	Quality assured several training packages.
3.3	Ensure that appropriate level 3 specialist Multi-Agency Safeguarding training is available to Halton's workforce.	Workforce has necessary skills and knowledge to effectively safeguard children.	LSCB multi-agency Training Programme in place. Courses added to reflect LSCB priorities.
3.4	Evaluate Safeguarding related training and its impact on practice and outcomes for children and young people in Halton	Inform future learning & development activity to improve outcomes for children and families from a suitably skilled and knowledgeable workforce.	Process for measuring impact of training upon outcomes for children revised and more qualitative information received.
3.5	Ensure the lessons from national, regional and local SCRs and Multi-Agency Practice & Learning Reviews are disseminated across the workforce, including the Voluntary Sector	Improved safeguarding and reducing the likelihood of similar circumstances occurring in the future.	Workshops on lessons learnt delivered.

3.6	Ensure that those staff who may undertake IMRs and chronologies as part of SCRs and Multi-Agency Practice & Learning Reviews are appropriately trained.	Effective SCR and PLR processes are in place, ensuring that recommendations are implemented to reduce likelihood of similar circumstances occurring in the future.	Executive members registered with NSPCC training website.
3.7	Provide development and support to members of the Child Death Overview Panel to enable them to fulfil their role to review the deaths of C&YP	Effective Child Death Review process is in place, ensuring that recommendations are implemented to reduce likelihood of deaths under similar circumstances in future.	Development event for Pan-Cheshire CDOP.

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

	Action required	**Intended Impact**	**Achievements**
4.1	Ensure that appropriate processes are in place to measure the effectiveness of local work to safeguard and promote the welfare of children.	Children are effectively safeguarded.	Section 175/157 Audits of schools undertaken. LSCB recruited a Quality Assurance & Safeguarding Development Officer to provide additional capacity to the LSCB to support its scrutiny work.
4.2	Ensure that appropriate processes are developed to scrutinise the effectiveness of Early Help in Halton.	Children access Early Help appropriately, preventing unnecessary escalation up the Levels of Need.	6 monthly reports to LSCB in place. LSCB has directed Children's Trust to undertake work on levels of need and coordination of early help to older young people.
4.3	Ensure that appropriate processes are in place to	Children are effectively safeguarded in situations of Domestic Abuse.	Reports from Halton Domestic Abuse Forum received regularly.

	measure the impact of Domestic Abuse on children & young people and the effectiveness of reduction strategies.		Domestic Abuse services in process of being commissioned.
4.4	Scrutinise performance of Safeguarding activity to ensure Partners are working effectively together and targeting resources effectively in areas of Safeguarding need and identified compromised care.	Children are effectively safeguarded.	LSCB received regular reports from the Safeguarding Unit on safeguarding activity, alongside reports from partners. LSCB recruited a Quality Assurance Officer to provide additional capacity to support this area.
4.5	Provide scrutiny of the implementation of Single and Multi-Agency Action Plans arising out of Serious Case Reviews and Multi-Agency Practice & Learning Reviews undertaken by Halton Safeguarding Children Board.	Improved safeguarding and reducing the likelihood of similar circumstances occurring in the future.	LSCB undertook Multi-agency Practice & Learning Reviews and signed off the action plans. Further scrutiny will be undertaken during the year via the audit process.
4.6	Work with the Pan-Cheshire LSCBs to develop a regional CDOP that will review the deaths of all children and young people under 18 who normally reside in the area.	Reducing the likelihood of deaths in similar circumstances occurring in the future. Board undertaking its Child Death functions more efficiently.	Established Pan-Cheshire Child Death Overview Panel.

4.7	Conduct in-depth and meaningful reviews of cases which meet the criteria for Serious Case and Multi-Agency Practice & Learning Reviews as laid out in Chapter 8 of 'Working Together to Safeguard Children'.	Improved safeguarding and reducing the likelihood of similar circumstances occurring in the future.	Two Practice Learning Reviews completed.

5 Engage with Children and Young People, their families and communities in developing and promulgating the Safeguarding agenda

	Action required	**Intended Impact**	**Achievements**
5.1	Develop the Young People's Participation Group jointly with the Children's Trust to ensure the meaningful and effective participation of children and young people in Halton with Halton Safeguarding Children Board.	Children inform the Board's priorities, and hold the Board to account for its work.	Consultation events have taken place with children & young people on specific topics and generally on what would help with Board engagement.
5.2	Ensure that the Lay Members are providing effective challenge and scrutiny to the work of the Board on behalf of the community across Halton.	The community informs the Board's priorities, and hold the Board to account for its work.	Lay Members attend Main Board and Scrutiny Sub Group.
5.3	To ensure that all target groups are engaged and informed of the role and work of Halton Safeguarding Children Board	Raise the profile of the Board across all stakeholders.	Board members visited frontline staff to raise profile of LSCB.

	through an effective Communication Strategy		
5.4	Provide guidance and information in a suitable format to inform target audiences of Safeguarding related activity in Halton.	Ensuring that safeguarding awareness raising takes place across all stakeholders in an efficient manner.	Revised and further developed safeguarding messages to staff and public, such as how to report safeguarding concerns and e-safety.
5.5	To have a presence at key events and activities to promote the work of Halton Safeguarding Children Board and the Safeguarding Agenda.	Ensuring that safeguarding awareness raising takes place across all stakeholders in an efficient manner.	Attended public and staff events. Delivered Frontline event with Children's Trust.
5.6	To promote key Safeguarding themes through the organisation of workshops/ events and engaging in local and national campaigns.	Ensuring that safeguarding awareness raising takes place across all stakeholders in an efficient manner.	Supported and delivered safeguarding session at Crucial Crew for Year 5 pupils across Halton.

14. Budget:

Income 2012-13

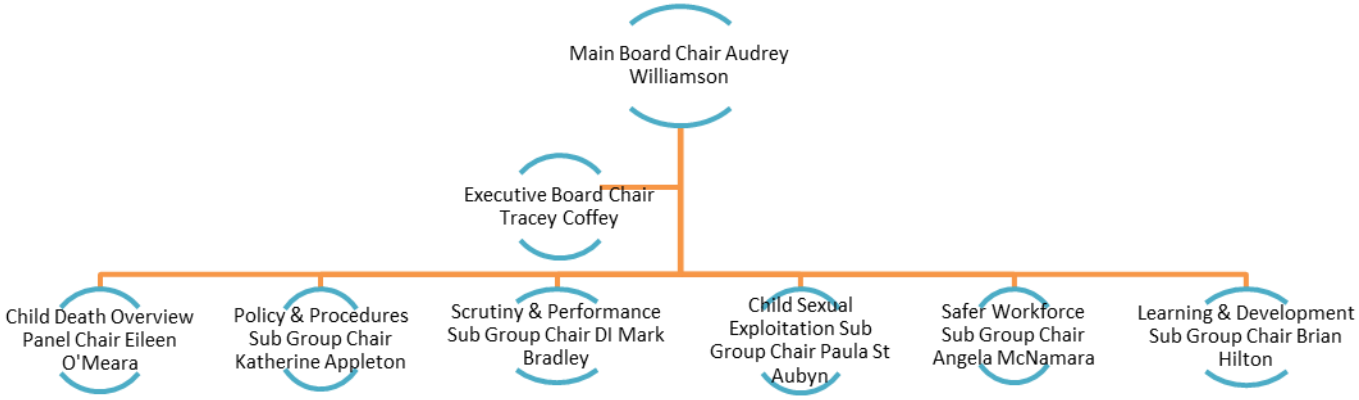
AGENCY	CONTRIBUTIONS
HBC – Children & Enterprise Directorate	45,817
HBC - Schools	33,000
NHS Merseyside/Halton CCG	45,817
Cheshire Constabulary	20, 000
Cheshire Probation	3, 230
Cafcass NW	550
Training Income	124
Carry Forward 2011-12	133, 365
Total:	**281, 903**

Expenditure 2012-13

Staffing	126, 419
Multi-Agency Training	14, 736
Staff Training including Travel Expenses	1, 802
Learning & Improvement Activity	11, 762
Advertising & Marketing	6, 455
Recharge/Overheads & Miscellaneous	10, 736
TOTAL:	**171, 910**
Carry Forward:	161, 703
Total:	333, 613

2012-13 Budget £51, 710
Net Expenditure from figures above £51, 710

Appendix A
HSCB Structure March 2013



Appendix B

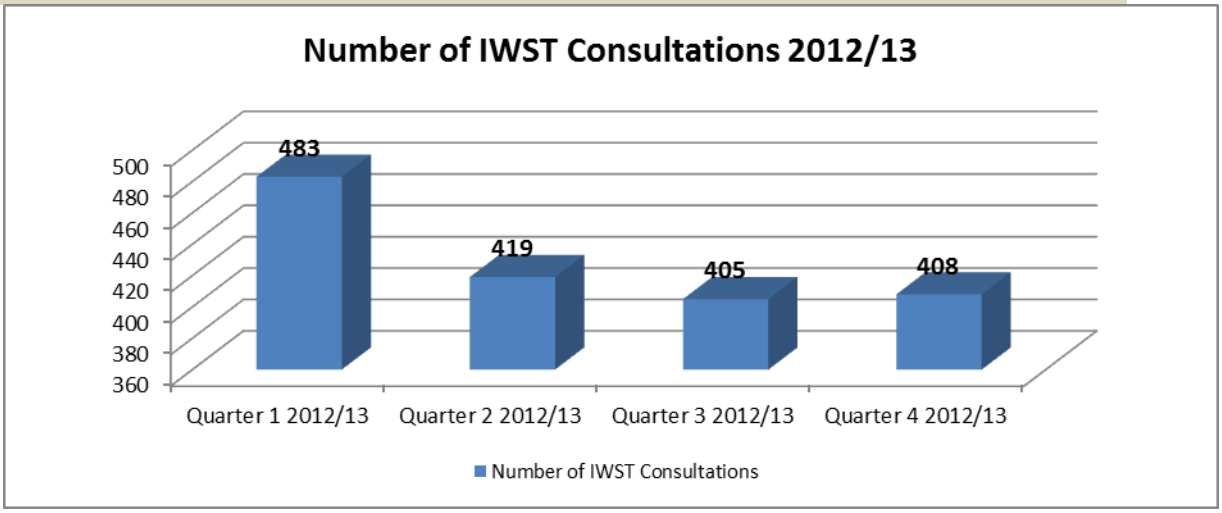
HSCB Membership 2012-13:

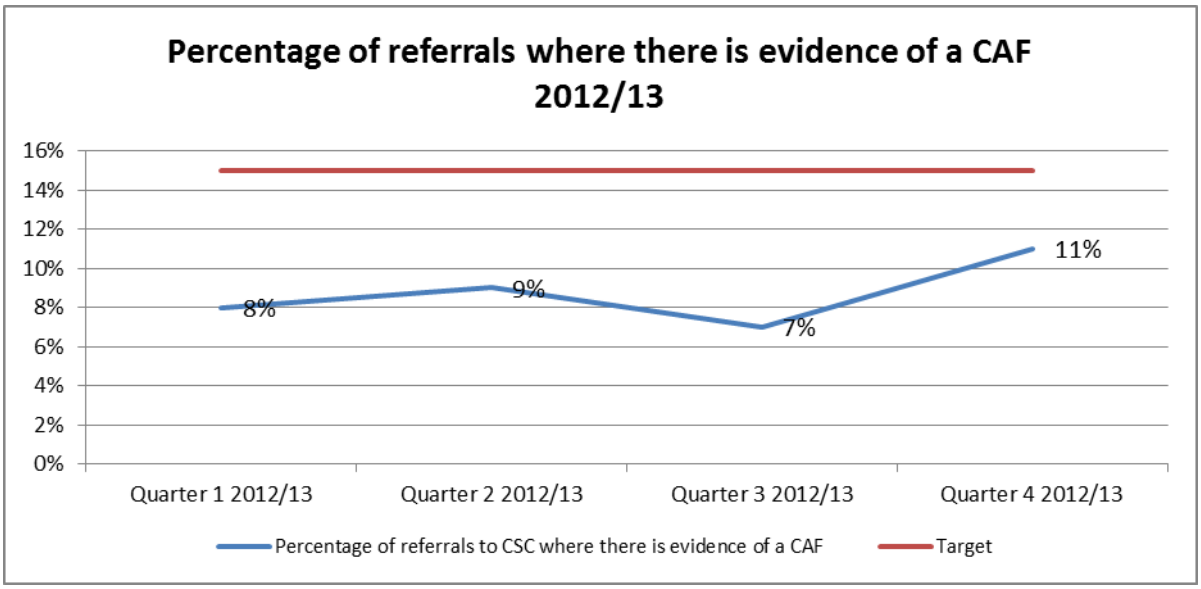
Independent and Overseeing Members	**Audrey Williamson (Independent Chair)**
	Cllr Ged Philbin, Lead Member Children & Young People (Participant Observer)
Lay Members	Marjorie Constantine, Lay Member
	Yvonne Shelley, Lay Member
Local Authority	Gerald Meehan, Strategic Director, Children & Enterprise
	Tracey Coffey, Operational Director, Children & Families
	Steve Nyakatawa, Operational Director, Learning & Achievement
	Paula St Aubyn, Divisional Manager, Safeguarding Quality & Review
	Lindsay Smith, Divisional Manager, Mental Health, Communities Directorate
	Eileen O'Meara, Director of Public Health
	Mike Andrews, Community Safety Manager
	Sarah Ashcroft, Domestic Abuse & Sexual Violence Coordinator
	Catherine Johnson, Principal Performance Officer
	Helen Rimmer, Legal Services
Health	Dr Suprio Bhattacharyya, Designated Doctor for Child Protection, Bridgewater Community Healthcare Trust
	Michelle Bradshaw, Assistant Director of Child & Family Health Services, Bridgewater Community Healthcare Trust
	Corina Casey-Hardman, Head of Midwifery, Bridgewater CHT
	David Melia, Director of Nursing, Warrington and Halton Hospitals Foundation Trust
	Phil Dearden, St Helens & Knowsley Teaching Hospitals NHS Trust
	Dr David Wilson, GP, Grove House Medical Practice, LMC Representative
	Dr David Lyons, GP, NHS Halton CCG Rep
	Linda Kellie, Head of Service, 5 Boroughs Partnership
	Jan Snoddon, Chief Nurse, NHS Halton CCG
	Ann Dunne, Designated Nurse, NHS Halton CCG
Police	Supt Martin Cleworth, Northern BCU, Cheshire Police
	DCI Nigel Wenham, Strategic Public Protection Unit, Cheshire Police
	DI Mark Bradley, Public Protection Unit, Cheshire Police
Criminal Justice Services	John Davidson, Assistant Chief Executive, Cheshire Probation Trust
	Gareth Jones, Head of Service, Cheshire West, Halton & Warrington Youth Offending Service
CAFCASS	Tom Cheadle, Service Manager, Cafcass
Schools and Colleges	Dee Denton, Head Teacher, Lunts Heath Primary, Primary Headteacher Rep
	Andrew Keeley, Headteacher, St Chad's, Secondary Headteacher Rep
	Jane Ainsworth, Governor, The Heath, Halton Association of Governors Rep
	Paula Mitchell, Programme Manager, Riverside College
Housing Sector	Niall McDonnell, Liverpool Housing Trust
HSCB	Tracey Holyhead, Business Manager
	Rosie Lyden, Safeguarding Training & Development Officer
	Rhonda Saul, Quality Assurance & Safeguarding Development Officer

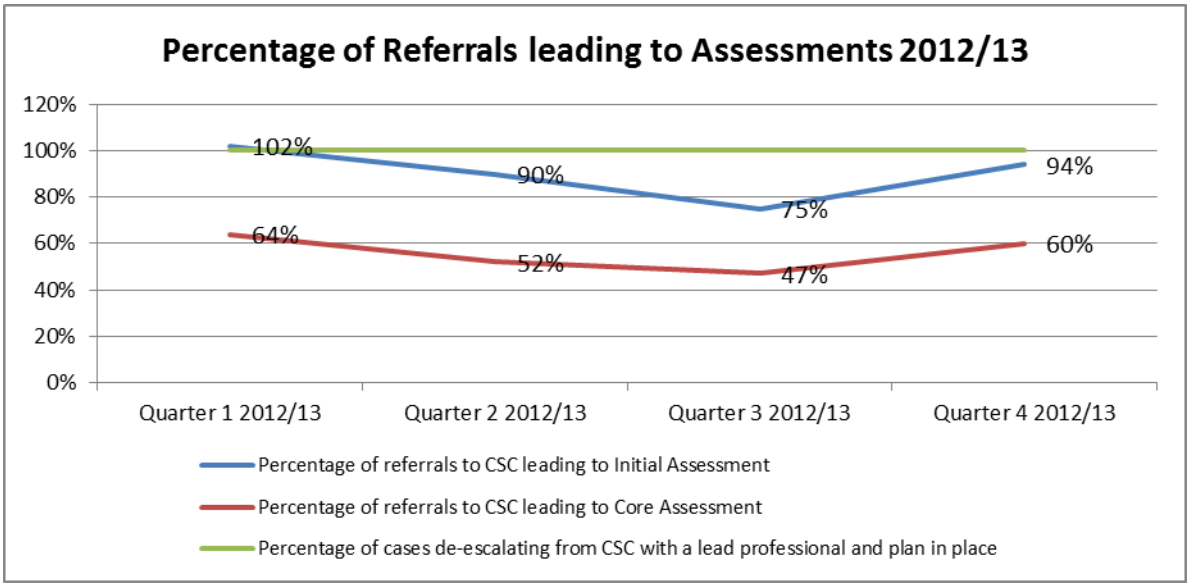
Appendix C
LSCB Performance Report Card 2012-13

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







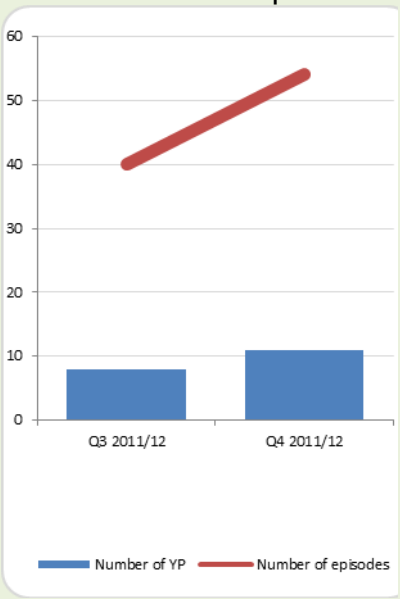
This chart details the percentage of referrals to Children's Social Care which continue to an Initial Assessment (90%+) or Core Assessment (50%+) which is a proxy for those cases where the referral is appropriately identified as at the correct level of need to warrant a thorough assessment of need and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

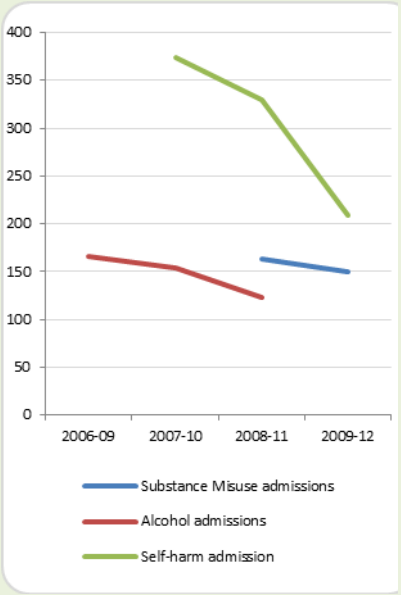
Children and Young People are protected from significant harm

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



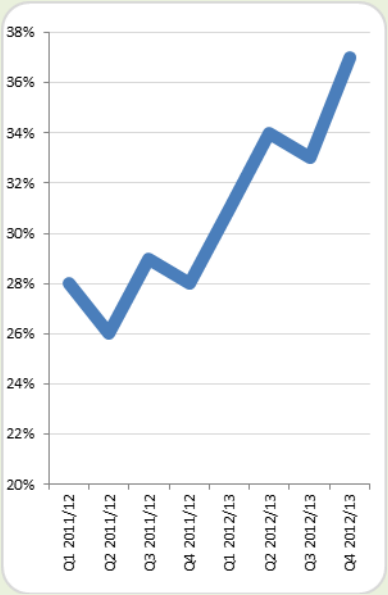
Q4 shows a slight increase in numbers; we have 54 repeat episodes from 11 repeat runners, however in this count there are 17 repeat episodes from 4 repeat CICOLA's. The service is working with all partners to reduce impact for future.

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.

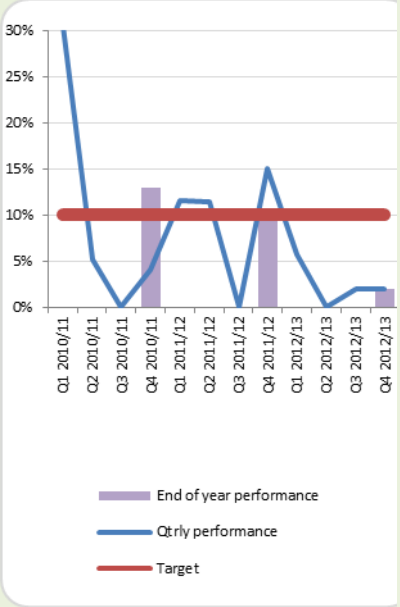
Reduction in the percentage of repeat MARAC



This data shows that the percentage of repeat MARAC's (rolling 12 months) has increased over the past 2 years.

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

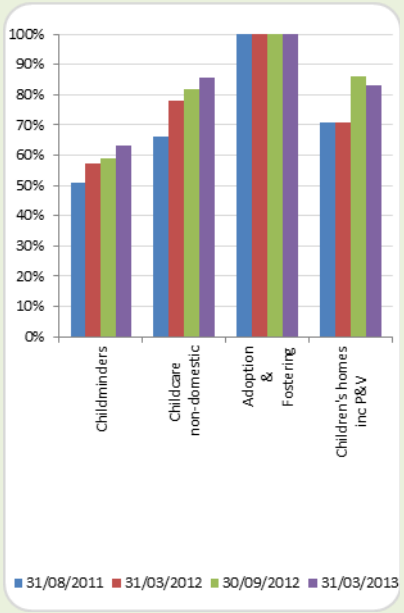
Reduce the percentage of children subject to a child protection plan for a second or subsequent time



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.

Currently for two of the children for whom child protection plans have been developed this is their second plan and the cumulative performance for the year is 2%, significantly below the target.

Increase the percentage of all inspected services with good or outstanding overall judgment



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.

There are a number of newly registered children's homes within the LA boundary who have yet to have an inspection report published. The data in relation to Children's Homes covers 6 establishments.

Increase the percentage of schools who have completed their Section 175 Safeguarding Audits

2 establishments did not return their section 175 audits from those required.

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

	2011/12	Q1	Q2	Q3	Q4	Target	Alert & DOT
Percentage of Initial Assessments completed within timescales (10 working days)	75%	79%	89%	75%	73%[1]	85%	☒ ↓
Percentage of Core Assessments completed within timescales (35 working days)	86%	72%	76%	79%	70%[2]	92%	☒ ↓
Percentage of Initial Child Protection Conferences held within 15 working days of S47 enquiry start	81%	89%	84%	n/a	n/a[3]	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	75%	50%	67%	69%	62%	100%	☒ ↓
Percentage of Child Protection Review Conferences with reports from GP's	55%	57%	48%	61%	76%	100%	☒ ↑
Percentage of children and young people participating in the Children in Care process through their statutory reviews (age appropriate)	97%	100%	100%	100%	100%	100%	☑ ↑

1 Provisional awaiting quality assurance as part of Statutory Returns process

2 Provisional awaiting quality assurance as part of Statutory Returns process

3 Provisional awaiting quality assurance as part of Statutory Returns process

Appendix D
Child Death Overview Panel (CDOP) Report

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 – known as "modifiable factors" - that, if changed, could help to reduce the risk of deaths under similar circumstances in the future.

Halton's CDOP has met as a multi-agency group chaired by the Director of Public Health. The core membership of the Panel includes: Public Health, Designated Doctor, Designated Nurse, Midwifery Services, 5 Boroughs Partnership NHS Trust, Cheshire Police, Children's Social Care, Learning & Improvement and Safeguarding Unit. 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

In 2012-13 there were 6 child deaths; however, it has subsequently been agreed that one of the child deaths will not be reviewed as the child died at only 20 weeks gestation. (The CDOP considers child deaths following live births from 22 weeks gestation onwards.) This is a slight increase on 2011-12 when there were 4 child deaths. However the number of child deaths continues to be lower than those in the initial years of the CDOP.

The Panel completed reviews on the death of one child, from April 2012-March 2013. In addition, a review of the death of a child was completed up to the point of Coroner's inquest. Consideration was also given to work undertaken by NHS Merseyside in relation to a further death that was awaiting a Coroner's inquest. This was a reduction of six in comparison to the previous year. This was due to two deaths awaiting Coroner's inquest, and two deaths occurring in the latter months of the year. From 1st April 2013 a Pan-Cheshire

CDOP arrangement will come in to place with dedicated admin and processes in place to ensure that information is collected to strict timescales.

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 no modifiable factors which may have contributed to the child's death were present in the case reviewed.

	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011 – March 2012	April 2012– March 2013
Number of Deaths	**14**	**12**	**14**	**4**	**6**
	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012	April 2012– March 2013
Number of Reviews	**9**	**14**	**13**	**7**	**1**

Category of death	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012	April 2012-March 2013
Deliberate inflicted injury, abuse or neglect	0	2	0	0	0
Suicide or Deliberate Self Inflicted Harm	0	0	1	0	0
Trauma & Other External Factors	1	1	1	0	0
Malignancy	0	1	0	0	0
Acute medical & surgical condition	0	0	1	0	0
Chronic medical condition	4	2	2	2	0
Chromosomal, Genetic or Congenital Anomalies	1	3	1	2	0
Perinatal/Neonatal Event	2	4	5	2	0

Infection	0	0	0	0	0
Sudden Unexpected, Unexplained Death	1	1	0	1	1
Total number of deaths reviewed	**9**	**14**	**13**	**7**	**1**

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

As the number of child deaths is small it has been difficult to identify trends. Moving to a Pan-Cheshire CDOP arrangement will provide a larger population which should allow for identification of learning and themes. This may include areas for collaborative working to further reduce the number of child deaths in the Cheshire region. This should be a more efficient arrangement in terms of administration and staff attendance, and will provide a standard agreed approach to reviewing CDOP cases across Cheshire.