Halton Safeguarding Children Board

Annual Report 2016-17

and

Business Plan 2015-17

September 2017

CONTENTS

1. Independent Chair's Introduction
2. Structure of the HSCB
3. Demographics of Halton
4. Key Priorities 2016-17
5. Safeguarding Activity 2016-17
6. The Work of the Sub Groups
7. Learning and Improvement
8. HSCB Challenge
9. Update from Ofsted Review of Effectiveness of the Board 2014
10. Key Priorities 2017-18 and Business Plan 2017-19
11. Budget Information

Appendices

i. HSCB Membership and Attendance 2016-17
ii. Halton Levels of Need Framework

1. Independent Chair's Introduction

I am pleased to present the Halton Safeguarding Children Board (HSCB) Annual Report 2016 - 2017. This has been an eventful year due to the impending legislative changes impacting on the role of LSCBs nationally alongside the local structural changes we have experienced. This report presents the work we have undertaken during this period and looks ahead to the challenges the Board faces.

We have seen significant progress against some of our most demanding priorities this year such as supporting partners to develop their joint response to neglect and multi - agency early help interventions. We have outlined this and other activity within the report to demonstrate the key activity undertaken to provide assurance that children and young people in Halton are appropriately safeguarded. The year ahead will be focused on continuing to strengthen our monitoring and scrutiny of key indicator information and the quality of safeguarding work of local services. This will include undertaking significant work around the future structure and governance of the local safeguarding partnership as new statutory guidance emerges. We welcome this opportunity to ensure that the HSCB moves forward with the most effective and efficient evidence based approaches. I would encourage members of the local community to use this Annual Report to understand the work of HSCB and invite them to contact us with any feedback.

Richard Strachan
Independent Chair
Halton Safeguarding Children Board

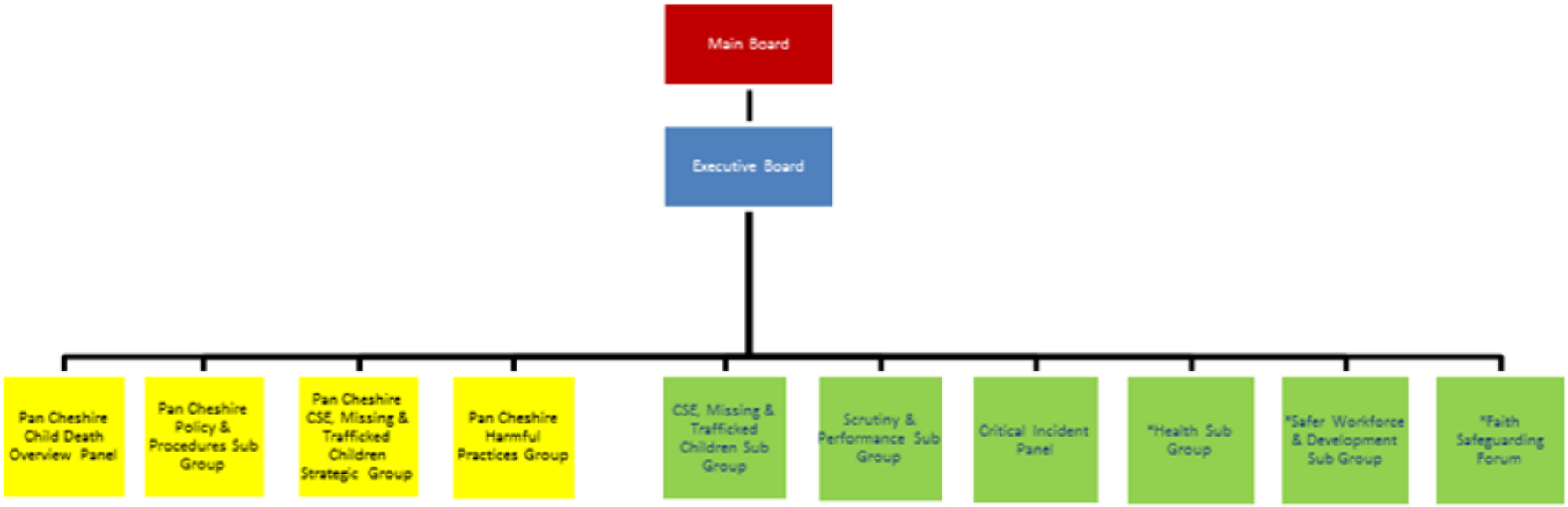
2. The Structure of the HSCB

The HSCB comprises of a Strategic Board, an Executive and a number of sub groups. All sub groups have defined terms of reference, work plans under the HSCB Business Plan and are accountable to the Strategic Board. The Main Board is the overarching decision making body and the Executive drives the business on behalf of the Board, with the sub groups reporting directly to it.

There are clear overlaps and common issues between children's and adults' services in relation to safeguarding vulnerable people, whatever their circumstances. Examples include: Sexual Exploitation, Cyberbullying and Female Genital Mutilation. The behaviours and personal situation of an adult at risk in a family can impact significantly on any children and young people in that family, and may impair parenting abilities. In addition, childhood experiences may have lasting effects into adulthood. For this reason, Halton has strong links between the Safeguarding Adults and Children Boards. The Safer Workforce and Development Sub Group was established in 2015-16 to be accountable to both Boards, as is the Faith Safeguarding Forum. During 2016-17 the Health Sub Group amended its terms of reference, membership and Work Plan to also become accountable to both Boards.

In addition to the three established sub groups which operate on a Pan-Cheshire basis - Child Sexual Exploitation, Missing & Trafficked Children; Policies & Procedures; and Child Death Overview Panel (CDOP) – a Harmful Practices group has been established to focus upon the issues of Female Genital Mutilation, Forced Marriage and Honour Based Violence. These Pan-Cheshire arrangements support the four LSCBs to work more effectively. The arrangement supports and enables improved information sharing arrangements to address issues which do not recognise local authority boundaries, such as Child Sexual Exploitation or Trafficking.

HALTON SAFEGUARDING CHILDREN BOARD STRUCTURE

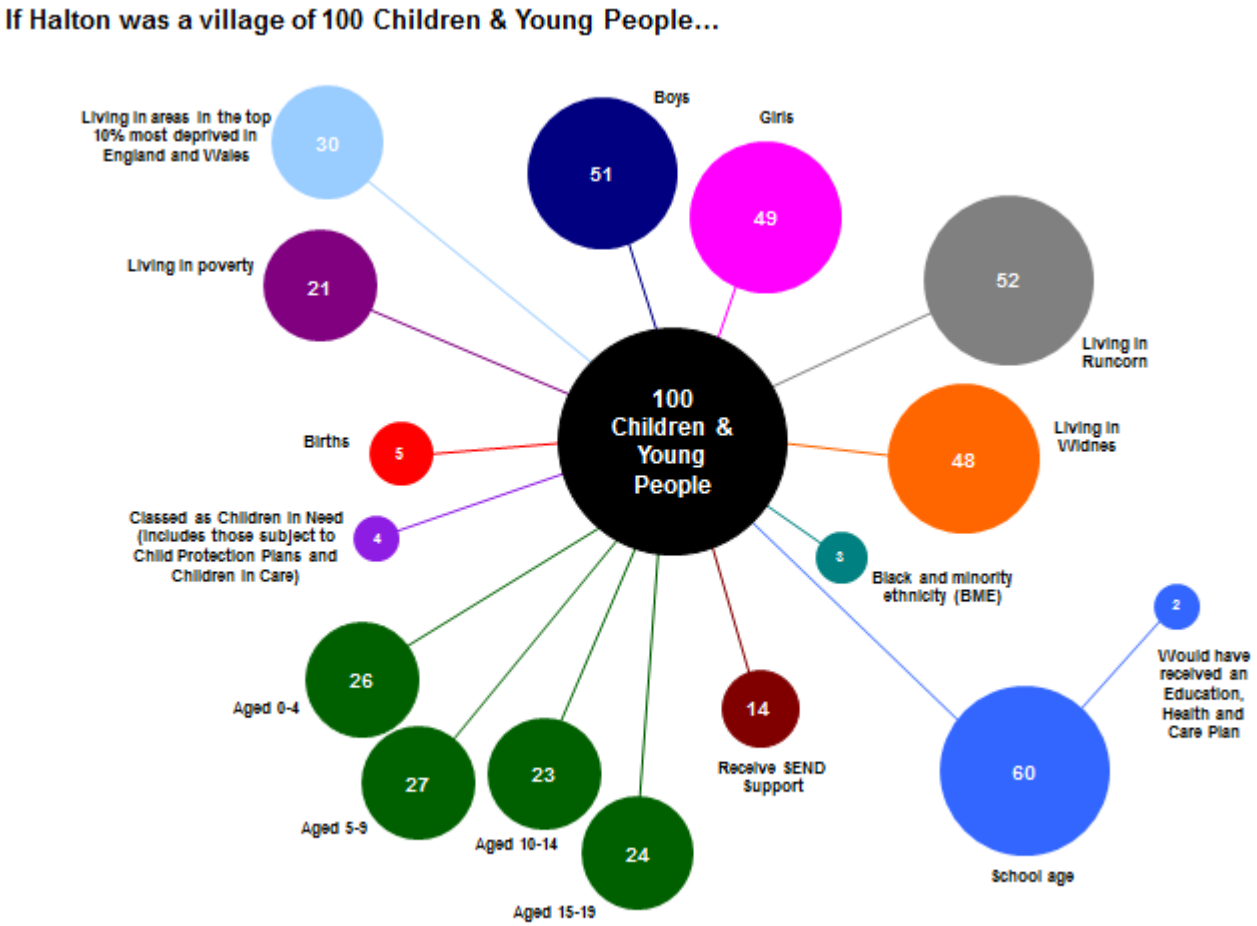


*Denotes joint Sub Group of the HSCB and Safeguarding Adults Board

3. Demographics of Halton

Halton has an estimated population of 126,900, of which approximately 29,900 children aged between 0-18 years are living in the borough. (Source: ONS, 2016 Population Estimates). The population is largely White British, 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, 2015) In 2014, 12% of children and young people were living in poverty. (Source: DWP, Out of Work Benefit Claimant Households, 2015)



4. Key Priorities 2016-17:

The HSCB's 2015-17 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.

During 2016-17 strategic priority 3 on early help and support was merged into existing priorities as it was one of the areas of focus to be considered across the strategic objectives.

In addition to the strategic objectives, the HSCB 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 the information collated through performance monitoring, audit of practice, the outcome of reviews, feedback from frontline staff and engagement work with children & families. Progress against these priorities is detailed in the body of the Annual Report.

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

Safeguarding Activity 2016-17

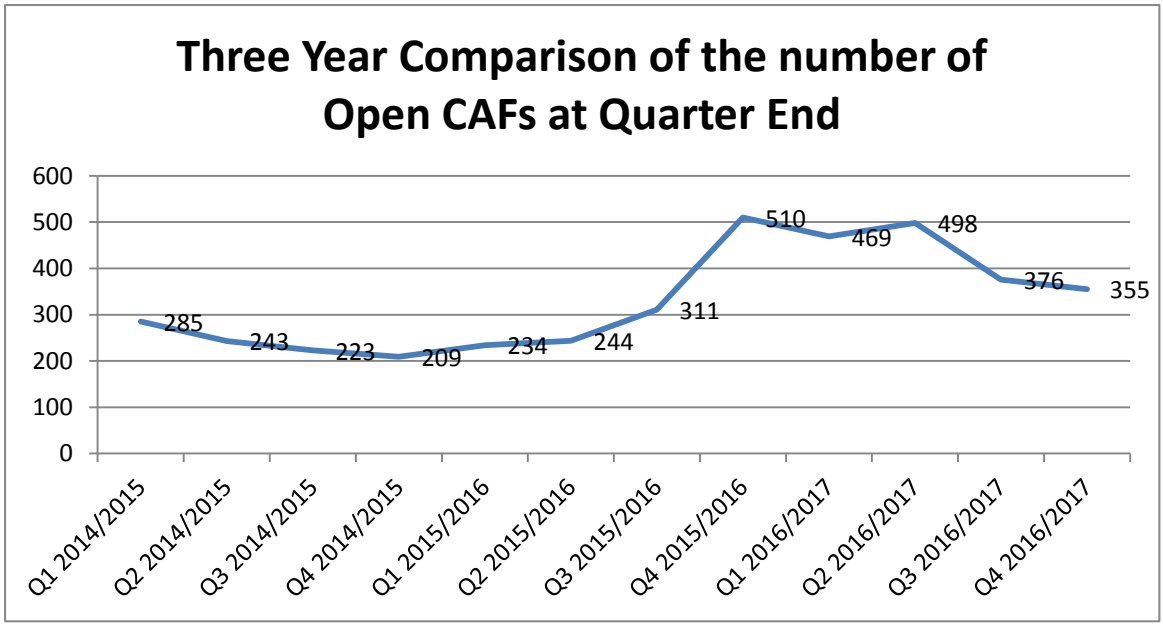
5.1 Early Intervention

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 HSCB and its partners have agreed the use of the Common Assessment Framework (CAF) which is a voluntary assessment 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 progress and outcomes 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.

Throughout 2015-16 there was an increase in the number of CAFs with this trend predicted to continue for 2016-17. However, at the end of quarter 2 some data quality issues were identified where CAFs which had been closed with the family had

not been closed on the recording system. During quarters 3 and 4 work was undertaken to address recording issues which resulted in the number of CAFs significantly reducing from the highest figure in 2015-16 quarter 3 of 510 to 355 (provisional figure) in Q4 2016/17. This is a 30% reduction.



Data in relation to step ups from CAF to Children's Social Care has been unavailable throughout the year, due to the recording systems. This data will be available for the next financial year following full implementation of a new recording system.

From this financial year, data has been available in relation to the number of CAFs advised by the integrated Contact & Referral Team (iCART) and from quarter 3 2017-18 further information will be available to ascertain how many CAFs were subsequently put into place. A recommendation from PLR Child A recognised the importance of being able to monitor this so that partners, if required, can be challenged as to why a CAF was not initiated as advised.

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 HSCB promotes messages to both the public and staff regarding what to do if concerned about a child's welfare. In addition, specific campaigns are also promoted by the HSCB; such as the "Know and See" Child Sexual Exploitation campaign.

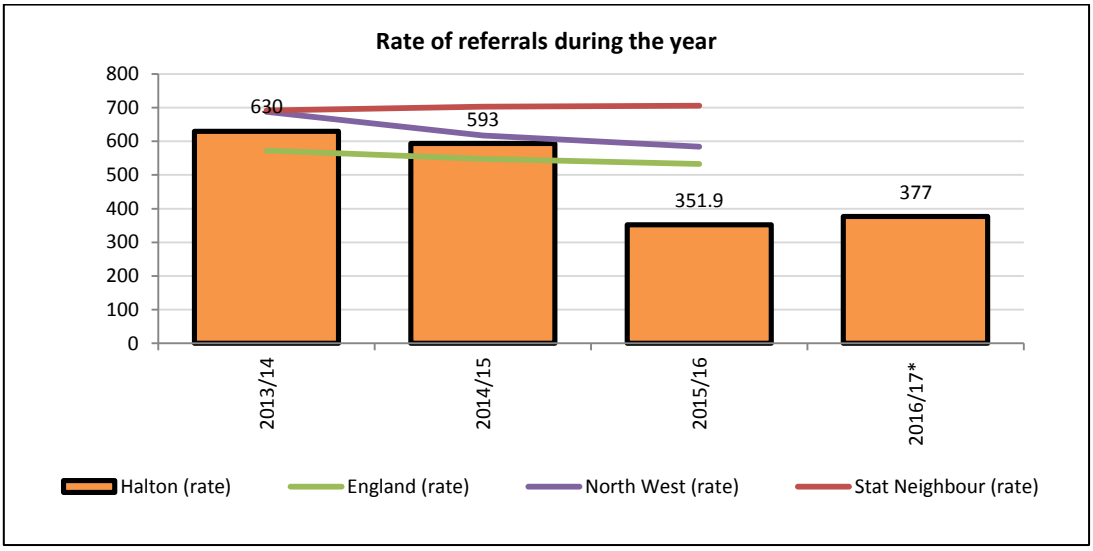
The following information is about children and young people in Halton who have been identified by the Local Authority and partner agencies as being in need of safeguarding.

The rate of Children in Need in Halton has remained relatively stable throughout the year, with the exception of quarter 2. The provisional rate for Halton at the end of

2016-17 was 382 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 2015-16 for Halton's statistical neighbours was 428.2 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, signpost to early intervention services or to undertake a Social Worker led single assessment.



Data suggests that Halton's rate of referrals slightly increased in 2016-17 on the previous year, but has not returned to the levels seen in 2013-14 and 2014-15.

Halton remains below that of the comparator data.

5.4 Re-Referrals:

Re-referrals to Social Care are defined as a referral being received within 12 months of the previous referral. Provisional data suggests that in 2016-17 Halton had 65 such re-referrals which equates to 6% of all referrals. This is a reduction from the previous year's published data which reported 10% re-referrals. This remains good performance.

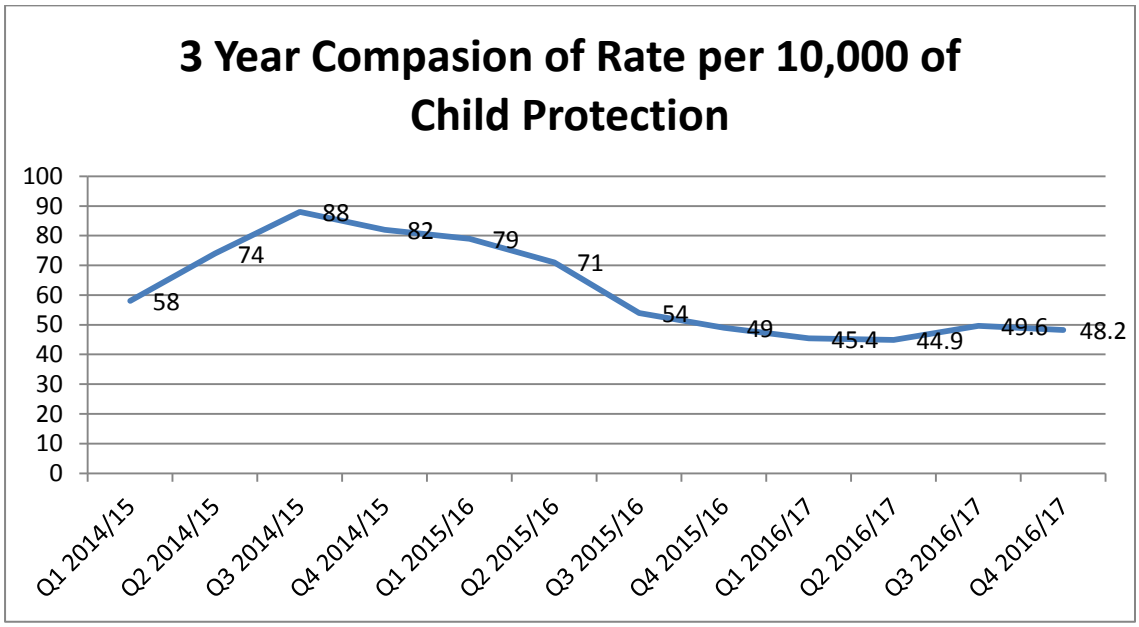
5.5 Assessments:

When Children's Social Care accepts a referral an assessment is undertaken by a Social Worker. Checks are built into the process to ensure that the child is seen in a timely manner and that the assessment is progressing to timescale. 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. The HSCB set a target to complete 95% of Single Assessments within 45 days and positively, this target was exceeded for the whole year. At the end of 2016-17 98% of assessments

had been completed within the 45 day timescale, an improvement on the previous year's average of 84%.

5.6 Children Subject to Child Protection Plans:

Children become the 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 lans.



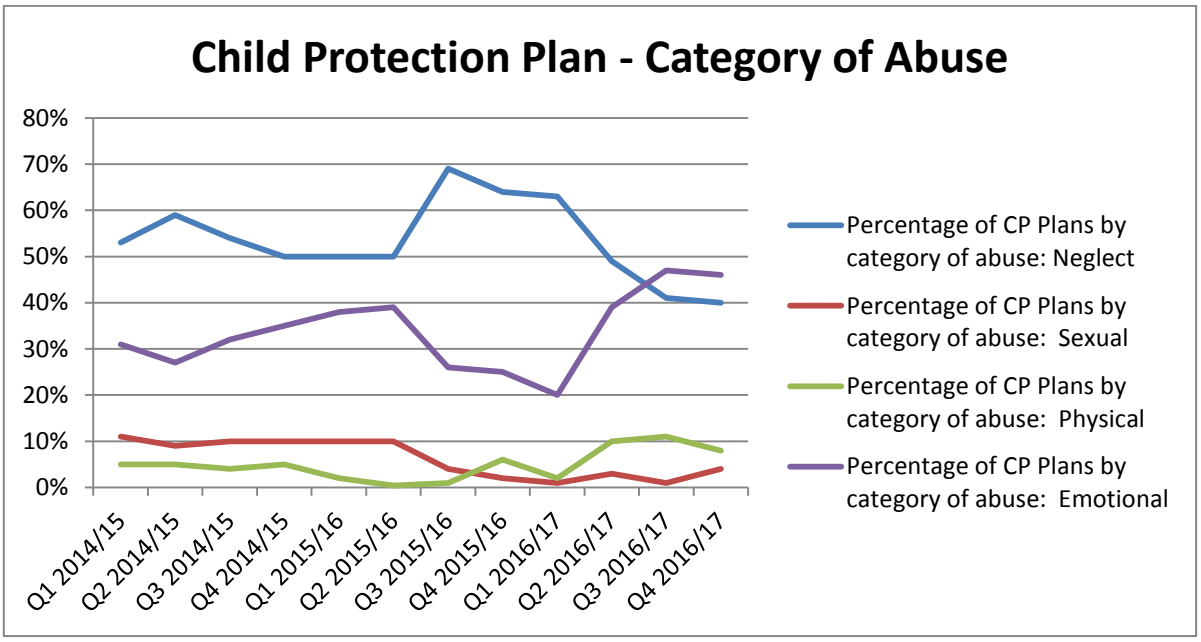
The rate per 10,000 of Child Protection Plans has remained in line with where it was at the end of quarter 4 2015-16. There has been a slight fluctuation during the year. The rate is significantly less than at the start of 2015-16 when the rate per 10,000 was 79, with the end of year rate being 47.8, which was a 39% reduction. The latest available data shows that Halton was slightly below the North West average of 55.2 per 10,000 and statistical neighbour average of 61.3 per 10,000 at the end of 2015-16.

Category of Abuse for Child Protection Plans:

The category of abuse reflects the most significant risks to the child.

There has been a reduction in Child Protection Plans with Neglect as the category of abuse. The data shows reduction from quarter 1 to quarter 4 of 23%. During the same period there was a 26% rise in the number of Plans with the category of abuse as Emotional Harm. In quarter 3 Emotional Harm overtook Neglect as the main recorded category of abuse for Plans.

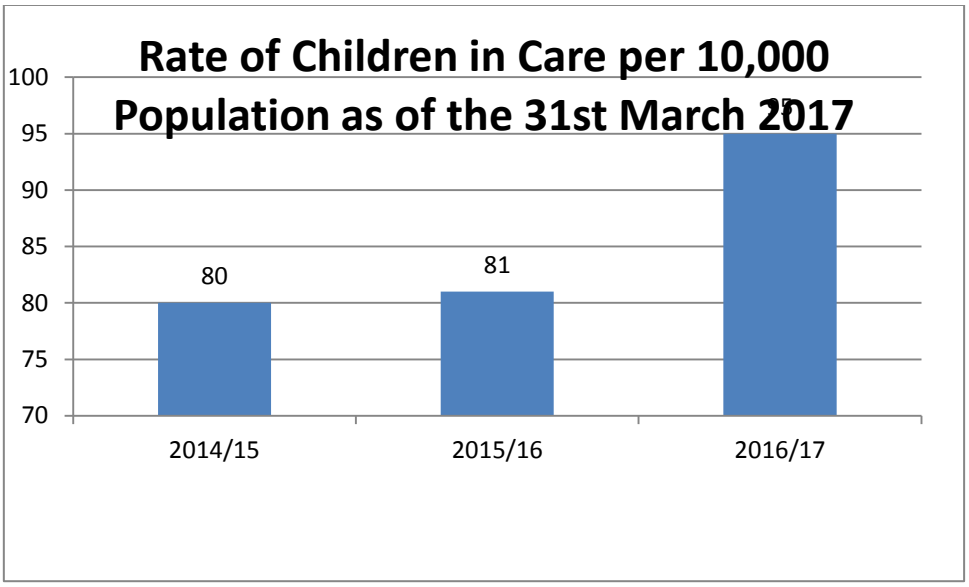
An audit was undertaken in late 2015 in relation to the low numbers of Plans in relation to Physical or Sexual Harm. There has been a slight increase in the number of Plans in relation to Physical Harm during 2016-17. A further audit has been planned for 2017-18 to provide assurance that the category of abuse is being recorded correctly, as given Halton's demographic we would expect to see more Plans where the primary concerns are in relation to Neglect.



5.7 Children in Care

At 31st March 2017 there were 268 Children in Care. This is an 11.6% rise over the previous year. This is a rate of 95 per 10,000 population. The latest available data in relation to statistical neighbours shows that Halton's rate is similar to their average of 87.9 per 10,000 population. The numbers of Children in Care remained relatively static during the financial year until the final quarter where an increase of 15 was seen.

The Board receives reports form the Local Authority's Children's Commissioning Team on the quality of residential placements for Halton children placed within or outside the borough. 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.



5.8 Children in Care of Other Local Authorities (CiCOLA)

Some children living in Halton are Children in Care of other local authorities (CiCOLAs); 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 2017 there were 149 children on the CiCOLA list, which is a 15% decrease on last year. As there has not been a reduction in residential places in the borough, it would appear that the fall in CiCOLAs is due to less independent Foster Care placements being available. 2016-17 saw the first ever decline in recruitment of independent foster carers in the North West. Local authorities have also experienced difficulties in recruiting new foster carers with the impact being that children and young people with more complex needs are more likely to be placed in residential care. Residential care homes may then experience more challenging behaviours to deal with which increases their use of services such as the police. Cheshire police introduced a scheme whereby each residential care home has a named Police Officer or Police Community Support Officer assigned. This supports development of stronger relationships between the Police and residential providers to address issues such as multiple call outs to deal with challenging behaviour or children who go Missing from Care on multiple occasions. This has developed further under local policing priorities with problem solving meetings being held with providers where, for example, there is a much higher number of missing children reports.

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 (ie 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 HSCB, which the HSCB reviews and responds to any findings as necessary.

Whilst private fostering spans most age groups it more commonly occurs for young people between the ages of 13-16 years old. In research undertaken in 2015 the reasons for being privately fostered were identified as follows:

- 25% said they became privately fostered because their parents were on holiday;
- 17% said they were privately fostered because their parents had long term health problems;
- another 17% said their parents were working away from home;
- 10% said their parents were living somewhere else;
- 9% said they'd had a row with their mum and dad;

- and 5% said their parents were in prison.
- A further 34% cited 'other' as the reason they became privately fostered. (BAAF)

In light of the research focus this year has been on developing arrangements for identifying children whose parent has received a custodial sentence. In order to do this the Board wrote to local prisons to enquire as to how they identify offenders whose children may be living in a private fostering arrangement. In addition Cheshire & Greater Manchester Community Rehabilitation Company (CRC) also agreed to undertake a piece of work to consider how they could improve notification and reporting pathways.

CRC have developed a process to support identification at the earliest opportunity during the assessment stage undertaken by the custody team (within the first 8 days of custody). CRC will look to explore with individuals where and who children are staying with whilst they are in custody. They will check to see if it meets the 'private fostering criteria' and action taken with the case manager from there, if necessary. This will be in place in all Merseyside, Cheshire and Greater Manchester prisons. However, this will not cover those from Cheshire who are serving sentences elsewhere.

The target for awareness raising in the forthcoming year will be focused on local solicitors who are in an ideal position to provide early notification to Children's Social Care where a custodial sentence is expected or takes place.

Additional targeting of hospitals will take place in order to ensure systems are in place to identify children whose parents are being sectioned due to mental health concerns and those who experience long term hospital stays due to ill health.

Private fostering activity during 2016-17 was as follows:

	2016/17
Notifications received during the report year	3 (8 abandoned)
Private Fostering Arrangements starting during the reporting year	3
Arrangements open during the year	9
Average age of those children & young people with Private Fostering arrangements during the year	11.5yrs
Private Fostering arrangements ending during the reporting year	7 (four families)
Number open at end of reporting year 31st March 2017	2 (two families)

Within Halton many of the notifications around private fostering are as a result of parental separation where the parents were not married and the child chooses to live with the parent who is not biologically related. Private fostering results but often ends as the carer is granted a formal order of care by the court.

5.10 Children who are Adopted

The number of adoptions from care during the reporting period was 13, all of whom were placed with prospective adopters within 12 months of the decision to adopt.

The government sets two threshold measures for adoption:

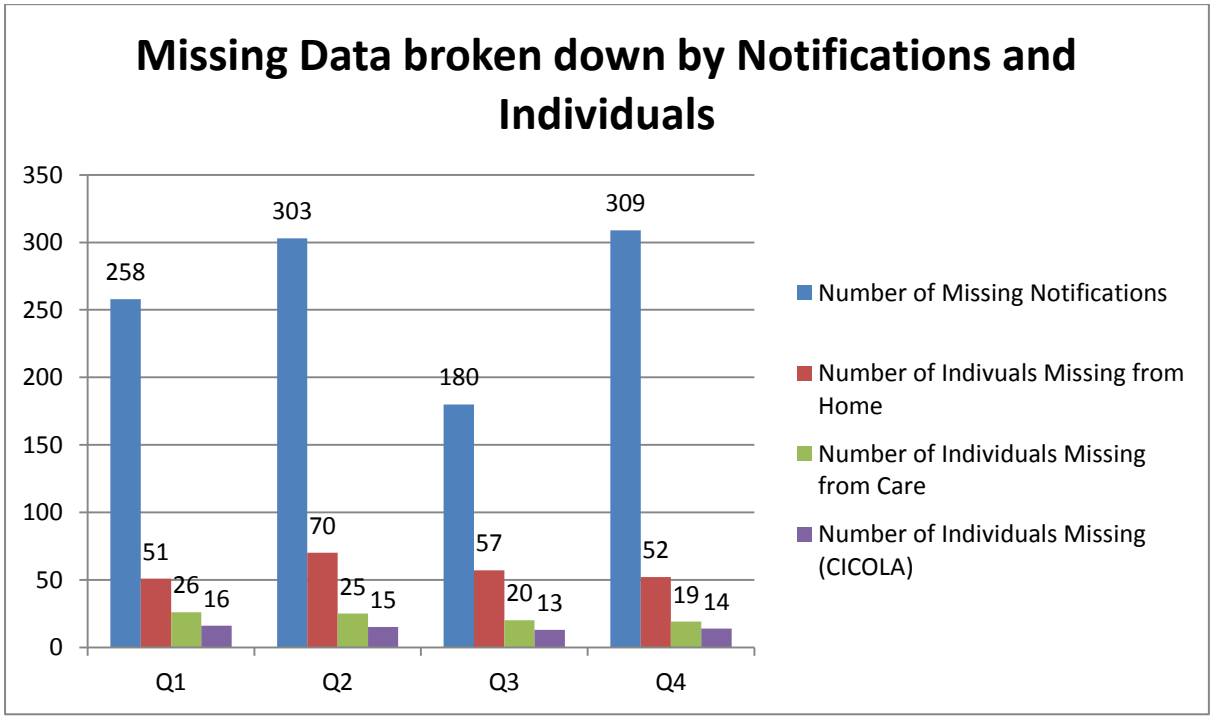
A1: Average time between a child entering care and moving in with its adoptive family. This threshold is 426 days and Halton's forecast is 467 days suggesting an improvement from the previous three year period, but not below the threshold.
A2: Average time between a Local Authority receiving court authority to place a child and the Local Authority deciding on a match to an adoptive family. This threshold is 121 days and Halton's forecast is 187 days suggesting an improvement from the previous three year period, but not below the threshold.

Despite an improvement in both indicators Halton did not meet either of the thresholds. Data published from the previous year suggests that few local authorities met the thresholds. Data is awaited to confirm the position for the three year period ending 31st March 2017.

5.11 Missing Children

Catch22 has been commissioned to provide 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 Halton's children in care, placed outside Cheshire, but living within a 20 mile radius.

Missing Children Data April 2016 – March 2017



In total, the Local Authority have recorded 1050 incidents relating to children being reported missing or absent.

The below is a breakdown by missing incident relating to whether the children were currently open to Social Work when they went missing.

473 Children in Care
236 CiCOLA
71 Child in Need
34 Child Protection

Of these 814 incidents the actual number of children who have been reported missing is 251.

The breakdown below shows the numbers currently open to Social Work when they went missing.

44 Children in Care
37 CiCOLA
40 Children in Need
18 Child Protection

Children in Care in Halton – both Haton's children and CiCOLAs - equate to 68% of all missing incidents.

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.

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

In April 2016 Catch22 were commissioned to provide a Domestic Abuse Service for families in Halton which includes a range of interventions:

- Halton Domestic Abuse Family Service for those receiving tier 3 services ie known to Children's Social Care. This includes safety planning for children to support them in keeping safe within the home; a structured programme for victims/survivors that ensures risk reduction strategies and education and awareness around domestic abuse and the impact on parenting.
- The Gateway Programme to raise awareness of the impact and dynamics of controlling relationships.
- The Jigsaw Programme to provide children who have lived with Domestic Abuse the opportunity to share their experiences in a safe and supportive environment.

Following involvement with the service one young person attended a trustee visit as a Peer Mentor to share their experiences of the service. 12 adult victim/survivors

have agreed to be Peer Champions. For 2017-18 there are plans to provide a service for young people who need help managing conflict in their relationship with their parents or carers.

Operation Encompass aims to safeguard and support children and young people who have been involved in a domestic abuse incident. Following such incidents the Police contact a trained member of staff at school/college who then offers appropriate support to the child. Following a pilot the approach was rolled out to all schools in Halton from January 2016, and is now embedded across all schools in Halton, as well as Riverside College. This is an initiative which has been welcomed by schools. Reporting has been improved during the year with schools informing the police as to the support they have provided to children and families following information received.

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 HSCB. 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 2016-17 the HSCB coordinated three Multi-Agency audits and from this good practice and areas for improvement were identified.

Key Achievements:

- 100% return on S175/157 audits of schools to demonstrate the effectiveness of their safeguarding arrangements.
- Revision of the audit process to improve attendance at focus groups by frontline staff to improve learning.

6.2 Child Sexual Exploitation, Missing and Trafficked Children Sub Group

The Sub Group achieved the following in 2016-17:

- Developing a Pan Cheshire Modern Slavery Strategy for launch in May 2017 that covered children and adults, and a Safeguarding Trafficked Children Protocol.
- Bridgewater Community Healthcare NHS Foundation Trust embedded child trafficking training into their safeguarding training programmes and the content has been updated and extended to include Human Trafficking and Modern Day Slavery. There has been development and ratification of new safeguarding children guidelines including Human Trafficking and Modern Slavery.
- Cheshire Police produced guidance on Modern Slavery for frontline officers; delivered training, and identified Modern Slavery single points of contact in each Local Policing Unit.

- Lead staff in the Youth Justice Service (YJS) completed Trafficking training to inform development of agency guidelines.
- CSE Peer review of a neighbouring area.
- Revising the Pan Cheshire CSE Protocol.
- The re-launched CSE Operational Group further developed ensuring good representation from partners and oversight of all CSE Screening Tools by the CSE Coordinator at Cheshire Police, and a consistent approach to identifying children at risk of CSE recorded by partners.
- Revising processes within iCART to ensure that the risks identified via CSE Screening Tools are considered by a multi-agency group including Police, Catch22, Social Work and Early Help practitioners.
- The YJS has its own CSE/Missing/Modern Slavery Group Meeting where strategic and operational updates from the four Cheshire areas, update and monitoring of YJS CSE data, update on interventions and training are all discussed. The YJS also has a CSE Practitioner Panel which includes the Lead CSE Practitioners and considers any cases where there are CSE/Missing/Modern Slavery concerns and the YJS is providing an intervention.
- CSE training in place across a range of partner agencies which compliments multi-agency training.
- CSE Champions have been evidencing the work they have been doing within their organisations in order to continue to promote CSE and the responsibilities within their agencies which has included:
  - A song written by the YJS Girls Group, Captive
  - Use of social media to promote #talkinghands
  - Market stalls for public, students and staff in local hospitals and Riverside College.
  - CSE is a topic on the Tutorial scheme of work at Riverside College, along with awareness raising via the health & wellbeing magazine.
  - Police Youth Engagement Officers deliver CSE awareness in schools to pupils.

Priorities for 2017-18 include:

- Revising the terms of reference of the Sub Group to include Modern Slavery.
- Delivering Modern Slavery training across the workforce to embed pathways and good practice.
- Partners to complete a CSE audit.

6.3 Health Sub Group

The Health Sub Group achieved the aim to broaden its remit to sit under both the Safeguarding Adults and Children Boards. The terms of reference, membership, priorities and Work Plan were reviewed.

There have been a number of changes in key personnel across the Health Sector partners. Most significantly NHS Halton Clinical Commissioning Group (CCG)

appointed a new Chief Nurse towards the end of the year, and will be recruiting to the roles of Designated Nurse Safeguarding Children & Children in Care, Designated Nurse Safeguarding Adults, Named GP for Vulnerable Groups (incorporating both Adults and Children), and Designated Doctor Safeguarding Children. It is of concern that the Designated Doctor post has been vacant throughout 2016-17.

The Sub Group achieved the following in 2016-17:

- Developing the Sub Group to report to both the Safeguarding Adults and Children Boards.
- Halton CCG coordinated a mapping exercise with providers against the Joint Targeted Area Inspection (JTAI) Domestic Abuse thematic inspection framework.
- Providers attending and reporting to MARAC (Multi-Agency Risk Assessment Conference which is a victim-focussed meeting where information is shared on the highest risk cases of domestic abuse) and MAPPA (Multi-Agency Public Protection Arrangements where agencies work together to assess and manage violent and sexual offenders to protect the public from harm)
- Provider involvement in a range of awareness activity relating to CSE, Domestic Abuse and Honour Based Violence.
- Revised and delivered training on a reporting template for Primary Care to Child Protection Conferences.

Priorities for 2017-18 include:

- Managing risk within out of area placements
- Ensuring outcomes in Children in Care health processes
- Full implementation of findings from all case review processes
- Implementation of recommendations relating to the Health Sector from inspections

6.4 Safer Workforce & Development Sub Group

The Safer Workforce & Development Sub Group reports to both the Safeguarding Adults and Children Boards in Halton. This year Cheshire Fire and Rescue Service became members of the Sub Group which has improved their engagement with learning and development activity in Halton which had been identified as an area for improvement during the Ofsted review of the HSCB in November 2014.

The Sub Group achieved the following in 2016-17:

- Revision of the joint safeguarding adults and children Training Needs Analysis.
- Compliance of schools against Sub Group priorities including training, safer recruitment processes and LADO scrutinised via the S175/157 Audits.
- Bridgewater Community Healthcare NHS Foundation Trust revised and updated their Safeguarding Supervision Policy
- Warrington & Halton Hospitals Foundation Trust increased capacity in the Trust to deliver supervision training by training staff on the NSPCC's safeguarding supervision training.
- Revision of Health provider organisations' Allegations Management procedures and monitoring via Key Performance Indicator reporting to Halton CCG.

- Implementation of an electronic Training Management System for the 2017-18 Training Programme which allows individuals and single points of contact within partner organisations to manage training records.

Although the Training Pool was enhanced by the addition of staff from the Safeguarding Nursing Team at Bridgewater Community Healthcare NHS Foundation Trust and HR staff from Halton BC maintaining a multi-agency, multi-disciplinary Training Pool is an ongoing concern for the HSCB. Without maintaining sufficient capacity within the Training Pool the HSCB will be unable to continue to deliver the range of multi-agency training currently on offer.

Priorities for 2017-18 include:

- Securing training pool representation and commitment to deliver courses from a broader range of partner agencies.
- Undertaking quality assurance of the LADO process.

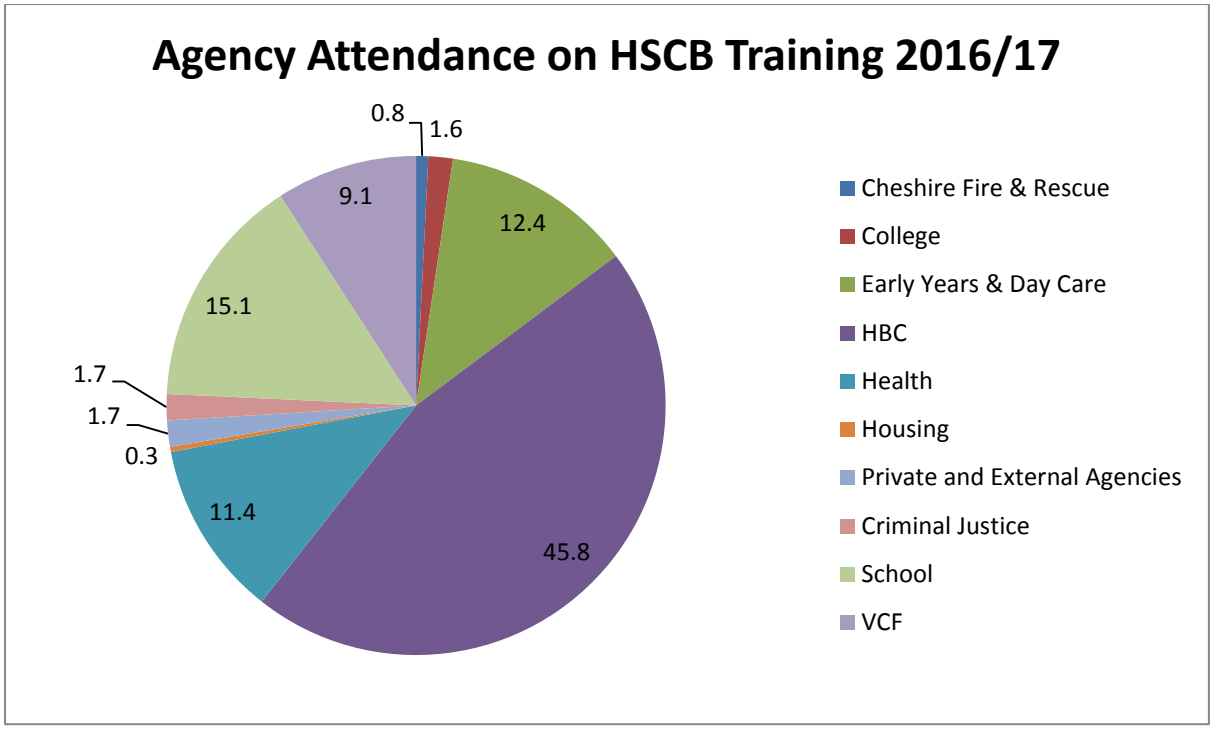
6.5 Training Activity 2016-17

The HSCB has a responsibility to ensure that appropriate safeguarding training is available to the workforce across the borough. This work is led by the Safer Workforce & Development Sub Group.

The 2016-17 training programme saw 44 courses delivered with 886 participants attending. The HSCB also promoted a range of local and national e-learning. In addition bespoke training was delivered by the Board to Home Tutors and an Academy chain.

Overall Agency Attendance on HSCB Courses 2016-17:

Between 1st April 2016 and 31st of March 2017 16 different courses were offered in the HSCB Training Programme. Delivery ranged from 2 hours to two day face to face courses. In addition a range of local and national e-learning courses are also available. The pie chart 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 Safer Workforce & 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.

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

- "My school is located in a very challenging area where a large proportion of our families have difficult circumstances. The training allowed me to revisit how to deal with difficult and challenging parents and meant that I could reaffirm our school's procedures and my own personal ways of managing such situations." *Senior Designated Person, School.*
- "My colleagues and I have been able to understand the impact of CSE and the recognised signs. We are far more aware of CSE through our interventions and now have a clear referral process into support agencies." *Housing Solutions Advisor.*
- "I have a case where I have used the CSE Screening Tool. The training informed how I complete the Screening Tool and share with others, e.g. making sure others are aware of whom the young person is associating with. I use this to see if other young people they are associating with are known to other agencies and if they have any concerns." *Supervising Social Worker, Fostering Service.*
- "This added awareness has meant that following a meeting in school, I telephoned a parent to talk in private as I had concerns about the potential

for coercive behaviour in the relationship from what I had witnessed within the meeting." *Senior Designated Person, School*

- "I have recently picked up a case from out of borough that I will be going out on a home visit to next week where there are Mental Health issues. I will take the relapse indicators out with me as part of the assessment tools I use. I will also ask for consent about obtaining a copy of the Crisis Plan." *Education Welfare Officer, Attendance and Behaviour Service.*
- "I was able to communicate more effectively with Social Workers and Leaving Care PAs to ensure that I had a full picture of the young person's situation and needs. This meant that when I was referring to other organisations in relation to education, employment or training I was able to do this more appropriately and also to share information (with consent where necessary) to help them better support the young person to engage effectively and meet their potential." *Young People Caseworker, 14 -19 Team..*
- "There was one young person who lives with their grandmother under a Special Guardianship Order. They were acting quite strange, out of character. I talked to school and spoke to the Social Worker. The Social Worker did a home visit as a result and it turned out that the grandmother had developed Alzheimer's and the young person was trying to look after her. Before the training I might not have noticed this. The outcome was that Adult Social Care provided input supporting the young person and the family. The young person is now a lot happier, engaged and back to their old self." *SEN Caseworker, SEN Assessment Team.*
- "Since attending the training myself and the wider team have started sharing more information with other health providers regarding children who are known to the Service." *Nursery Nurse, Bridgewater Community Healthcare NHS Foundation Trust.*
- "I was at a step up meeting yesterday for a family who have been in and out of services for a long time. I asked where Dad was in all of this as no one had engaged with him. He did not go to meetings and was upstairs playing on the Xbox during visits. My rationale was that he is still in the family home and we cannot ignore his impact on the family. We focus so much on Mums and in this case Mum, who was attending the meetings, was being criticised for what she hadn't done." *Social Worker, iCART.*

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

The 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.

In 2016-17 the LADO received 140 consultations. This is a significant increase on 73 consultations in 2016-17 and 67 consultations in 2014-15. Of these 59 were dealt with as allegations that resulted in strategy meetings, compared with 33 in 2015-16 and 30 in 2014-15. Proportionately this shows a slight reduction in the number of consultations converting into referrals, at 42% compared with 45%. This conversion rate is similar to that reported by other LADOs in the North West and should not be seen as a concern. This demonstrates the positive links and awareness of the LADO role, and that agencies feel able to contact the LADO for advice and guidance. It also reflects the expectations of OFSTED on providers to contact the LADO even when it is clear that the threshold is not met.

Due to the particular vulnerabilities of disabled children the LADOs operate slightly differently for such cases. Where a child is non-verbal these allegations are overseen by the LADO regardless of whether there is a specific professional identified. In the main this is due to non-verbal children not making the allegation themselves rather they tend to be made by other caregivers and often relate to injuries that cannot be explained. The importance of medical advice in these cases should not be under estimated and there has been a case recently whereby the medical report was not provided in a timely manner. Another instance identified the need to go back to the medic with specific questions about equipment and the child's disability in terms of understanding whether injuries could be explained.

Last year the LADO began reporting on how quickly strategy meetings are convened from point of referral. Only 5 strategy meetings out of 59 were convened outside of the agreed 7 days from referral during 2016-17. This is an improvement on last year. This was due to factors including: it not being possible to get the right professionals together within the time period; capacity within the Safeguarding Unit meaning that there is no Chair available within the agreed timescale; and the referral being received late leading to a meeting being held retrospectively, or managed virtually and therefore there is not a date attached to the strategy.

Last year the HSCB agreed to develop a process for quality assuring the LADO investigations. A process has been ratified by the HSCB which will be undertaken by members of the Safer Workforce & Development Sub Group in 2017.

It was reported in last year's Annual Report that following the Department for Education's decision to reinstate the outcome "unfounded" across the workforce, including teachers, the HSCB agreed that the LADO would reinstate use of there had been no cases which had concluded during the year where it had determined that the outcome of the case was "unfounded".

Training this year focused on developing safer organisations and the identification of emotional harm. Anonymised real case examples were used to reflect the audience and help conceptualise the information. An increase in consultations was seen as a result of this awareness raising and the training received positive feedback. Next year's training will focus upon Codes of Conduct due to the type of consultations received during 2016-17.

6.7 Policy & Procedures Sub Group

The Pan Cheshire Policy & Procedures Sub Group terms of reference and membership was reviewed. The group now consists of multi-agency membership across Cheshire and is chaired by the Independent Chair of Cheshire West & Chester and Cheshire East LSCBs. The group has a forward plan against which updates are reported to the four Cheshire LSCBs. The key functions of the group are to:

- Coordinate revision of the Pan Cheshire LSCB Multi-Agency Safeguarding Children Procedures Manual
- Identify topics which can benefit from a Pan Cheshire procedures approach

The Sub Group achieved the following in 2016-17:

- Produced an LSCB Escalation Policy
- Produced Female Genital Mutilation Procedures
- Coordinated revisions to the Pan Cheshire LSCB Multi-Agency Safeguarding Children Procedures Manual

Priorities for 2017-18 are:

- Sexually Harmful Behaviours Principles
- Child Protection Appeals (parents who appeal the safeguarding decision)
- Information Sharing Agreements

6.8 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 review of child deaths for Halton is undertaken by the Pan Cheshire Child Death Overview Panel. The Panel has an Independent Chair, Hayley Frame.

In 2016-17 there were eight deaths of Halton children reported to the Pan Cheshire Child Death Overview Panel. This is a slight increase on the previous year of 6 deaths. 18 Halton child deaths were reviewed and closed by the Panel during the year; five from 2014-15, six from 2015-16 and seven from 2016-17.

Published data shows that during a similar period (2013-15) the rate of child death (aged 1-17 years) in Halton was 14.5 deaths per 100,000 population, which is slightly higher than the England and North West averages. However, the infant mortality rate (under 1 year of age) during the same period was lower in Halton (3 per 1,000 live births) than the national (3.9) and regional (4.2) averages.

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

7. Learning and Improvement Activity:

The HSCB undertakes a range of activity under the Learning and Improvement Framework including case reviews, audits and performance reporting. The Board published a Serious Case Review report referred to in last year's Annual Report which focussed upon a case of a young person who suffered a life threatening incident due to neglect.

A Practice Learning Review was undertaken on a case which did not meet the criteria for a Serious Case Review, but which the HSCB agreed would benefit from a review of multi-agency working by an independent reviewer. The learning from this review focusses upon how agencies work together when young people are repeatedly missing from home, including cross border working. The HSCB has drawn up an action plan to address the learning and to measure the impact. The agencies involved have also drawn up their own action plans which they will report on to the HSCB.

An audit schedule of Multi-Agency practice audits continued. Themes for 2016-17 were: Child Sexual Exploitation, Children with Disabilities and Sexual Abuse. Additional audits were undertaken on Early Intervention, Single Assessments, Return Interviews and how they inform children's plans and a Pan Cheshire audit on the quality of Return Interviews for missing children. The learning from the audit schedule continues to be used to inform practice.

8. HSCB Challenge:

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

- Attendance at Case Conferences and Submission of Reports – reporting from the Safeguarding Unit identified a range of concerns in relation to Child Protection Conferences, including failure to share reports with families prior to conference and attendance of agencies. The issues were impacting upon the conferences which in some instances were cancelled in order to give families the opportunity to consider the content of reports. The Chair of the Board wrote to all partners asking them to respond to the concerns and to provide assurance as to how they were managing to meet their statutory requirements. Partners responded and changes were made. For example, Bridgewater Community Healthcare Trust put a process in place to ensure that one member of staff could report on behalf of the service; Cheshire Police also made changes with dedicated civilian staff being recruited to attend in place of Police Officers.
- Response Times by the Children's Social Care Contact Centre to Calls – one of the partners raised concerns regarding the significant time it could

take for safeguarding calls to be answered by the Contact Centre. This was of particular concern should members of the public call to report safeguarding concerns as they may be less likely to wait for their call to be answered.
The Board asked for a report on call waiting and response times from the Manager of the Contact Centre. This demonstrated the priority given to calls for children or adult safeguarding over calls to the general switchboard number. All partners were reminded of the direct number for the Children's Social Care Contact Centre, and times of anticipated high demand highlighted. Changes were also made to the Halton BC internet page to make it clearer for the public. No further concerns have been raised by partners.

- CiCOLA Notifications – the Board recognises that CiCOLAs are a particularly vulnerable group. Notification to the Local Authority prior to placement and when the child leaves is therefore important. Local authorities placing children often fail to notify Halton BC. The Director for Children's Services has written to his counterparts to highlight these requirements. In addition, the Chair of the Board wrote to children's homes and independent fostering agencies in the area to remind them of their responsibility to also notify Halton BC when a child is placed with them from another area.
- Private Fostering Awareness in Relation to Prisoners – an area identified for improvement was in developing arrangements for identifying children whose parent has received a custodial sentence. The Chair of the Board wrote to local prisons to enquire as to how they identify offenders whose children may be living in a private fostering arrangement. In addition Cheshire & Greater Manchester Community Rehabilitation Company (CRC) also agreed to undertake a piece of work to consider how they could improve notification and reporting pathways. This new pathway will be introduced in 2017-18 and the HSCB will monitor the impact.

9.0 Update from Ofsted Review of Effectiveness of the Board 2014:

In November/December 2014 a review of the effectiveness of the HSCB took place during the Local Authority single inspection of services for children in need of help, protection, children looked after and care leavers. Nine areas for improvement were identified from Ofsted's review of the HSCB. Since the review the areas for improvement have been addressed as follows:

i. Ensure that the Board's annual safeguarding report is published immediately – the report was published on the HSCB website and a schedule implemented to ensure that future reports are published each September.
ii. Ensure that all partner agencies attend Board meetings regularly and are active participants in the work of the HSCB – attendance at all levels of Board meetings is reviewed on a regular basis via the attendance logs; any issues are picked up and addressed by chairs at the earliest opportunity.
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 – an Independent Chair was appointed under a Pan Cheshire arrangement.

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 – all health partners signed up to information sharing agreements, and the Health Sub Group ensures that any delays are identified and challenged.

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 – actions are tracked and it is expected that the planned restructure of the HSCB with the implementation of the Quality Assurance & Scrutiny Board form April will improve the completion rate of actions given that a layer of reporting has been removed and that the Board will meet more frequently than the Executive whose functions it replaces.

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 – a Faith Safeguarding Forum has been established; the Forum delivered a well attended safeguarding event in March 2017.

vii. Ensure that relevant staff from all partner agencies attend regular multi-agency training events to maximise opportunities for learning to support professional development – training attendance is monitored and reported to the HSCB; a new electronic Training Management System will come on line from April 2017 to support reporting.

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 – specific work is outlined in the Private Fostering section of the Annual Report (see Section 5.9).

ix. Put in place opportunities for children and young people to inform the work of the Board – this continues to be an area which the HSCB needs to focus upon. Opportunities have been taken to engage with children and young people via local events, work with the Children's Trust and during the Crucial Crew workshops. This will be a strategic priority for the Board in its 2017-19 Business Plan.

10.0 Key Priorities 2017-18:

The HSCB has focussed its key strategic priorities for 2017-18 on the following:

1. Ensuring that the Board has effective and efficient structures, processes and resources in place to undertake its objectives and functions effectively.
2. Engage with children, young people and families in the work of the Board and safeguarding activity undertaken by partners.
3. Assuring the quality of practice in the local safeguarding context.
4. Support the development of a safe and informed workforce, including volunteers.

A new Business Plan for 2017-19 will track progress against these priorities.

1.0	Identify and prevent children suffering harm				
	Outcome	Performance Measurement	Lead	Key Milestones in year 2	Timescale
1.1	Ensure that the revised integrated front door is working effectively to ensure that there is a prompt and assured response when contacts and referrals are made or new information is received about child care concerns.	Audits and quarterly performance activity show how integrated front door arrangements improve information sharing and ensure that referrals are dealt with within timescales.	Scrutiny & Performance Sub Group	• Audit of referrals completed and reported to S+P Sub Group • Multi-Agency Audit on CSE cases July 2016 reported to S+P and CSEMTC Sub Groups • Early Intervention Audit reported to S+P Sub Group • HSCB Chair's visit to iCART • Performance reporting from CSC has shown that timely referrals have been made and managed within statutory timescales • The new multi-agency model of working following restructure of iCART and Early Intervention has led to further improvements in timely sharing of information and assessment of children • More efficient and streamlined VPA assessment utilising co-	March 2017

				location with partners. • Introduction of 360 assessment by iCART • Unannounced visit from the HMIC where Police received positive feedback on supported information sharing	
2.0	**Protect children who are suffering or at risk of suffering harm**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 2	Timescale
2.1	Ensure that the revised integrated front door is working effectively to ensure that there is a prompt and assured response when referrals are made or new information is received about child care concerns.	Audits and quarterly performance activity show how integrated front door arrangements improve information sharing and ensure that referrals are dealt with within timescales.	Scrutiny & Performance Sub Group	• Audit of referrals completed and reported to S+P Sub Group • Multi-Agency Audit on CSE cases July 2016 reported to S+P and CSEMTC Sub Groups • HSCB Chair's visit to iCART • PLR Child A reported to Critical Incident Panel and Main Board	March 2017
2.2	Ensure that partner agencies are working together effectively to ensure that there is a prompt and assured response when safeguarding			• Multi-Agency Audits have evidenced an improvement in multi-agency working and outcomes for children • PLR Child A reported to Critical Incident Panel and Main Board	

	concerns are identified.			• Audit of categorisation of CP Plans • Case Conference Strategy discussions now completed by DS in Referral Unit	
3.0	**Support the development of a safe and informed workforce, including volunteers**				
	Outcome	Performance Measurement	Lead	Key Milestones in year 2s	Timescale
3.1	Ensure that staff from all agencies have access to quality single and multi-agency safeguarding children training appropriate to their role to ensure that Halton has a skilled, knowledgeable and confident workforce.	HSCB Learning & Development Activity Reports evidence that staff across multi-agency partnership 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	• Impact Evaluation of 2015-16 Training on Outcomes for Children & Young People reported to SWD Sub Group • Learning & Development Activity 2015-16 reported to SWD Sub Group and Main Board • Learning & Development Activity Q1-4 2016-17 reported to SWD Sub Group	March 2017
		Training Needs Analysis provides evidence of training available to frontline staff provided by partners.		• Safeguarding Adults & Children Training Needs Analysis completed and reported to SWD Sub Group	
		Quality Assurance of single and multi-agency training.		• Training Validation Panel reports to SWD Sub Group	

3.2	Ensure that robust Allegations Management processes are in place across all partners to ensure that there is a prompt response to cases where allegations are made against staff, including volunteers, in order to support safer organisations providing services to children.	LADO reports evidence that partners are consulting with and referring cases to the LADO appropriately in order to ensure safer working practices are in place, safeguarding children and young people and supporting safer organisations.	Safer Workforce and Development Sub Group	• LADO Report 2015-16 reported to SWD Sub Group, Executive and Main Board • LADO Report 2016-17 reported to SWD Sub Group and Executive/Quality Assurance & Scrutiny Board • Increase in reporting for LADO areas around neglect and emotional harm demonstrating impact of awareness raising in 2015-17 • Improved complaints process implemented for Ofsted and their liaison with Local Authority. • All LADO meetings attended by police other than those agreed with LADO for non-attendance in advance • Any criminal investigation decision taken at LADO meeting and if already ongoing Officer in Charge will attend with DS.	Nov 2016
3.3	Ensure that effective Safer Recruitment	S11 and S175 Audits demonstrate how Safer	Scrutiny & Performance	• S175 Audit 2015-16 outcomes reported to S+P	March 2017

	processes are in place across all partners to deter, detect and act upon unsuitable individuals entering the children's workforce; this includes volunteers.	Recruitment processes are used to deter, detect and act upon unsuitable individuals entering the children's workforce.	Sub Group	Sub Group • S11 Audit outcomes 2016-17 reported to S+P Sub Group • S175 Audit 2016-17 completed and Action Plans sent to schools • LADO training sessions focused upon safer recruitment and safer working culture • Sessions on LADO and safer working practices for volunteers delivered at Faith Safeguarding event	
		HSCB Learning & Development Activity Reports evidence that staff across multi-agency partnership attend Safer Recruitment training and provide evidence of the impact of training on outcomes for children and families.	Safer Workforce and Development Sub Group	• Learning & Development Activity 2016-17 reported to SWD Sub Group	
4.0	**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 2	Timescale
4.1	Partners are held to account to ensure that the engagement	S11 and S175 Audits demonstrate how the voice of the child is used to inform	Scrutiny & Performance Sub Group	• S175 Audit 2015-16 outcomes reported to S+P Sub Group	March 2017

	and participation of children and young people is effective and informs improved services and outcomes.	service planning and delivery.		• S11 Audit 2016-17 outcomes reported to S+P Sub Group • Addaction worked with Cammordos to do a whole feedback approach consultation and used findings to shape change. • Addaction have participation undertaken via Youth Cabinet, MYP and Involve.	
		Frontline visits demonstrate how the voice of the child is used to inform practice.	Executive	• Outcome of frontline visits reported to Executive	
		Children and families are engaged in audit processes and partners are able to demonstrate how feedback has been used to improve services and outcomes.	Scrutiny & Performance Sub Group	• MAA process reviewed engagement with parents, carers and children.	
		Children and families are engaged in case reviews and the Board is able to demonstrate how feedback has been used to improve services and outcomes.	Critical Incident Panel	• SCR presented to Main Board 2016. • PLR presented to Main Board 2016. • PLR Child A presented to Main Board 2017.	
		Participation from children and	Safer Workforce	• Local and national case	

		families is used to inform the delivery of training.	& Development Sub Group	reviews used to inform HSCB training. • Feedback from parents and young people involved with CSE Service used to inform CSE training. • New training package for CSE is being written in conjunction with young people. • Competition to design radio advert on key risks such as sexting led by Safer Schools Partnership.	

11.0 Budget Information

Income 2016-17	
HBC – Children & Enterprise Directorate	45, 817
HBC - Schools	27, 995
NHS Halton Clinical Commissioning Group	45, 817
Cheshire Constabulary	25, 000
National Probation Service (NPS)	634.59
Community Rehabilitation Company (CRC)	1, 158
Cafcass NW	550
Training Income	7, 316
Carry Forward 2015-16	17, 261
Total Income:	**171, 548.59**

Expenditure 2016-17	
Staffing	106, 111
Multi-Agency Training	9, 608
Total:	
Carry Forward 2016-17:	16, 616

Appendix A
Halton Safeguarding Children Board Membership & Attendance 2016-2017

Attendance Log		Meetings 2016-2017						
			14.06.2016 (Extraordinary)	05.07.2016	13.09.2016	06.12.2016	08.03.2017 (Extraordinary)	28.03.2017
Independent and Overseeing Members	Richard Strachan, Independent Chair		✓	✓	✓	✓	✓	✓
	Cllr Tom McInerney, Lead Member Children & Young People (Participant Observer)		✓	D	✓	✓	✓	✓
Lay Members	Marjorie Constantine, Lay Member		A	✓	A	✓	✓	✓
Local Authority	Mil Vasic, Strategic Director of People		-	-	-	D	✓	✓
	Ann McIntyre, Operational Director, Education, Inclusion and Provision		✓	✓	✓	✓	✓	A
	Tracey Coffey, Operational Director Children & Families		✓	✓	✓	✓	✓	A
	Katherine Appleton, Senior Manager, Safeguarding Quality & Assurance		✓	✓	✓	✓	✓	✓
	Lindsay Smith, Divisional Manager, Mental Health, Communities Directorate		✓	✓	✓	✓	A	A
	Eileen O'Meara, Director of Public Health		✓	✓	✓	✓	A	✓
Health	Kristine Brayford-West, Associate Director for Safeguarding, Bridgewater Community Healthcare NHS Foundation Trust		A*	R*	A*	✓*	R	R
	Lisa Cooper, Deputy Director, Quality & Safeguarding, NHS England North (Cheshire & Merseyside)		✓	✓	A	A	D	D
	Gary O'Hare, Clinical Lead Children's Safeguarding, Halton CCG		A	✓	A	A	D	A
	Michelle Creed, Chief Nurse, Halton CCG		✓*	R*	✓*	A*	✓	✓

Attendance Log				Meetings 2016-2017				
			14.06.2016 (Extraordinary)	05.07.2016	13.09.2016	06.12.2016	08.03.2017 (Extraordinary)	28.03.2017
Police	Peter Shaw, Detective Superintendent, Cheshire Police		✓*	R*	✓*	R*	R	✓
Criminal Justice Services	Donna Yates, Assistant Chief Executive, Cheshire & Greater Manchester Community Rehabilitation Company		A	A	R	D	A	A
	John Davidson, Chief Executive, National Probation Service		A	✓	R	R	A	R
	Gareth Jones, Head of Service, CWHW YOS		✓	A	✓	✓	R	✓
CAFCASS	Joe Banham, Service Manager		✓*	✓*	✓*	✓	A	✓
Schools and Colleges	Karen Highcock, Head Teacher, Westbank Academy, Primary Headteacher Rep		A*	✓	A	✓	✓	✓
	John Rigby, Secondary Headteacher Representative		✓*	✓*	✓*	A*	D*	✓
	Paula Mitchell, Programme Manager, Riverside College		✓	✓	✓	✓	✓	✓
VCF Sector	Donna Wells, Service Manager Young Addaction, Voluntary Sector Rep		A	✓	✓	D	A	A
Advisors to the Board	Hayley McCulloch, Designated Nurse Safeguarding Children, NHS Halton CCG		✓*	✓*	R*	✓*	✓*	✓
	Designated Doctor, NHS Halton CCG		-	-	-	-	-	-
	Tracey Holyhead, HSCB Business Manager		✓	✓	✓	✓	✓	✓
	Marion Robinson, Legal Services HBC		✓	A	A	A	A	✓

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.
*Denotes attendance of previous Board Member in this role

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.