Halton Safeguarding Children Board

Annual Report 2014-15

and

Business Plan 2015-17

September 2015

CONTENTS

Appendices

1. Independent Chair's Introduction

I am pleased to present to you the Halton Local Safeguarding Children Board (HSCB) Annual Report for 2014 - 2015. I hope you will find it useful in understanding the way all services in Halton work together to safeguard children who are or may be at risk of harm. This report is intended to provide information for all involved in the work of, or who are interested in safeguarding children and young people.

The HSCB recognises that the work of partners to safeguard children and young people is continuing against a backdrop of a challenging economic environment and fundamental reshaping of public services. This has brought a greater need for organisations and services to work even closer together. The audit and scrutiny work led by the HSCB ensures that safeguarding remains a priority for all partners.

The HSCB does not work in isolation and has defined Governance and Accountability agreements in place for how we work with other Strategic Partnerships in Halton. The HSCB has continued to develop its structure and membership to ensure that it can deliver effective scrutiny and challenge to promote improving safeguarding practice.

The recent Ofsted review of HSCB recognised that partners in Halton are working well together to address key safeguarding areas whilst identifying some areas for improvement. The Board welcomed the scrutiny provided by Ofsted and has developed a comprehensive action plan to build upon our continuous improvement ambition. The Board needs to strengthen its communication with faith and community groups and will continue to focus on engaging with and listening effectively to children and young people to ensure their views are influencing safeguarding practice.

Work with other Safeguarding Children Boards in Cheshire has strengthened arrangements for dealing with Child Sexual Exploitation and has provided high quality communication and information to young people and their families so that they can recognise risk and abusive relationships.

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 HSCB 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 wellbeing of the children of Halton.

Richard Strachan
Independent Chair
Halton Safeguarding Children Board

2. The Structure of the LSCB

The Main Board is the overarching decision making body; the Executive and Sub Groups are accountable to the Board. The LSCB Executive drives the business on behalf of the Board, with the Sub Groups reporting directly to it.

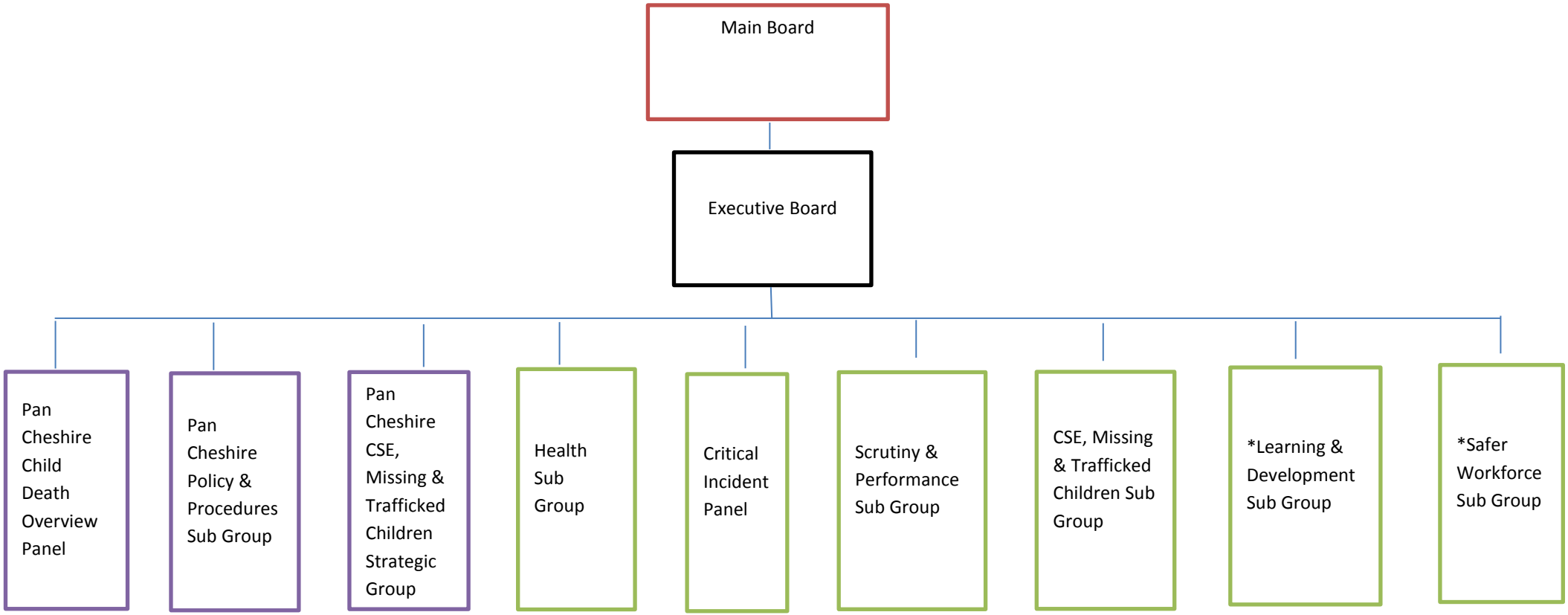
The Health Sub Group has proven to be an effective addition to the structure of the Board. All NHS Trusts providing services to Halton residents sit on the Sub Group alongside representation from Primary Care (i.e. GP Practices) and Public Health and NHS Halton Clinical Commissioning Group (CCG) as the commissioners. The Sub Group Chair sits on the Executive and Main Board to ensure that NHS provider services are represented alongside commissioners.

The remit of the CSE and Missing Children Sub Group has broadened to include Trafficking. This reflects the additional vulnerabilities that children who are trafficked face in terms of risk to CSE. This also reflects the broadened remit of the Pan Cheshire Strategic Group.

We now have three sub groups which operate on a Pan-Cheshire basis: Child Sexual Exploitation, Missing & Trafficked Children; Policies & Procedures; and Child Death Overview Panel (CDOP). These Pan-Cheshire arrangements support the four LSCBs to work more effectively. We are able to share and compare information to address issues which do not recognise local authority boundaries, such as Child Sexual Exploitation or Trafficking. We can also pool our diminishing resources to develop effective awareness raising campaigns such as Safe Sleep or Child Sexual Exploitation.

The LSCB has joint protocols in place with the Children's Trust and Health & Wellbeing Board, and Safeguarding Adults Board. This supports work on issues which overlap the strategic partnerships, as well as ensuring that the LSCB can hold to account, and be held to account by, these strategic partnerships.

HALTON SAFEGUARDING CHILDREN BOARD STRUCTURE

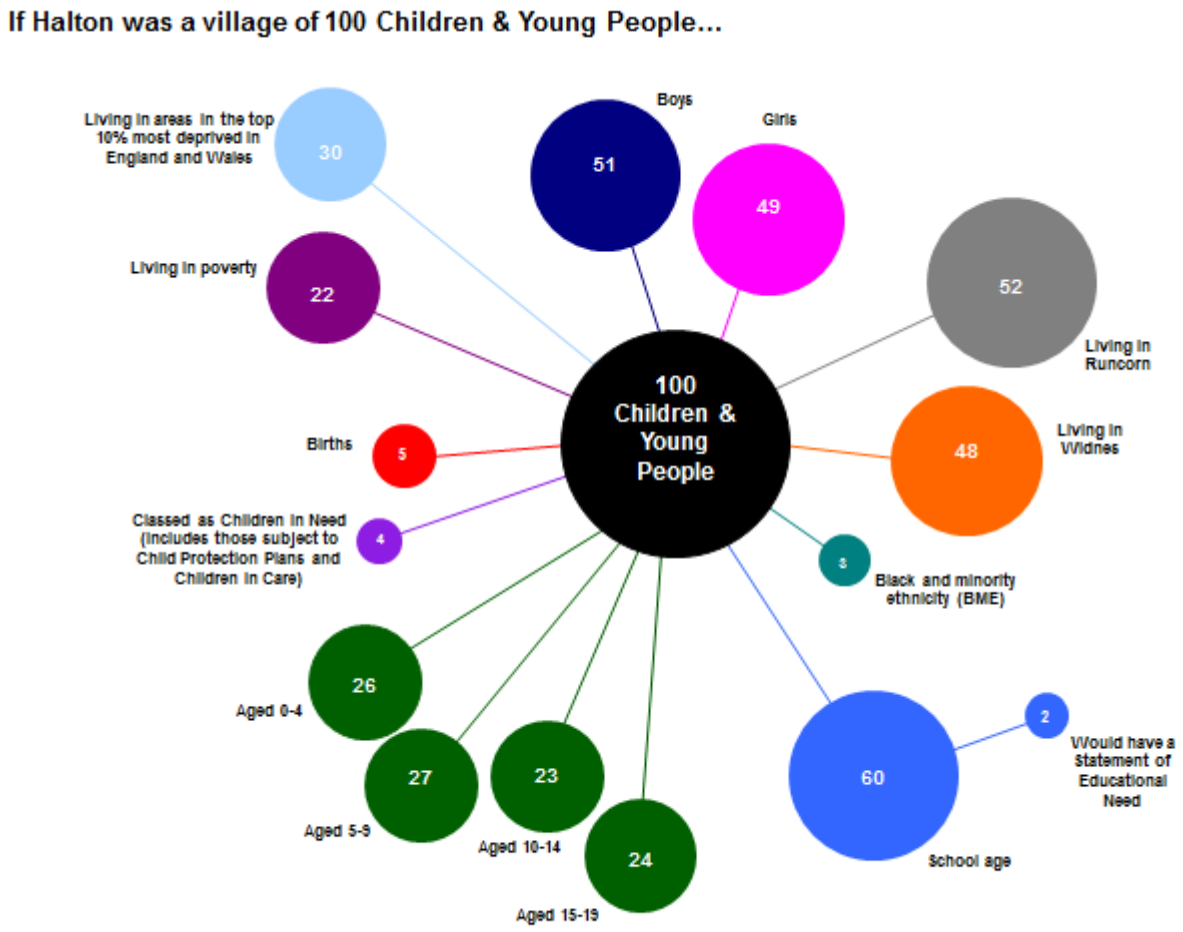


*Denotes joint Sub Group of the LSCB and Safeguarding Adults Board

3. Demographics of Halton

Halton has an estimated population of 126,400, of which approximately 29,700 children aged between 0-18 years are living in the borough. (Source: ONS, 2014 Population Estimates). The population is largely white, with only 3.2% of the population identified as being from a minority ethnic group. (Source: 2011 Census)

Halton is the 27th most deprived local authority area in England out of 326. 26% of the population live in areas that fall in the top 10% most deprived nationally. (Source: Index of Multiple Deprivation, 2010) In 2014, 22% of children and young people were living in poverty. (Source: DWP, Out of Work Benefit Claimant Households, 2014)



4. Key Priorities 2014-15:

The LSCB's 2013-15 Business Plan identified five strategic objectives:

1. Identify and prevent children suffering harm.
2. Protect children who are suffering or at risk of suffering harm.
3. Ensure that children are receiving effective early help and support.
4. Support the development of a safe and informed workforce, including volunteers.
5. Engage with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding.

In addition to the strategic objectives, the LSCB identified five areas of focus to be considered across all of the strategic objectives:

a) Neglect
b) Early Help and Support
c) Children in Care
d) Child Sexual Exploitation and Missing Children
e) Domestic Abuse

The five areas of focus were identified from performance monitoring, audit of practice, the outcome of reviews, feedback from frontline staff and engagement work with children & families. Our partners undertook a range of activities in relation to the LSCB's key priorities:

Cheshire Police

- Implemented new Vulnerable Persons Assessment (VPA) process
- Delivered Operation Encompass pilot in Widnes, reporting daily to schools on Domestic Incidents
- Supported a range of activities across schools in Halton aimed at raising awareness of CSE and risk associated with online activity, including Crucial Crew and E-Safety Officers programme
- Committed dedicated resources to the CSE Team
- Aligned dedicated local officer and/or PCSO to all children's homes under Operation Arundel
- Developed consistent data tracker to share information with partners on missing children

Cheshire West, Halton and Warrington Youth Offending Service (YOS)

- Expanded Divert Team into a wider Divert and Court Team
- Undertake 6 monthly Domestic Abuse Audits
- Analysed re-offending rates of children in care looking at profile, type of offending and prevalent factors for offending
- Highlighted cases where trafficked children were being prosecuted for offences rather than treated as victims of modern slavery triggering a learning review to be reported to the LSCBs in Cheshire
- Participate in quarterly multi-agency reviews of children detained in police custody overnight
- Involved in developing a transfer protocol with Police and Children's Social Care for children with post charge accommodation requirements

Children and Families Court Advisory Support Service (CAFCASS)

- Commission accredited agencies to undertake Domestic Abuse courses for perpetrators which are then included in court assessments
- Developed a CSE strategy
- Following Cafcass' "good" Ofsted judgement in April 2014, implemented an action plan to address recommendations; an audit in November 2014 assessed that the safeguarding actions had been met.
- Use funded research into best practice to support evidenced based assessment to improve practice.

Children's Social Care

- Revised strategic approach to Early Intervention to move to multi-agency integrated teams and reconfigured Early Intervention Teams into 3 localities
- Introduced Early Help Officer into the Contact and Referral Team (CART) as a single point of contact to advise on Level 2 cases in the Halton Levels of Need Framework
- Piloted aligning Family Support with settings to improve school readiness
- Young Person's Domestic Abuse and Sexual Violence Advocate undertook survey of young people's experiences of Domestic Abuse in their relationships leading to revised training delivery
- Supported CSE Team with secondment of a Social Worker, management oversight and accommodation alongside CART
- Reviewed and re-commissioned a service which has increased the range of interventions for emotional health and wellbeing advice, support and assessment to children in care, care leavers, post adoption, including support for carers/social workers to support placement stability

NHS Halton Clinical Commissioning Group (CCG)

- Coordinated GP Practice Safeguarding Leads meetings
- Ensured GPs are actively engaged with local early help and support services
- Supported Domestic Abuse awareness raising
- Used Commissioning for Quality and Innovation (CQUIN) to improve coverage of health assessments and outcomes for children in care

Public Health

- Provided part funding for Child Death Overview Panel Chair
- Commissioned Wellbeing magazine promoting safeguarding messages to children in secondary and special schools and Children's Centres
- Appointed a School Nurse to work with the multi-agency CSE Team
- Ran campaigns on: Foetal Alcohol Spectrum Disorder and Drinking in Pregnancy, Smoking in Pregnancy, Co-sleeping with Babies, Domestic Abuse
- Produced briefings on Legal Highs and Cannabis use

Riverside College

- Work in partnership with agencies such as YoungAddaction, the Amy Winehouse Foundation and Terrence Higgins Trust to support young people.
- Developed a counselling service to provide intervention at an early stage for students who need it

- Use Health & Wellbeing magazine to promote positive messages and raise awareness amongst students
- Track and monitor attendance on a daily basis in order to trigger intervention in relation to absences immediately
- Recognised centre for distribution of foodbank vouchers
- Supported Domestic Abuse White Ribbon events and Advice Zones set up to support healthy relationships
- In conjunction with the Local Authority, put protocol in place for supporting transition of children in care

5. How safe are our Children and Young People in Halton?

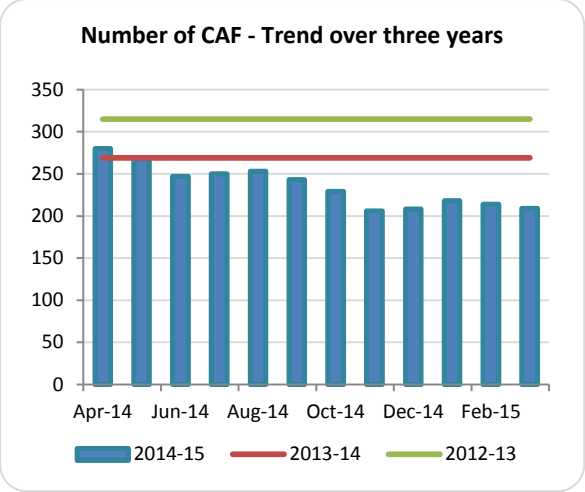
Safeguarding Activity 2014-15

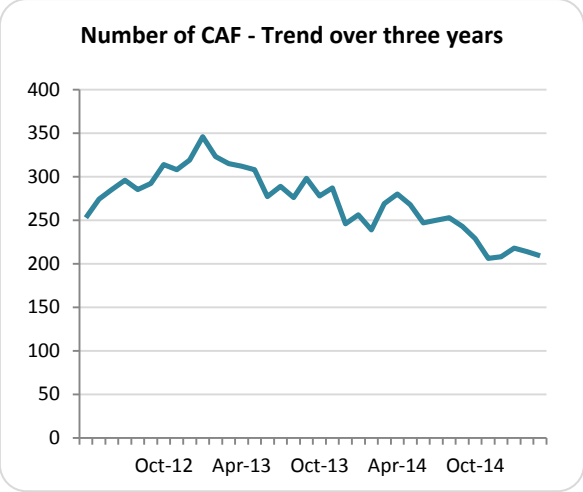
5.1 Early Intervention

Halton's Early Intervention Strategy ensures that identified and assessed needs of children and families are met at the lowest, safe level of service possible. In some instances children may have additional needs 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. The child's needs are assessed holistically, services delivered in a coordinated manner and reviewed regularly.

The CAF may also be used when the level of risk has been reduced so that families no longer need a service from Children's Social Care. This is to ensure that any ongoing needs of families continue to be met and/or that families and young people are supported to access universal services.

Since September 2014 all new referrals to early intervention and Children's Social Care are through an integrated front door staffed by social workers and early intervention workers. This Contact and Referral Team (CART) currently process on average approximately 100 early intervention referrals a month.





At the end of 2014-15 there were 209 open CAFs in Halton. This was a reduction from 269 in the previous year. A total of 466 children had been subject of a CAF during 2014-15. This compares with 536 for 2012-13 and 618 for 2013-14. The graph above shows the downward trend in the number of CAFs over the past three years. The reduction in the total number of children subject to a CAF can, in part, be attributed to the ongoing monitoring systems now in place, ensuring that all CAFs in place are active. This means that there is a plan in place which is regularly reviewed.

The number of CAFs does not represent all the work that is taking place to support children at the early intervention level. The Locality Early Intervention teams also use TAFs (Family Assessments) for children and families whose needs are multiple and complex. Since the introduction of the Locality Early Intervention teams, Halton has also introduced use of a pre-CAF to enable partners to identify needs quickly and easily. The pre-CAF is used to identify if a CAF would be appropriate or if needs could be met through signposting and referral to other services. Halton is in the process of introducing an electronic CAF (eCAF) and once this system is live it will be possible to report on the use and outcomes of pre-CAFs, CAFs and TAFs, which will better represent the broad range of support offered to families at the early intervention level.

In addition, the Health Sub Group has been undertaking work to identify whether the low proportion of CAFs led by health practitioners is due to staff using universal and targeted approaches with families when a multi-agency coordinated approach via CAF would be more beneficial to the child; or whether the work undertaken by health services at this early help level has been preventing the need for early intervention. The outcome of this work will be reported to the Board in 2015-16.

Also, as reporting of advice given at the front door by staff in CART on initiating CAFs has become more robust, the Board will be able to receive information on instances whereby initiating a CAF is advised but does not lead to a CAF being put into place. This will help the Board in challenging the multi-agency partners on the reasons for this.

5.2 Children in Need and Child Protection

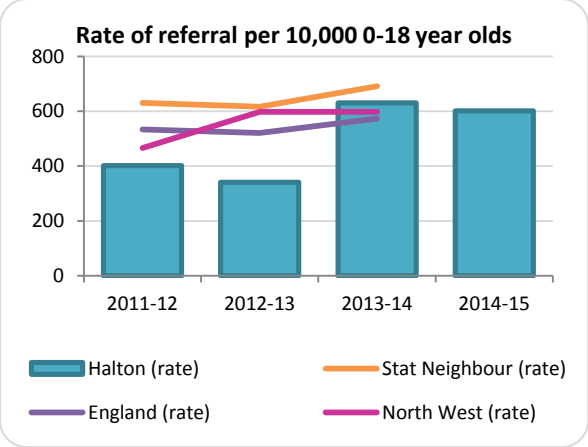
All services and the community in Halton need to be vigilant and have the confidence to report concerns where they think that a child may be at risk of harm. We also need to ensure that children have opportunities to speak out when they are at risk, or are being harmed. Specialist services such as Children's Social Care and the Police can only intervene to protect children if they are alerted to concerns. The LSCB promotes messages to both the public and staff of what to do if concerned about a child's welfare. In addition, specific campaigns are also promoted by the LSCB; such as recognising Child Sexual Exploitation, or how to keep safe using social media and the Internet.

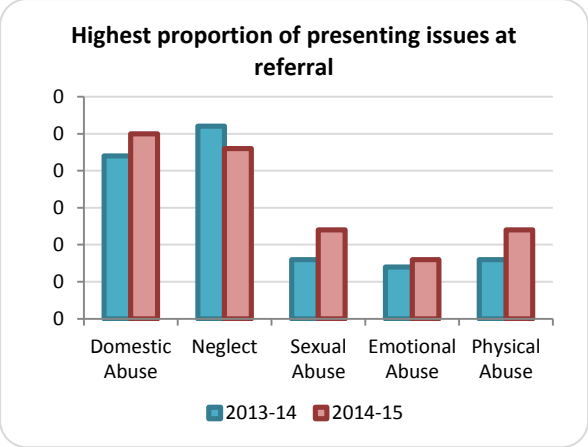
The following information is about children and young people in Halton who have been identified by the Local Authority and partner agencies as being in need of safeguarding.

The rate of Children in Need in Halton on 31st March 2014 is 462 per 10,000 population based on those children and young people who have been involved with Social Care across the Levels of Need Framework (see Appendix B Halton Levels of Need Framework). This includes those receiving an assessment, subject of Child Protection Plans, Children in Need and Care Leavers. The latest available data from 2013-14 shows that the average for Halton's statistical neighbours was 456.2 per 10,000 population.

5.3 Referrals

A referral is information received by Children's Social Care where there are concerns about a child. The response may be to provide advice, a single agency response, early intervention or to undertake a Social Worker led single assessment.





The number of referrals to Children's Social Care has reduced slightly in comparison to last year. However, since 2011-12 there has been an 85% increase in referrals. Halton's statistical neighbours have also seen high rates of referral. The latest available data for 2013-14 shows that statistical neighbours had a rate of referral of 691 per 10,000 population. In Halton we are still seeing high levels of referrals in relation to Domestic Abuse and Neglect as seen in previous years.

5.4 Re-Referrals:

We also look at re-referral rates. Over the last two years the re-referral rate has risen from 9% to 24% in 2014-15. Previously the rate has been below that of our statistical neighbours. This was of concern as a proportion of re-referrals should be expected as circumstances can change, putting children at risk despite previous work undertaken. The latest available data for 2013-14 reported that statistical neighbours had a re-referral rate of 21.1%. Although we are now more in line with statistical neighbours, the LSCB is concerned that almost a quarter of all cases were re-referrals during 2014-15. The LSCB is to scrutinise this further in order to understand what the reasons behind this may be.

5.5 Assessments:

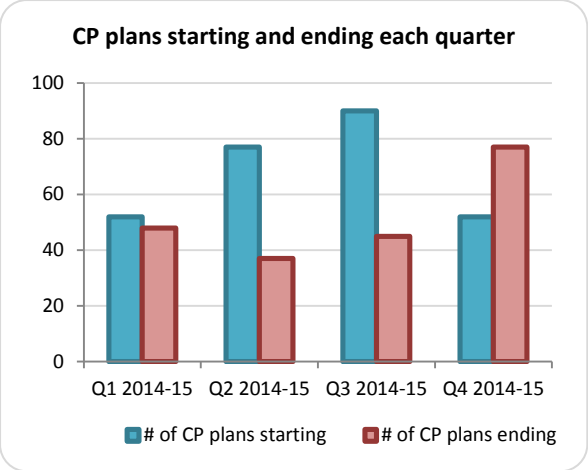
When Children's Social Care accepts a referral an assessment is undertaken by a Social Worker. The Single Assessment process replaced Initial and Core Assessments during 2013-14. In 2014-15 all assessments were undertaken as Single Assessments. Social workers have up to 45 working days to complete their assessment and determine what services, if any, are appropriate for that child/children and family. At the end of 2014-15 73% of assessments had been completed within the timescale. There is no nationally set target but the indicative national benchmark in 2013-14 was 82.2%. The locally set target is 90% which may be overly ambitious. Local intelligence suggests that completion in timescale across the North West has worsened, with provisional data indicating that only 9 out of 22 local authorities achieved in excess of 82.2% completion within 45 working days in 2014-15.

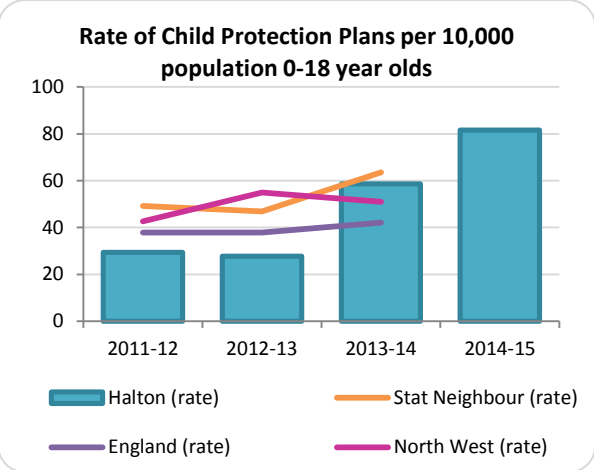
Performance was on track to be significantly improved with 86% of assessments completed within timescale at the end of December 2014. However the Ofsted Inspection in November/December 2014 had an adverse impact on the capacity of the service as staff and managers met the needs of the inspection. This resulted in staff accruing significant amounts of leave and time owing that had to be taken; there

was also an increase in sickness absence in the months immediately following the inspection.

5.6 Children Subject to Child Protection Plans:

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 the most vulnerable children have child protection plans.





A range of work was undertaken last year to better understand the reasons behind our low child protection numbers. This was reported on in last year's Annual Report. The rate of Child Protection Plans continued to increase during 2014-15.

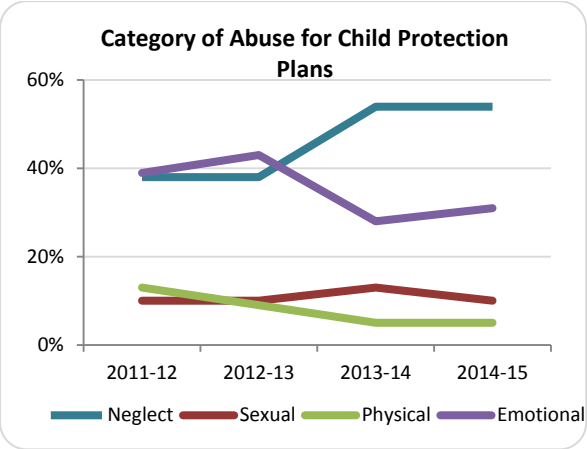
271 Child Protection Plans were commenced in 2014-15. This was an increase of 57 on the previous year. Although the number of plans has risen again, the increase has levelled off towards the end of the year. In quarter 4 (January – March) this related to 112 families; compared with 75 families at the same point last year. Halton continues to see the impact of families with large sibling groups entering the child protection process. The rate of children who were subject of a Child Protection Plan at 31st March 2015 per 10,000 population is 81.6 for Halton. The latest available data from 2013-14 shows that the average for Halton's statistical neighbours was 63.5 per 10,000 population.

The Local Authority responded to the increased demand for conferences by recruiting to an additional Conference Chair in the Safeguarding Unit during 2014-15. However, a continued increase in the number of children subject to Child Protection Plans during the year meant that conference chairs continued to have high caseloads. The impact of this on the chairs' ability to monitor the progress of plans between conferences was identified as an area for improvement in the Ofsted inspection report. Increasing the chairs' capacity is included in the Local Authority's inspection action plan and will be monitored by the LSCB via quarterly reporting from the Safeguarding Unit.

The increase in Child Protection activity has impacted across agencies. Staff across the partnership are being asked to attend and provide reports for more meetings.

The LSCB had previously been alerted to issues with attendance and reporting to conferences. If staff do not attend or submit written reports this impacts on information sharing, decision making and can lead to much longer meetings which can be difficult for the family. The LSCB undertook an audit of attendance and reporting to conferences. This has informed administration processes within the Safeguarding Unit and work on multi-agency good practice in the Child Protection process.

Category of Abuse for Child Protection Plans:



	2011-12	2012-13	2013-14	2014-15
Neglect	38%	38%	54%	54 %
Sexual	10%	10%	13%	10%
Physical	13%	9%	5%	5%
Emotional	39%	43%	28%	31%

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

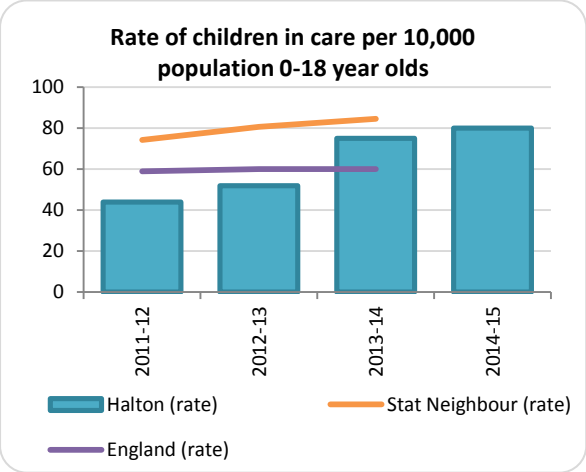
Neglect remains the most common reason for children to become subject of Child Protection Plans. There has been an increase in the proportion of plans under the category of emotional harm which reflects the national trend. This year has seen a slight decrease in Child Protection Plans where sexual harm is identified. This is a concern given the work undertaken in previous years to raise awareness of sexual abuse. The LSCB will be exploring this further in 2015-16.

At the end of the year 20% of children had become subject of Child Protection Plans for a second or subsequent time. Although this is only a 1% increase on last year, it is a high level given the increase in Child Protection Plans overall. Some of this will be due to changes to the Public Law Outline which has resulted in all children subject to pre-proceedings being subject of a Child Protection Plan given the level of risk and multi-agency coordination required. The LSCB will undertake further analysis of this group focusing upon children who have become subject of Child Protection Plans for a second or subsequent time within the previous one to two years, in order to understand how all agencies are working to reduce risk in the longer term.

Quality of Child Protection Plans:

The quality of Child Protection Plans was an issue identified in the Ofsted inspection report. Work is already underway to address this across all levels of the safeguarding continuum from early intervention to child protection. The LSCB's multi-agency training will support these changes with its audit activity scrutinising all partners to evidence improvement.

5.7 Children in Care



At 31st March 2015 there were 229 Children in Care. This was similar to the previous year. This is a rate of 83.0 per 10,000 population. The latest data in relation to statistical neighbours shows the rate as 84.6 per 10,000 population in 2013-14. In addition the majority of these children were aged 11 years or under. This is significant as it shows that the work requested by the Board of the Children's Trust last year in relation to early intervention and neglect has had an impact on reducing the number of older children coming into care.

The LSCB receives reports form the Commissioning Team on the quality of residential placements for Halton children. There is a clear process in place for reviewing any provision that falls below the Ofsted "good" judgement whilst a Halton child is placed there. In addition arrangements are in place whereby the Commissioning Team receive information from local authorities in the North West, North East and Pan London on the quality of independent placement providers which inform decisions on where to place children.

5.8 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.

Each local authority is required to maintain a current list of the children placed into its area.

On 31st March 2015 there were 169 children on the CICOLA list. Five neighbouring local authorities - Cheshire West & Chester, Knowsley, Liverpool, St Helens and Warrington account for 65% of those placements. 87% of placements overall come from North West local authorities. This shows a further continuation in the positive trend of children being placed nearer to home.

The commissioner responsible for the oversight of notifications attends the Children Missing from Education meetings to support information sharing and confirm the school/educational placement of these children. The Commissioning Team also support the Placement Provider Forum which has developed links between the independent providers in the borough and multi-agency partners such as the Local Authority, Police, Health Services, Missing & CSE Service and young people's Drug & Alcohol Service. The forum provides an opportunity for local providers to share good practice on themes such as Missing from Care, CSE, Health Improvement offer, LADO procedures and Legal Highs.

5.9 Private Fostering

Private fostering is an arrangement, usually made by a parent, for a child under 16 years (or under 18 years if they have a disability) to be cared for by someone other than a close relative (i.e. grandparent, brother, sister, aunt or uncle) for 28 days or more. It does not apply to children who are looked after by the Local Authority.

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 2014-15 five private fostering notifications were received by the Local Authority, which led to four arrangements. This was an increase of two on 2013-14, and in line with previous years. Three of the arrangements are ongoing, with one ending in the year.

The Ofsted inspection identified that more needed to be done to raise awareness, identification and notification of private fostering in Halton. The Private Fostering Group has been reviewed and is working to raise awareness. Significantly two young people are supporting the group in its work and will be reporting to the Board during 2015-16.

5.10 Children who are Adopted

The number of adoptions from care during the reporting period was 18. The average time (over three years performance) between a child entering care and moving in with their adoptive family was 521 days which has once again reduced from the previous year, and remains better than the England average of 628 days and the threshold of 547 set by government.

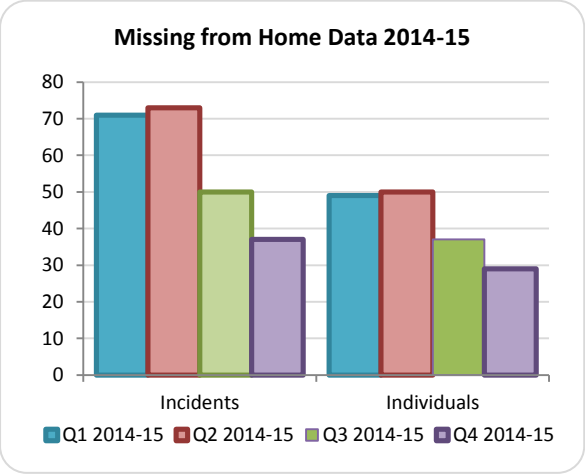
5.11 Missing Children

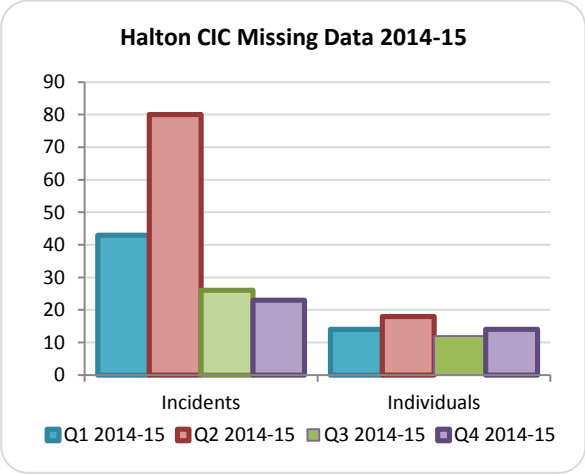
Catch22 is the commissioned service which has been providing the Missing from Home Service across Cheshire since 2012. Staff from Catch22 work closely with the police Missing from Home Coordinator and other partners. They undertake return interviews and assessment, followed by direct intervention work as required. They also undertake independent return interviews with children in care, placed outside Cheshire, but living within a 30 mile radius.

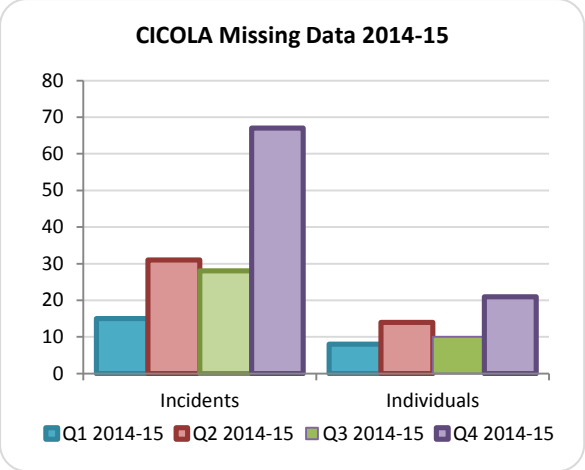
In April 2014 the revised Pan Cheshire Missing from Home Protocol was launched to reflect the updated National Guidance on Missing Incidents. The Catch22 Case Worker receives a notification for all missing incidents for children and young people under the age of 18 years. Cheshire Police forward notifications regarding all young people reported missing Pan Cheshire to the Catch22 service. For Halton children in care placed outside Cheshire, but living within a 30 Mile radius, it is the responsibility of the child's Social Worker to inform the Catch22 service of the missing incident in order that the young person can be offered an independent 'Return Home Interview.'

The Ofsted inspection found that not all children who go missing from home received a return interview and in some cases where they did receive a return interview, the record of this did not influence planning and decision making in a timely way. The Local Authority were given a priority action to ensure that all children and young people who go missing from home and care have a return home interview, and that information is made available to relevant professionals in a timely manner to inform risk assessment, management and planning. The processes were reviewed with significant improvements to recording and reporting made and staff briefed on their roles and responsibilities. The LSCB will monitor the impact of this during 2015-16.

Missing Children Data April 2014 – March 2015







Of the children reported missing 45% were male and 55% female. The average age Pan Cheshire was 15.4 years; the average age in Halton was 14.5 years. Halton missing children being on average younger than those in the other areas of Cheshire has been a consistent trend seen over previous years.

188 individuals accounted for 835 missing episodes. 65% were missing from home which was an increase from 50% the previous year. This can be attributed to the change in the Pan Cheshire Missing from Home Protocol. Those children missing from care were most likely to go missing multiple times.

The reasons reported for the missing incidents are often different depending on the young person's situation. For young people living at home, the main reasons for missing incidents were family conflict and peer pressure from friends/associates. For young people that were in the care of Halton the main reason was visiting family and friends and also associating with other young people, from home and in the care of other local authorities that go missing. There has been an increase in young people talking about the use of legal highs within the last quarter of the year with the commissioned drug and alcohol service for young people, YoungAddaction, undertaking work to address.

5.12 Child Sexual Exploitation (CSE)

Sexual exploitation can happen to boys and girls from any background. Any child under the age of 18 may find themselves in a situation that makes them vulnerable to CSE. Perpetrators can be male or female, adults or other young people.

Halton is part of the Pan Cheshire approach to tackling CSE. A Strategic Group consisting of the chairs of each LSCB Sub Group, the Lead Commissioner for the CSE and Missing Service, Police and NHS England (Cheshire & Merseyside) has developed a Pan-Cheshire multi-agency CSE Strategy which all 4 LSCBs and partners have ratified and agreed to work under. All 4 Cheshire local authorities use the CSE screening tool and procedures developed by the Strategic Group to ensure a common approach to the assessment of the risk of CSE. This consistent approach supports partner agencies who operate across local authority boundaries.

All four LSCBs in Cheshire work together to address the risks in relation to CSE. Each LSCB informs the work of, and is informed by, the Pan Cheshire CSE, Missing

and Trafficked Children Strategic Group. During 2014-15 the Pan Cheshire Strategic Group was chaired by Cheshire Police. However, at the request of the Chief Constable and Police & Crime Commissioner chairing arrangements for 2015-16 have been handed over to Halton Borough Council's Chief Executive on behalf of his Cheshire colleagues. An annual summit on CSE takes place between Cheshire Police & Crime Commissioner and the 4 LSCB Independent Chairs.

During 2014-15 the Strategic Group has:

- Reviewed the Pan Cheshire CSE policy
- Reviewed the CSE screening tool
- Promoted the 'Know and See' campaign
- Developed a Pan Cheshire multi-agency Communication Strategy
- Led on a communication plan targeting key groups including children and families
- Promoted training
- Looked at the 4 LSCB Operational Groups to promote consistency and improvements
- Considered data collection systems for implementation from 2015 onwards

Publication of Professor Alex Jay's report on CSE in Rotherham led to local MPs, elected members and the Police and Crime Commissioner seeking assurances from each local authority in Cheshire that CSE was being addressed in their area and that children were not being failed by the agencies which should be protecting them. As many LSCB partner agencies work across more than one borough, the LSCBs proposed to undertake an internal audit of CSE cases and a review of organisational practice using the same template. In Halton the outcome of the case audits and organisational review were reported to the LSCB in November 2014. The outcome was subsequently reported to elected members and the Police and Crime Commissioner in December 2014, with further development work taking place at a CSE Thematic meeting of the LSCB in January 2015.

The case audit and organisational review provided significant learning in relation to how agencies flagged those children and young people identified at risk of CSE. This informed changes implemented across Halton whereby the multi-agency CSE Team are now the central point which determines whether a child should be flagged as being at risk of CSE and when the flag should be removed. Partners are informed of this by the CSE Team. This has led to more robust and consistent reporting and recording.

Learning was also identified in relation to use of the CSE screening tool across partners which led to a thematic audit of CSE screening tools in January 2015. This has informed revision of the screening tool on a Pan-Cheshire basis and informed the CSE Basic Awareness training. There is an expectation that any referrals to Children's Social Care Contact and Referral Team (CART) in relation to CSE are accompanied by a completed CSE screening tool which should be shared with other agencies involved. The CSE Team has reported improvements in the quality of the screening tools submitted by a range of partners. Anonymised good practice examples are being used to further develop the quality of screening tools completed across partner agencies.

Findings and recommendations from the case audits and organisational review have been incorporated into the Pan Cheshire CSE Multi-Agency Strategy 2015-17 which can be viewed on the HSCB website: http://haltonsafeguarding.co.uk/wp-content/uploads/2014/01/Pan-Cheshire-CSE-Strategy-2015-17.pdf

CSE Awareness Raising:
During 2014-15 HSCB coordinated local awareness raising under the Pan Cheshire CSE communications plan. Key recipients were targeted as follows:
October/November 2014 – Schools and education: this included performances of "Risking It All" to Yr. 9 & 10 pupils supported by staff from Catch22, YoungAddaction and the Young Person's Domestic Abuse and Sexual Violence Advocate. The Behaviour and Attendance Service wrote to 59 parents and pupils accessing home tuition or receiving elective home education, providing information about CSE and a link to other sources of information. Home Tutors were also briefed on CSE.

November 2014 - Residential Children's Homes and Foster Carers: this included a performance of "Risking It All" hosted by Riverside College for children in care, including those placed in Halton from other local authorities, and staff from independent children's homes and foster care agencies in Halton supported by staff from Catch22, YoungAddaction and the Young Person's Domestic Abuse and Sexual Violence Advocate. Awareness raising was also disseminated via the Children's Provider Forum where CSE is a standing agenda item.

January 2015 - Young people, parents and general public: the website http://www.knowandsee.co.uk/ was up-dated and publicised via graphics on buses and taxis in the borough. Partners used social media to promote the website; a banner was displayed outside HBC Municipal Buildings in Widnes; and staff displayed stickers in their vehicles.

February 2015 - Hotels and taxi drivers: licensed premises received a range of information materials to display in both staff and public areas, along with briefings from Catch22. All taxi drivers licensed in the borough were written to and received awareness raising materials to display in their vehicles.

18th March 2015 – National CSE Awareness Day: HSCB, Catch22 and Cheshire Police used their twitter accounts to tweet "helping hands" and signposting to "know and see" on national CSE day. Catch22 undertook sessions with young people at risk of CSE to develop awareness raising resources.

Further detail of CSE work in Halton is set out in the section on the CSE, Missing and Trafficked Children Sub Group.

5.13 Domestic Abuse

A high percentage of referrals are received about domestic abuse. Following challenge from the LSCB regarding a need for services to support families, Core Assets were commissioned to deliver the Domestic Abuse Family Service in November 2013. The service provides information, advice and direct support to families in a variety of ways. It works directly with parents to reduce the impact of domestic abuse on parenting capacity, helping them to understand and address the impact on the child's behaviour, both individually and in groups. It gives children and

young people who have lived, or are living with domestic abuse, opportunities to share their feelings in a safe environment, through an Art Therapy service as well as within Child Safety Planning work. The service also supports Children's Social Care with the Cheshire and Merseyside Local Authority Pre-Proceedings Protocol.

During 2014-15 the service has been working at capacity and has had to stop receiving referrals at times. This led to a review of the service to work only with families open to Children's Social Care at a pre-proceedings level. This change offered more scope to staff from the service attending meetings and becoming more integrated in the multi-agency work with the family.

The service provides evidence of the impact of its work. After one to one support all children reported that they felt safer, and that their home was a better and safer place to live.

The LSCB also supported the Operation Encompass pilot in Widnes. Four neighbourhoods in each of the Cheshire local authorities were identified to take part in the pilot. The purpose of Operation Encompass was to safeguard and support children and young people who have been involved in a domestic abuse incident. Following any such incident, the Police contacted a trained member of staff at school who would then offer appropriate support to the child. The pilot has been evaluated and will be rolled out across Cheshire during 2015-16.

Although schools were receiving notification of domestic abuse incidents in a timely manner, in some cases this was in advance of Children's Social Care which led to a delay in assessing and managing risk to safeguard children. This is a priority action following the Ofsted Inspection and as a result the LSCB will be monitoring timescales for the police referring these incidents to Children's Social Care.

6. The Work of the Sub Groups

6.1 Scrutiny and Performance Sub Group

The role of this Sub Group is central to the monitoring and evaluation function of the LSCB. The Sub Group oversees actions from a programme of audit activity across the Levels of Need Framework including the Common Assessment Framework, Child in Need and Child Protection Plans, Children in Care and Care Leavers.

During 2014-15 the LSCB coordinated three Multi-Agency audits and from this good practice and areas for improvement were identified.

Areas of good practice identified and reported back to frontline staff included:

- Evidence of the voice of the child being heard and impacting on practice.
- Good multi-agency communication and working.
- Individual agencies working hard to address issues within their areas of specialism.

Areas for improvement included:

- Lack of evidence of use of escalation processes and demonstrating effective challenge.
- Evidence of drift in cases.

- Evidence of supervision within case records not consistently shown across agencies.

In addition, recommendations were made regarding improvements in the audit process:

- The need to proactively engage children and families in the audit process to ensure that their views influence practice.
- Training for the multi-agency audit group to ensure consistent grading of cases.

An action plan is in place to address learning identified from the audit process which is overseen by the Scrutiny & Performance Sub Group. In addition, the audit programme for 2015 will revisit previous themes and recommendations to evidence impact.

Appointment to the vacant Quality Assurance Officer post in a joint arrangement with Cheshire West & Chester LSCB has enabled the Sub Group to develop the LSCB Performance Framework, including additional reporting on indicators from Board partners. In addition, the Quality Assurance Officer has developed a reporting schedule for partner agencies to present the findings and progress against recommendations identified from undertaking safeguarding related audits.

Key Achievements:

- Undertaking Section 11 audits of LSCB partner agencies to demonstrate the effectiveness of their safeguarding arrangements
- 100% return on S175/157 audits of schools to demonstrate the effectiveness of their safeguarding arrangements.

Priorities for 2015-16 include:

- Reporting from partner agencies on safeguarding audit activity and its impact.
- Revision of the audit process in line with areas of improvement identified in the Ofsted inspection report.
- Revise audit process themed on specific areas to revisit previous learning to measure progress.
- Scrutiny of effectiveness of the Early Intervention Model as it becomes embedded.
- Scrutiny of impact of the Neglect Strategy.

6.2 Child Sexual Exploitation, Missing and Trafficked Children Sub Group

During 2014-15 the Child Sexual Exploitation and Missing Sub Group broadened its scope to include oversight of child Trafficking. This recognises the potential links between these vulnerable groups. Further work is to be undertaken in 2015-16 to develop the understanding of child Trafficking in the local area, alongside the work of the Pan-Cheshire Strategic Group.

Key achievements:

- Developing an Advanced CSE course for practitioners working with young people identified as being at risk of, or suffering from, CSE for roll out in 2015-16.
- Engagement in the targeted Pan-Cheshire CSE awareness raising campaigns and activity on national CSE awareness day.
- Targeted activity to raise awareness of CSE amongst parents and carers.
- Roll out “Risking It All” interactive theatre presentation to all Year 9 & 10 pupils across Halton.
- Revision of the Pan-Cheshire Missing from Home and Care Protocol leading to more detailed reporting to the Sub Group.

Priorities for 2015-16 include:

- Developing the Sub Group Work Plan to include Trafficking.
- Ensuring that missing children receive a return interview under the Pan Cheshire protocol and evidencing how this informs their plan.
- Evaluating impact of the multi-agency CSE Team.
- Longer term support for young people who have been sexually exploited and their transition to Adult Services.
- Raising awareness across a younger age range of healthy relationships.

6.3 Health Sub Group

The newly established Health Sub Group further developed during 2014-15. Health partners feel that the Sub Group is beneficial and have engaged in development and oversight of the Sub Group Work Plan. Membership broadened during the year to include Public Health in recognition of their key role as commissioners alongside NHS Halton CCG.

Key Achievements:

- Review of functions and appointment of a Named GP.
- Improvement in completion of health assessments for children in care to timescale.
- Developing links between School Health and GP Practices.

Priorities for 2015-16:

- Reporting and Safeguarding Assurance to the Board.
- Ensuring senior engagement across all health providers.
- Audit for assurance across providers.
- Reporting on provider key performance indicators.
- Neglect and early intervention, ensuring all early assessment and interventions are recognised and are effective.
- Submission of conference reports and information (GP attendance).

6.4 Learning & Development Sub Group

The Learning & Development Sub Group jointly sits under both the Safeguarding Adults Board and the LSCB. The Sub Group coordinates a joint Safeguarding Training Needs Analysis, and considers opportunities to jointly deliver training.

The Sub Group oversees the LSCB Training Programme and the evaluation of the impact of training on improved outcomes for service users. Examples of this can be seen in the Training Activity section of this report.

Key achievements:

- Developing a Learning and Improvement Framework specific to Halton
- Working across Cheshire to develop training opportunities which include delivery of Female Genital Mutilation workshops and developing a Pan-Cheshire Advanced CSE course, delivery of which will commence in May 2015.
- Broadening impact evaluation of training to include all courses
  Delivery of Crucial Crew – safeguarding workshops delivered by a range of partners including Police, Fire & Rescue Service, School Health and Road Safety - to 1500 Year 5 pupils from all Halton's primary schools.

Priorities for 2015-16 include:

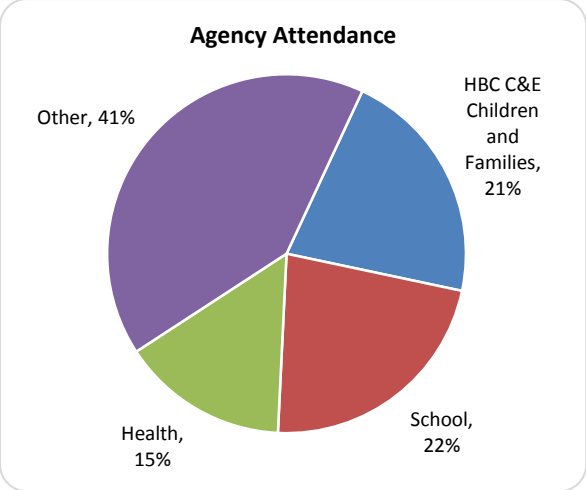
- Improving attendance from staff from the two Probation service agencies and Cheshire Fire & Rescue Service on HSCB training.
- Develop the HSCB Training Pool.
- Revising core programme courses and introducing targeted workshops on key aspects of the safeguarding process to improve practice.
- Roll out of the Neglect and Graded Care Profile training.

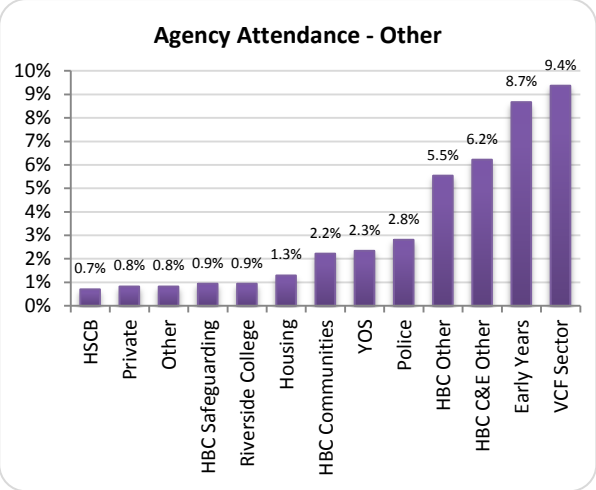
6.5 Training Activity 2014-15

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 2013-14 training programme saw 23 courses delivered with 854 places accessed. The LSCB also promoted a range of local and national e-learning.

Overall Agency Attendance on HSCB Courses 2014-15:
Between 1st April 2014 and 31st of March 2015 10 different courses were offered in the HSCB Training Programme. Delivery ranged from e-learning to two day face to face courses. The graph below indicates the overall distribution of training places by agency and across sectors.





All courses are subject to immediate post course evaluation which is collated and used to develop delivery of future courses. In addition members of the Learning & Development Sub Group undertake post course impact evaluation telephone interviews with a sample of participants. The telephone interviews provide an opportunity for reflective interviews with course participants in order to identify how learning has made a difference to their day to day practice with children and families. In 2014-15 all courses were evaluated in this way for the first time.

Examples of how training had made a difference to practice include:

- A Support Worker who identified that a young person had a significantly older boyfriend, and subsequently completed a CSE screening tool which they would have not considered if they had not attended training.
- A Social Worker who identified a counselling service for a child following the resources provided on the Domestic Abuse training.
- A Teacher who felt prepared and informed by the training when they attended their first Child Protection Conference which lead to better information sharing to safeguard the child.
- An Early Help Worker who was working with a family where a young person went missing from home. They were able to provide the family with the correct process to follow which lead to a multi-agency approach and the missing child being found safe and well.
- An Educational & Child Psychologist who advised a school to open a CAF for a vulnerable child which led to additional needs being identified and reassessment with a view to move up to Child in Need.
- An Early Years Worker who was able to give a parent information about, and support them through, the Child Protection process, as well as providing time to the child to ensure their emotional needs were being met.

The Board recruited to the vacant Learning & Development Officer post in a joint arrangement with Cheshire West & Chester LSCB. In addition, we have also appointed a Training Administrator under the joint arrangements. These are interim arrangements until March 2016 which allows both Boards to benefit from joint training initiatives and streamlining of learning and development processes.

6.6 Safer Workforce Sub Group

The Safer Workforce Sub Group also reports to both Safeguarding Boards in Halton.

The Sub Group achieved the following in 2014-15:

- Trained staff to deliver the Safer Recruitment Consortium course and rolled out the revised training to schools.
- Developed guidance for schools on the Disqualification by Association legislation.
- Revised the Local Authority Designated Officer (LADO) Procedures.

However, despite the work undertaken during the previous year to refresh the Sub Group, it became apparent that it was not operating effectively. Therefore it was agreed with the Safeguarding Adults Board that the Safer Workforce Sub Group would merge with the Learning & Development Sub Group. A Chair has been identified and the Sub Group will develop terms of reference and membership prior to setting work plan priorities that will be overseen by both Safeguarding Boards.

6.7 Local Authority Designated Officer (LADO)

Each local authority has a 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
- Behaved 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 to safeguard children from individuals and practices which may be harmful. This process also safeguards staff by ensuring that malicious or unsubstantiated allegations are thoroughly investigated and resolved in a timely manner.

Inclusion of schools in the Disqualification by Association legislation led to an increase in calls for advice due to lack of guidance from the Department for Education (DfE) and lack of advice from Ofsted on managing cases. In Halton the LADO, Safeguarding Children in Education Officer and HBC Human Resources worked together to issue guidance to schools. This was circulated to all schools in Halton, as was the revised DfE guidance.

A consultation form was introduced this year which agencies complete where they are seeking advice from the LADO. This ensures that the employer and LADO have the same information recorded. 67 contact forms were sent to the LADO in 2014-15. Of these 30 were dealt with as allegations that resulted in strategy meetings, this compares with 39 in the previous year.

Those that did not progress to strategy meeting were mainly complaints regarding restraints rather than allegations of assault. The LADO encourages such contacts in order to ensure that a potential assault does not get overlooked. There has also been an increase in retracted allegations. This mainly relates to children in care. In such cases the LADO expects the placing authority Social Worker to visit the child to ensure that the retraction has not been coerced by the setting.

90 multi-agency staff attended the annual LADO briefing in April 2015. The briefing was supported by a local High School who presented a case study on their experiences of the process. Next year's briefing will consider previous public enquiries and Serious Case Reviews which focus upon developing safe environments for children.

The Ofsted inspection identified the LADO as a strength in Halton advising that partner agencies were confident with the role of the LADO. The inspection identified that the LADO should report on how quickly strategy meetings are convened from point of referral. A new dataset has been developed to ensure that this is included in future reporting.

In March 2015 revisions to the LADO role were published in *Working Together to Safeguard Children*. The LADO is now referred to as the Designated Officer; and the referral pathway can be determined by the Local Authority. As there is good awareness of the term LADO across the region, it has been agreed in the North West that the role will still be referred to as LADO. The process for referral also remains the same in Halton.

6.8 Policy & Procedures Sub Group

The Pan Cheshire Policy & Procedures Sub Group revised the multi-agency safeguarding children procedures which were produced as a web enabled manual. This ensured that they were easier to navigate, and provided access to procedures, guidance and research all in one place.

Sub Group attendance was inconsistent during the year which impacted upon identification of work plan priorities whereby Pan-Cheshire guidance could be developed as a more efficient use of resources. The 4 Cheshire LSCB Business Managers will be working with the Sub Group Chair to address this.

6.9 Child Death Overview Panel (CDOP)

All Boards have a statutory requirement to review the circumstances of the deaths of every child under the age of 18 years, who normally reside in the borough. This is in order to identify any potentially preventable child deaths.

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

The Board recognises that the death of a child is a tragedy. Enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. The objective of the review is not to allocate blame, but

to learn lessons. The purpose of the review is to help prevent further such child deaths. Professionals supporting parents and family members during this time assure them of this, explaining the process and providing leaflets to support their understanding.

The number of all child deaths up to the age of 18 is low in each LSCB area across Cheshire. This means that it is difficult for individual LSCBs to identify trends and factors affecting the child death rate from such a low number in their area. A Pan Cheshire CDOP was therefore formed in April 2013 in order to bring together an understanding of recommendations and learning from child deaths across Cheshire. Unfortunately the CDOP Chair stepped down suddenly in October 2014 which affected the reporting arrangements from the panel to the LSCBs. Interim cover was provided by Halton Public Health. As the Directors of Public Health were unable to sustain the consistent commitment required to chair the panel, they have provided financial support to the LSCBs to part fund an Independent Chair. An Independent Chair has been appointed to the CDOP for 2015-16. This will ensure the leadership, appropriate scrutiny and reporting required to ensure that the CDOP meets its functions on behalf of the Cheshire LSCBs.

The CDOP Protocol was reviewed during the year to reflect changes in *Working Together to Safeguard Children* 2015 and to strengthen reporting to the LSCBs on local information including trends and themes. The Independent Chair of the CDOP has been given a clear remit to ensure robust reporting to the LSCBs during 2015-16.

The Pan Cheshire CDOP Annual Report is published on the LSCB's website.

7. LSCB Challenge

The LSCB has provided challenge in respect of a number of issues over the year. This has included:

- The LSCB asked the Emotional Health & Wellbeing of Young People Board and Director of Public Health to provide assurance that Halton's Mental Health Strategy was robust in addressing locally identified need and service demands in relation to children; and requested assurance of commissioning arrangements for Tier 2 and Tier 3 Child & Adolescent Mental Health Service (CAMHS) provision. The Chair of the Emotional Health & Wellbeing of Young People Board and Public Health commissioners attended the LSCB Executive to present their response.
- The Executive challenged delay in presentation of the Health of Children in Care Annual Report which was impacting upon the LSCB undertaking its business. The Executive also challenged delay in presentation of a Serious Untoward Incident (SUI) Report from 5 Boroughs Partnership. Both of these challenges resulted in the development of an Information Sharing Protocol between Health partners and the LSCB.
- GPs raised concern regarding the lack of dialogue between themselves and School Health with the LSCB Chair. This was addressed via the Health Sub Group. Contact details for School Health staff were provided to all GP Practices, as well as the role of School Health being discussed via safeguarding training for GPs.

8. Learning and Improvement

During this period the Critical Incident Panel made a recommendation to the Independent Chair for the Board to commence one Serious Case Review and to commence one lower level multi-agency Practice Learning Review. Both recommendations were endorsed by the Independent Chair. Independent Reviewers have been appointed to undertake both reviews. Both reviews will conclude and report their findings to the Board in 2015-16. The LSCB disseminated learning from national Serious Case Reviews by embedding learning across a range of courses and via the LSCB's newsletters. A link to the NSPCC case review portal is also provided via the Serious Case Review page of the LSCB's website.

An audit schedule including the CAF, Children & Families Services and the Multi-Agency practice audits continued. One of the Children & Families Services' audits was cancelled as it was due to take place at the same time as Ofsted announced an inspection of Halton. The learning from the audit schedule and the cases tracked during the Ofsted inspection has been used to inform practice.

9.0 Key Priorities 2015-16:

The LSCB's five strategic priorities are set out in our Business Plan 2015-17. In addition the Board has an improvement plan in place to meet the nine actions identified from Ofsted's review of the LSCB. The nine areas for improvement identified from Ofsted's review of the effectiveness of the LSCB are:

i. Ensure that the Board's annual safeguarding report is published immediately.
ii. Ensure that all partner agencies attend Board meetings regularly and are active participants in the work of the HSCB.
iii. Work with pan-Cheshire partner LSCBs to ensure that a chairperson for the Pan-Cheshire Child Death Overview Panel is appointed as soon as possible to ensure that the panel's work does not lose momentum.
iv. Establish effective information sharing arrangements with health partners to ensure that their own internal processes do not create delays in the work of the Board.
v. Ensure that actions identified at Board meetings are followed through systematically to hold all partners to account for the work they do on behalf of the Board.
vi. Establish an effective working partnership with local faith-based organisations, utilising the role of the appropriate Board members to engage with the wider community.
vii. Ensure that relevant staff from all partner agencies attend regular multi-agency training events to maximise opportunities for learning to support professional development.
viii. Ensure that all partner agencies have a good understanding of private fostering arrangements and that effective processes are in place to promote the notification and understanding of private fostering arrangements across the partnership.
ix. Put in place opportunities for children and young people to inform the work of the Board.

Oversight of the LSCB's improvement plan is undertaken by the HSCB Executive.

HSCB Business Plan 2015-17

1.0	**Identify and prevent children suffering harm**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 1	Timescale
1.1	Ensure that all partner agencies have an appropriate understanding of private fostering arrangements and that effective processes are in place to promote the notification and understanding of private fostering arrangements across the partnership.	Reports from the Private Fostering task Group evidence the impact of the Communication Plan and notifications provided by staff across multi-agency partners with arrangements identified at the earliest opportunity and notifications reported to Children's Social Care. Private Fostering Annual Report evidences that partners have effective processes in place to identify, record and provide notification of private fostering arrangements.	HSCB Executive		July 2016
1.2	Work with pan-Cheshire partner LSCBs to ensure effective operation of Pan-Cheshire Child Death Overview Panel.	Quarterly and annual reports from the Pan Cheshire Child Death Overview Panel (CDOP) inform the Board of learning, trends and themes from child death reviews, and measure the impact of any publicity campaigns undertaken by CDOP.	HSCB Chair and Business Manager		March 2016

2.0	**Protect children who are suffering or at risk of suffering harm**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 1	Timescale
2.1	Reduce the emotional and physical impact of harm including the risk of sexual exploitation, missing and trafficking on our most vulnerable children's health and development.	Audits provide evidence that staff across the multi-agency partnership have provided well timed, good quality involvement and practice with the outcome that children were effectively safeguarded. Quarterly performance reporting against the CSE and Missing Children datasets provide evidence of activity across the multi-agency partnership which has effectively safeguarded children.	CSE, Missing and Trafficked Children Sub Group Scrutiny & Performance Sub Group		March 2016
2.2	Children and young people who go missing from home or care have a return interview, and that information is made available to relevant professionals in a timely manner to inform risk assessment,	Quarterly performance reporting provides evidence that return interviews are taking place; audits evidence that the return interviews are informing risk assessment, management and planning.	CSE, Missing and Trafficked Children Sub Group		September 2015

	management and planning.				
2.3	Children and young people subject of Child Protection Plans have improved outcomes supported by the consistency of core groups in analysing the impact of actions on intended outcomes.	Audits evidence that core groups analyse the impact of actions on outcomes demonstrating the impact of revised guidance and multi-agency training on professional practice.	Safer Workforce and Development Sub Group Scrutiny & Performance Sub Group		March 2016
2.4	Children and young people at risk of harm are protected by strategy discussions with SMART actions and contingencies recorded.	Audits evidence that strategy discussions have SMART actions and contingencies recorded demonstrating the impact of revised guidance and multi-agency training on professional practice.	Safer Workforce and Development Sub Group Scrutiny & Performance Sub Group		March 2016
3.0	**Ensure that children are receiving effective early help and support.**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 1	Timescale
3.1	Early Intervention meets the needs of children and families.	Audits and quarterly performance reporting provide evidence that staff across the multi-agency partnership have provided well timed, good quality involvement and practice with the outcome that children received effective early intervention.	Scrutiny & Performance Sub Group		June 2016
3.2	There is a prompt	Audits and quarterly	Scrutiny &		March 2016

	and assured response when referrals are made or new information is received about child care concerns.	performance activity show how integrated front door arrangements improve information sharing and ensure that referrals are dealt with within timescales.	Performance Sub Group		
4.0	**Support the development of a safe and informed workforce, including volunteers**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 1	Timescale
4.1	Ensure that relevant staff from all partner agencies attend regular multi-agency training to maximise opportunities for learning to support professional development.	HSCB Learning & Development Activity Reports evidence that staff across multi-agency partners attend multi-agency safeguarding training and provide evidence of the impact of training on outcomes for children and families.	Safer Workforce and Development Sub Group		May 2016
4.2	The workforce is informing learning and improvement.	Audits evidence a link between quality assurance and feedback from the workforce.	Scrutiny & Performance Sub Group Critical Incident Panel		July 2016
5.0	**Participation and Engagement with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding.**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 1	Timescale
5.1	There are opportunities for children and young people to inform the	Business Plan evidences a link between priorities and engagement work with children and young people.	Lay Members HSCB Business Manager		September 2016

	LSCB's work.				
5.2	The views of children, young people and families are contributing to learning and best practice.	Audits evidence a link between quality assurance and feedback from children, young people and families.	Scrutiny & Performance Sub Group Critical Incident Panel		March 2017
5.3	Parents, carers and the public have an improved understanding of the work of the LSCB and safeguarding in Halton.	LSCB Communications Plan implemented.	Lay Members Learning & Development Sub Group		September 2016
5.4	The workforce has an improved understanding of the LSCB.	LSCB Communications Plan implemented.	Learning & Development Sub Group		March 2016
5.6	An effective working partnership is established with local faith-based organisations to improve their understanding of the LSCB and provide opportunities for faith-based organisations to inform the LSCB's work.	LSCB Communications Plan implemented. Faith Sector Safeguarding Forum in place and Work Plan implemented.	Faith Sector Safeguarding Forum		October 2016

10.0 Budget Information

Income 2014-15	
HBC – Children & Enterprise Directorate	45, 817
HBC - Schools	29, 000
NHS Halton Clinical Commissioning Group	45, 817
Cheshire Constabulary	20, 000
Cafcass NW	550
Carry Forward 2013-14	137, 206
Total Income:	**298, 888**

Expenditure 2014-15	
Staffing	126,366
Multi-Agency Training	10,761
Supplies & Services	120,591
Support Services	13,980
Premises	3,820
Total:	275,518
Carry Forward 2015-16:	49,650

Appendix A
Halton Safeguarding Children Board Membership & Attendance 2014-2015

Attendance Log			% Attendance	Meetings 2014-2015				
				08.07.2014	04.09.2014	16.09.2014	09.12.2014	31.03.2015
Independent and Overseeing Members	Richard Strachan, Independent Chair		100%	✓	✓	✓	✓	✓
	Cllr Ged Philbin, Lead Member Children & Young People (Participant Observer)		40%	✓	D	D	D	✓
Lay Members	Marjorie Constantine, Lay Member		100%	✓	✓	✓	✓	✓
Local Authority	Gerald Meehan, Strategic Director, Children & Enterprise		100%	✓	✓	✓	✓	✓
	Steve Nyakatawa, Operational Director, Learning & Achievement		80%	✓	✓	D	✓	R
	Tracey Coffey, Operational Director, Children & Families		100%	✓	✓	✓	✓	✓
	Paula St Aubyn, Divisional Manager, Safeguarding Quality & Assurance, HBC		100%	✓	R	R	✓	✓
	Lindsay Smith, Divisional Manager, Mental Health, Communities Directorate		80%	A	✓	✓	✓	✓
	Eileen O'Meara, Director of Public Health		80%	✓	D	✓	✓	R
Health	Suprio Bhattacharyya, Designated Doctor for Child Protection, Bridgewater Community		75%	A		✓	✓	

Attendance Log			% Attendance	Meetings 2014-2015				
				08.07.2014	04.09.2014	16.09.2014	09.12.2014	31.03.2015
	Healthcare Trust				R			-
	Kate Fallon, CEO, Bridgewater Community Healthcare Trust		80%	✓	A	✓	R	R
	Lisa Cooper, Deputy Director, Quality & Safeguarding, NHS England North (Cheshire & Merseyside)		20%	✓ *	A*	A*	A*	A
	Gary O'Hare, Clinical Lead Children's Safeguarding, Halton CCG		60%	✓	D	✓	A	✓
	Ann Dunne, Designated Nurse, Safeguarding Children, Halton CCG		100%	✓	✓	R	R	R
	Jan Snoddon, Chief Nurse, Halton CCG		80%	✓	A	D	✓	✓
Police	Martin Cleworth, Superintendent Northern BCU, Cheshire Police		60%	✓	A	R	✓	A
	Nigel Wenham, Detective Superintendent, Cheshire Police		80%	A	✓	✓	✓	✓
Criminal Justice Services	Donna Yates, Assistant Chief Executive, Cheshire & Greater Manchester Community Rehabilitation Company		60%	✓	A	✓	A	R
	Chris Gwenlan, Risk and Practice Development		50%	-		✓*	✓*	

Attendance Log				Meetings 2014-2015				
			% Attendance	08.07.2014	04.09.2014	16.09.2014	09.12.2014	31.03.2015
	Manager,, Probation NPS				D*			A
	Gareth Jones, Head of Service, CWHW YOS		80%	A	✓	✓	✓	✓
CAFCASS	Tom Cheadle, Service Manager		80%	✓	D	✓	✓	✓
Schools and Colleges	Dee Denton, Head Teacher, Lunts Heath Primary, Primary Headteacher Rep		80%	✓	A	✓	✓	✓
	Andrew Keeley, Headteacher, St Chad's, Secondary Headteacher Representative		75%	✓	A	R	✓	-
	Joanne Tringham, Halton Association Governors Rep		66%	✓	A	✓	-	-
	Paula Mitchell, Programme Manager, Riverside College		80%	✓	A	✓	✓	✓
VCF Sector	Donna Wells, Service Manager Young Addaction, Voluntary Sector Rep		60%	✓ *	A*	A*	✓*	✓
HSCB	Tracey Holyhead, Business Manager		100%	✓	✓	✓	✓	✓

Key:
A – denotes apologies received, but no-one attended in their place.
R – denotes a representative attended in their place.
D – denotes no apologies received and no-one attended in their place.

Appendix B
Halton Levels of Need Framework

The Halton Levels of Need Framework aims to support agencies to meet the needs of children, young people and their families to ensure the best possible outcomes. It aims to assist practitioners and managers in assessing and identifying a child's level of additional needs and how best to respond in order to meet those needs as early as possible to prevent needs escalating further.

Halton Levels of Need Framework was revised and launched in April 2013. The framework sets out three levels of additional needs above Universal Services that captures the full range of additional needs as they present. Universal Services remain at the heart of all work with children, young people and their families and are in place for all whether additional needs present themselves or not.

The fundamental relationship between Universal Services and the three levels of additional needs is captured in the diagram below:

The key principles of the Framework include:

- Safeguarding runs throughout all levels.
- Provide early help and support at the first possible stage and meet needs at the lowest possible level.
- The focus is on Halton's more vulnerable groups and directing service responses at preventing vulnerability.
- Builds on existing good multi-agency working and formalises shared responsibility for meeting all needs.
- Supports work of all agencies and is equally applicable to all agencies.
- Flexible and fluid, allows free movement between levels as additional needs increase or reduce.
- Clear and understandable
- Focus on the needs of the child and family to ensure the best outcomes for all.

Working Together 2015 seeks to ensure that all local areas have effective safeguarding systems in place and sets out two key principles that should underpin all safeguarding arrangements:
SAFEGUARDING IS EVERYONE'S RESPONSIBILITY: for services to be effective each professional and organisation should play their full part; and

A CHILD CENTRED APPROACH: for services to be effective they should be based on a clear understanding of the needs and views of children

The Halton Levels of Need Framework has been developed in line with this guidance and meets the requirement for the publication of a 'thresholds document' for Halton. It is based on a robust application of the Framework for the Assessment of Children (underpinned by the Children Act 1989), Team around the Family procedures and is consistent with LSCB procedures. The Halton Levels of Need Framework can be used as a central focal point to bring the right agencies together at the right level.

In terms of the **Children Act 1989**, our responsibilities include:

Where a child is accommodated under section 20 (when parents retain the parental responsibility for the child), the local authority has a statutory responsibility to assess the child's needs and draw up a care plan which sets out the services to be provided to meet the child's identified needs.

Under section 31A, where a child is the subject of an Interim Care Order or a Full Care Order, the local authority (who in these circumstances shares responsibilities, as a corporate parent, for the child and becomes the main contact around the child's every day needs) must assess the child's needs and draw up a care plan which sets out the services which will be provided to meet the child's identified needs.