Hull Safeguarding Children Board

ANNUAL REPORT

2015/16

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Foreword

Welcome to the Hull Safeguarding Children Board's annual report. As Independent Chair it is my responsibility to ensure a report is published that provides an analysis of the work being conducted by agencies and how effective they are in safeguarding and promoting the welfare of children in Hull.

It has without doubt been a challenging year for agencies, many of whom have undergone considerable organisational and cultural change to meet the challenge of managing increased demand set against a background of reducing resource.

However despite this our partnership as a board has remained strong and intact, and, albeit on rare occasions, the board has applied an appropriate level of challenge to partners to ensure their commitment and work to safeguard children is as robust as ever.

I recognise though as the Independent Chair that the socio-economic pressures upon children and families in Hull are some of the most difficult in the country. With such pressures and the established correlation between poverty and worsened outcomes for children it is essential the board has systems in place to closely monitor the effectiveness of agency practice in keeping children safe. The need to further develop our quality assurance framework is a priority for the board in this coming year.

I cannot recall a time during my working life in Hull when there is more of a need for strong, focused, strategic leadership which engages the whole partnership. We need to help our communities maximise the opportunities that wealth creation through the City Plan is seeking to nurture but with a recognition some may get left behind if we don't "join up" the activity of the various boards and partnerships across Hull. Ensuring necessary support mechanisms are in place for children and families, for example the establishment of the Early Help and Safeguarding Hub must remain a priority for all partners. As budgets reduce, continued investment in "Early Help" across the whole partnership has to be a priority to help children and families at an early stage in addressing their problems before they spiral further into crisis.

As board chair I am extremely proud of the work that has been undertaken by the staff at the board. They work tirelessly to bring about improvements to practice leading on numerous excellent pieces of work. Examples of such include the development of the pre –birth vulnerability pathway, raising awareness of female genital mutilation and strengthening the multi -agency response for children at risk of Child Sexual Exploitation.

I would wish to place on record my sincere thanks to my vice chair Kate Munson (National Probation Service) and my board

manager Neil Colthup for their outstanding support in my role as Independent Chair. Without them my job would be impossible.

Rick Proctor

Hull Safeguarding Children Board - Independent Chair.

The Role of the LSCB

Hull Safeguarding Children Board (HSCB) is a statutory body established under the Children Act 2004. It is independently chaired (as required under statutory guidance) and consists of senior representatives of all of the agencies and services which work together to keep children in Hull safe and to promote their welfare.

The HSCB has a range of roles and statutory functions, including developing local safeguarding policy and procedures and scrutinising local arrangements (how well local agencies work together to keep children safe). The statutory objectives of the HSCB are to:

- Coordinate what is done by each of the Board's partners to safeguard and promote the welfare of children in Hull; and
- Ensure the effectiveness of this work.

Local Safeguarding Children Boards (LSCBs) also have a number of statutory functions, including:

- The development of policies and procedures for safeguarding and promoting the welfare of children, including the action to be taken where there are concerns about a child's safety; training of people who work with children or in services affecting the safety and welfare of children; recruitment and supervision; investigation of allegations; the safety and welfare of children who are privately fostered; and, cooperation with neighbouring authorities.
- Communication about the need to safeguard and promote the welfare of children and about how this can best be done
- Monitoring and evaluating the effectiveness of what is done locally and providing advice on ways to improve
- Participating in the planning of services for children in the area
- Undertaking serious case reviews and advising Board partners on lessons to be learned
- Reviewing all child deaths in the area.

The purpose of the Annual Report

Each LSCB Independent Chair is required to publish an annual report on the effectiveness of child safeguarding in its area, including on the performance and effectiveness of local services and the action being taken to address any weaknesses.

The report also provides a summary of the key work undertaken by the Board during the course of the year in pursuance of the key objectives and main functions, including progress against the priorities identified by members in June 2015.

LSCB Partners

The legislation and statutory guidance describe a range of Board partners who must be included in the LSCB. These are:

- The local authority
- The police
- The National Probation Service and Community Rehabilitation Company
- The Youth Offending Team (Youth Justice Service)
- NHS England and clinical commissioning groups
- NHS Trusts and NHS foundation trusts
- Cafcass
- Representatives of maintained schools, non-maintained special schools, academies and further education institutions.

Board members should be people with a strategic role in relation to safeguarding children within their organisation, capable of speaking with authority for their organisation, committing their organisation on policy and practice matters and holding their own organisation, and others, to account.

The HSCB also includes, as members, the Designated Doctor & Designated Nurse (for safeguarding), the local authority City Manager for Public Health and a representative of the voluntary and community sector. The local authority is represented by the Director for Children's Services and the senior managers for safeguarding children, early help, housing and neighbourhoods and adult's social care. Member organisations share the responsibility to ensure that the LSCB is provided with reliable resources to enable it to be strong and effective.

The integrated inspection of the Board (published in February 2015) identified that "partnership work is mostly effective and all key partners are well engaged and make an active contribution to improve the delivery of services for children and young people."

The strong and consistent engagement in the Board itself continued in the main during the period, although there were some exceptions which need to be addressed in the next period:

- As a result of major internal reorganisation and personnel changes, Humberside Police were unable to provide a consistent representation at the Board for most of the period, although this situation had been resolved by January 2016.
- Cafcass were represented at only one of six Board meetings during the year and NHS England are now represented via the Designated Nurse. This reflects the challenges for both organisations in securing representation for 15 LSCBs on a regional basis.
- The Hull and East Yorkshire Hospital Trust was represented at each of the Board meetings, but each time

this was by a deputy rather than the designated senior Board member. The trust is reviewing its safeguarding lead arrangements and this is likely to improve significantly in 2016/17.

- There is strong and consistent representation from the primary schools sector in Hull, but both the secondary head teacher and special schools head teacher representatives resigned their roles and had not been replaced by the end of the period.

A 'core budget' of £412,550 was agreed for the Board for 2015/16, made up of the following contributions:

Hull City Council	£227,000
Humberside Police	£ 20,000
NHS Hull CCG	£ 85,000
Hull School's Forum	£ 80,000
Cafcass	£ 550
Total	**£412,550**

Individual partners, and the Board itself, entered the period with the benefit of the outcomes of the Integrated Inspection Pilot which took place during November/December 2014 and some clear judgements about where improvement was needed, individually and collectively, in order for help and support services for Hull's children to become consistently 'good'.

Amongst the common challenges identified (and described in more detail elsewhere in the report) are:

- The management of increasingly complex demand in the context of diminishing resources
- The 'drift and delay' experienced by a minority of children and young people in receiving the help and support they need
- The imperative of strengthening partnership targeted early help and support, to better meet need and reduce demand on acute services
- The need to strengthen responses to a range of safeguarding issues eg: child sexual exploitation and missing children, female genital mutilation
- The need to strengthen quality assurance and performance management arrangements in individual agencies and across the partnership as a whole.

HSCB partners recognise that "getting to good" will require effective multi-agency working at all levels. The Board itself identified five key improvement priorities:

- Monitoring and evaluating the quality and effectiveness of practice and influencing continuous improvement

- Lead on ensuring that the partnership work to tackle child sexual exploitation and children who go missing is consistently ‘good’ or better.
- Ensure that the learning from local ‘learning from practice’ exercises leads to sustained improvements in safeguarding practice.
- Develop mechanisms to consistently capture the views and experiences of children and young people and their families and use these to improve services and outcomes.
- Improve the way that the Board effectively communicates, across a range of audiences.

An assessment of progress against these priorities is described on pages 42-44.

The additional challenge for the Board, and the Board staff team, was to sustain work on its ‘core’ statutory functions, to manage the demands of an unprecedented volume of serious case review work and to respond to new development imperatives, whilst trying to create the capacity for an additional focus on the five priorities.

How the Board undertakes its work

The full Board continued to meet on a bi-monthly basis during 2015/16. The Board is a large partnership and the focus during the year remained upon how best to maximise the engagement and involvement of such a wide range of key partners, whilst also efficiently considering ongoing business.

Board meetings continued to be well-attended. They were structured to ensure the opportunity for a more in-depth conversation about identified key issues, often involving managers and practitioners directly involved. The Business Group, established in September 2014, continued to meet between main Board meetings and to develop as a mechanism for managing 'core business' and setting the agenda for the full Board.

The Board's 'engine room' remains its sub-committee, work streams and task groups (*Appendix 1),* the effectiveness of which is heavily dependent upon the Board's staff team and the continuing commitment of managers and staff from all partner agencies.

This set of arrangements is fairly typical of LSCBs, but it still represents a significant expansion over the years since 2011, reflecting the changed and growing demands and expectations on LSCBs.

In 2011, the Board 'governance' structure comprised the Board itself, an effective Guidelines & Procedures sub-committee, an 'ad-hoc' Training & Development sub-committee, Child Death Overview Panel, 'as and when' needed serious case review meetings and various work streams. By 2015-16, all of these arrangements remained in place, but with the addition of the Business Group, a more regular, established Training & Development sub-committee, standing Serious Case Review sub-committee, CSE sub-committee and Quality Assurance & Performance Management sub-committee.

Inevitably, servicing this infrastructure, and ensuring effectiveness, creates capacity challenges, not solely for the Board staff team but also across the partnership where engagement often relies upon the same key agency safeguarding leads.

In March 2016, the Board as a whole considered new proposals designed to make best use of the whole partnership and agreed (for 2016/17) to:

- Hold three full day (rather than six half-day) meetings of the full Board

- Undertake, on each occasion, a ‘deeper dive’ into a particular safeguarding ‘theme’, based on local priorities and joint targeted area inspection themes.
- Explore ways to hear directly from practitioners, link ‘walking the floor’ activity to themes and focus on the experience of children and young people
- Conduct meetings more informally, creating opportunity for small group work and facilitating the active engagement of all partners
- Focus on the impact on children of domestic abuse (July 2016) and then ‘the front door’ and early help (November 2016) as the first two themes
- Strengthen the Business Group to manage more of the routine business of the Board to free up time and space for the above.

The effectiveness of these arrangements will be reviewed towards the end of the next period (February 2017). At the same time, the wider governance arrangements will be reviewed to explore how essential core functions can be sustained and the pace of improvement accelerated.

Significant work in 2015/16

The following are examples of some of the work undertaken and led by the Board during the period:

- A development day in June 2015 to consider inspection outcomes and agree the Board’s priorities.
- A focus at Board meetings on key priorities throughout the period including: post-inspection improvement activity (local authority, police, health); early help and the proposed Early Help and Safeguarding Hub (EHaSH); young people’s emotional health and well-being and CAMHS provision (linked to key learning from the Child W SCR)
- The appointment of a new Independent Chair and agreement to fund an additional two days/month
- The continued, ongoing development of multi-agency procedures and practice guidance – a revised set of guidelines and procedures (based on revised statutory guidance) was launched in May 2015. The inspection of the Board in 2014 found that *“the LSCB ensures multi-agency policies and procedures are fit for purpose, reviewed effectively and are updated appropriately to incorporate statutory responsibilities and changes to practice.”*
- An agreement to strengthen quality assurance and performance management arrangements by focusing on developing a ‘drift and delay’ scorecard (a key theme from across the inspection reports) and measuring improvement
- A review of all of the Board’s safeguarding training courses to ensure that common themes and messages, including learning from serious case reviews, are consistently woven through all training. The inspectors found that *“training is well delivered, well received and highly rated by professionals.”*

- Continued effective multi-agency work on reviewing all child deaths (see pp 33-35 for more detail). Inspectors found that local arrangements were *"highly effective."*
- Conducting the next phase of section 11 audit work by focusing on early years services and providers
- Progress on developing FGM pathways, also informed by learning from a review of an FGM case
- Progress towards finalising revised 'unborn' procedures and pre-birth vulnerability pathways
- Auditing of practice to inform both FGM and pre-birth development work
- Further work on 'diversity' taken forward from the Board's diversity conference in February 2015
- Strengthened arrangements and multi-agency practice in relation to child sexual exploitation
- A strong children's safeguarding contribution to the commissioning of key services, including 0-19 public health nursing (health visiting, school nursing) and adult substance misuse services to ensure that contracts clearly describe safeguarding duties and requirements
- The maintenance of regular, weekly safeguarding bulletins, capturing key local and national messages and publications.

Examples of 'challenge'

LSCBs have a clear role to identify where improvement is needed and to both challenge and support partners in securing that improvement. This is very much integral to all of the Board's work (described above). Additional examples of specific challenge led by the Independent Chair include:

- To all partners to improve performance in relation to child sexual exploitation. Whilst a strategy was in place, there was no effective structure for delivery. A high level strategic sub-committee was established, led by the Chair, leading to the formulation of an initial 'problem-profile' and progress in relation to the three strategic strands
- To Humberside Police and the PCC in respect of consistent senior representation at the Board and assurance of progress in respect of the recommendations from the HMIC inspection (2014)
- To the police and local authority with regards to the provision of accommodation for children detained after charge
- To Humberside Police in relation to attendance at initial child protection conferences which helped to influence significant improvement during the year
- To the local authority, police and other partners in respect of the pace of progress in the development of the EHaSH
- To the local authority, and partners, in regards to the pace of progress in reviewing the arrangements for supporting vulnerable young people (key outcome of Child W SCR)

The effectiveness of the Board

This summary of the ways in which the Board undertakes its work shows that it has been able to sustain good practice and performance in relation to some key 'core' functions (guidelines & procedures, training, reviewing child deaths, serious case reviews) and make some good progress in relation to some key improvement priorities (eg child sexual exploitation). The narrative also shows where the Board has focused attention and sought to exert influence and developments in relation to important multi-agency work (eg pre-birth vulnerability, FGM).

Some progress has been made in relation to most of the priorities identified, but further focus is needed to accelerate the pace of change and development in some key areas:

- The decision to focus on developing a 'drift and delay' scorecard was informed by the outcome of inspection and made sense as an attempt to create something meaningful and 'bite-sized'. However, although significant progress was made, this was difficult to achieve, and still highlights deficits in relation to individual agency, and collective, data collection, quality assurance and performance management arrangements.
- The decision to focus in detail (in 2016/17) on specific key themes in order to understand quality and impact needs to be underpinned by a framework of regular, routine joint evaluation of cases.
- The Board has still not significantly developed mechanisms for direct engagement with children and young people
- Despite the continued focus of the Board, the pace of progress in some critical areas needs to be quicker: a key example being the development of the EHaSH.

Growing up in Hull

Based on the most recent estimates (2014), 257,710 people live in Hull, including 61,884 children and young people aged 0-19 years. Hull's population remains predominantly 'white British' (89.7%) with a BME population which is still relatively low compared with many areas in the country. However, the BME proportion has tripled between 2001 and 2011. Hull's BME population is also diverse, with relatively small numbers of people from a wide range of BME groups. At 16.0% the proportion of school children from minority ethnic groups has increased from 14.9% in 2014.

Hull is ranked as the third most deprived local authority out of 326, with 17 of its 23 wards amongst the most deprived 20% nationally. Child poverty is high in Hull with 31.1% of children under 16 living in poverty, compared to 18.6% nationally. The rate of family homelessness (3.1%) is higher than regional and national averages.

The Child and Mental Health Observatory report '*Key Risk Factors Indicating Harm or Poorer Developmental Outcomes in Children (2013),* states that:

"It is widely accepted that adverse factors relating to a young child's family and environment cause poorer outcomes for the child, both to their safety and to their development and behaviour"

The factors identified include parental mental health issues, substance misuse, domestic violence, financial stress and teenage motherhood.

Domestic abuse rates in Hull remain high and the number of incidents reported to the police increased significantly during 2015/16 by 22% (from 6,091 incidents in 14/15 to 7,423).

High smoking prevalence, alcohol and substance misuse, poor educational attainment and lack of employment opportunities all impact on the health of Hull's population.

Hull's 'Health and Wellbeing Strategy 2014-20' identifies that:

"What happens in early years has a lifelong impact. Giving every child the best start in life is crucial to reducing health inequalities across the life course. Healthy and informed parents who have control over their own wellbeing will have healthier babies and raise healthier children.

Children who are ready for school will be able to get the most out of their education and fulfil their potential. Building emotional resilience will help children handle the pressures of growing up and give them the right knowledge and skills to overcome challenges.

Families who make healthy lifestyle choices will thrive."

Given all of the indicators for the overall and adult populations in Hull, it is no surprise that the health and wellbeing of its children is generally worse than the England average (*Child*

Health Profile, March 2016, Public Health England). This is reflected in lower (than average) rates of development at the end of reception and at GCSE, higher rates of 16-18 year olds not in education, employment or training, higher rates of childhood obesity and tooth decay and higher (though reducing) rates of teenage conceptions.

'Our situation' is summarised in the Joint Strategic Needs Assessment in this way:

"Due to the increased levels of deprivation in Hull, the majority of children are at an increased risk of not fulfilling their potential and having worse health than England as a whole. A higher percentage of children in Hull live in poverty and many children have an immediate disadvantage in life due to their circumstances.

Compared to England, there is a higher rate of emergency admission for accidents and fewer children in Hull are ready for school and achieve five or more GCSEs at A-C level and there are more children with special educational needs.

Compared to England, babies are less likely to be breastfed and children more likely to have unhealthy lifestyle behaviours such as poor diets and low levels of physical activity. Children living in the most deprived areas are also more likely to be exposed to second-hand smoke and become smokers themselves. Children and young people living in the most deprived areas are more likely to have learning disabilities, poorer physical health, poorer emotional health and poorer dental health."

http://www.hullpublichealth.org/jsna.html

In this context, it is not surprising that Hull's 'safeguarding system' (see next section) is characterised by high rates of 'children in need' and of looked after children, with enduring demand on 'acute' and expensive specialist services, including children's social care. These high rates, and continued reliance, are unsustainable in the longer term and in the context of reducing public sector budgets.

The 'First 1001 Days' All Parliamentary Group aims to support the development of children who (by 2 years of age) "have the social and emotional resources that form a strong foundation for good citizenship" The Group has identified that, without intervention, "there will be in the future, as in the past, high intergenerational transmission of disadvantage, inequality, dysfunction and child maltreatment. These self-perpetuating cycles create untold and recurring costs for society. The economic value of breaking [them] will be enormous."

These local circumstances – significant deprivation, high and increasing levels of need and demand, and reducing public sector funding – reinforce the importance of providing and developing strong and effective multi-agency targeted early help and support provision for children and families.

The child's journey through the safeguarding system

Early Help

The Ofsted inspection of services for children in need of help and protection, children in need and care leavers (November/December 2014) found that families in Hull had access to a wide range of good quality early help services, with clear signs that they were accessing these services more quickly. However, professionals in Hull were still using different formats (or tools) for early help assessments which did not support consistency. Whilst the location of an early help social worker within the access and assessment team meant that the referral process led to swift and accurate assessment of cases which were appropriate for early help support from partners working within localities, processes for 'stepping down' cases from children's social care were underdeveloped and this meant that social workers were continuing to work with some families for longer than necessary.

Feedback to the Board from schools in Hull as part of the Section 11 audit process in 2014-15, reflected a growing awareness of the early help services and arrangements available via 'early help hubs' in localities and generally positive feedback about these and the 'Early Help Action Meetings' coordinating support for families needing help from multiple services.

Nevertheless, the need to continue to strengthen and further develop multi-agency targeted early help and support was identified as a critical element within the local authority's 'getting to good' improvement plan, including the creation of an Early Help and Safeguarding Hub, to facilitate the development of a more seamless system of help and support for children and families from targeted early help to children's social care.

The Board as a whole recognised the central strategic importance of 'early help' locally, both in terms of better meeting the needs of children and families at an earlier stage before needs become acute, and of managing the demand on specialist services in the context of increasing pressure and reduced resources. This imperative is widely recognised elsewhere: effective early help services have been identified by Ofsted as being closely associated with stronger outcomes for children (*'The report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2016: Social Care'*) and as one of the 'key enablers' in *'Safeguarding Pressures Phase 5', ADCS, 2016.*

During the period, the Board maintained a consistent focus on the development of early help, including Board member 'walking the floor' activity informing an extended discussion at the Board meeting in September 2015. The progress of the business mapping and planning work initiated in September 2015 to underpin the development of the Early Help and Safeguarding Hub (EHASH) has been monitored on a consistent basis at the Board and the Board's Business Group.

Some progress has been made: the local authority appointed an 'early help' consultant social worker and established an 'early help' pod located as part of the 'access and assessment' (front door) arrangements and during the second half of the period (Oct 2015 – March 2016) 498 'early help' referrals had been received in the early help 'single point of contact' email box. The local authority has adopted the 'Family Star' as the preferred early help assessment tool and this is increasingly being used both to assess need and measure progress in work with individual families. Children's social care also committed to investing in a replacement children's service recording system which has the capability to record 'early help' work as well as children's social care interventions. The reduced volume of referrals (and contacts) to children's social care (see 'The Front Door') may partly be explained by a growing 'early help' impact.

However, at the end of the period, detailed proposals for the EHASH had still not been completed and the provision and coordination of early help services remained too heavily dependent upon local authority provided or commissioned services.

The 'Front Door'

During the year, there were 9,031 contacts made with children's social care in Hull to share information or to discuss concerns about a child. Nearly 60% of these contacts were made by the Police (29%), schools (12%) and health services (16%). This was 7.4% fewer contacts than were made in 2014-15. The information provided is discussed with the caller by social work staff in order to determine the appropriate response.

43% of these contacts (3892) progressed as referrals. The remainder were recorded as 'information sharing' or were referred on to early help services. The number of referrals reduced by 16% (from 2014-15) and, for the first time, the local referral 'rate' is broadly in line with the statistical neighbour rate (having historically been significantly higher).

The number of referrals in Hull has reduced by nearly 42% since 2010/11 when the local rate was an 'outlier' compared to rates elsewhere. This reduction, to a rate which is now much more 'in line' with rates elsewhere, is likely to reflect a combination of factors including: the work undertaken across the partnership to better describe and understand 'thresholds'; some work to improve the quality of referrals; and, a developing 'early help' offer.

‘Referrals’ are those contacts which reach the threshold for action by Children’s Social Care (CSC). This action includes making further enquiries, contacting the family and other agencies and holding strategy discussions where a child is considered to be at risk of significant harm.

92.5% of all referrals progressed to a CSC assessment during the year. This is a higher rate than the SN and England averages – it means that a smaller proportion of referrals result in ‘no further action’ in Hull than elsewhere. The number of assessments opened to CSC in 2015-16 (3,600) was nearly identical to the number commenced in 2013-14 (3,602).

Arrangements for the provision of CSC services were ‘remodelled’ in January 2014 with the establishment of small social work ‘pods’ led by Consultant Social Workers and with access to support from Clinicians. A key element of the changes made was to increase social work capacity at the ‘front door’ as part of a conscious effort to ‘get it right first time’ for a higher proportion of children and families.

The rate at which children are referred back to CSC within 12 months of a previous referral is seen as a ‘proxy indicator’ of ‘getting it right first time’. The local ‘repeat referral’ rate has reduced in Hull for five consecutive years and, at 15.7%, is markedly lower than national and SN rates.

The ‘model’ for the provision of social work services in Hull means that CSC assessments are completed in Access and Assessment (at the ‘front door’), rather than children and families being ‘transferred’ to locality based services for completion of this work. This ‘model’ has an impact on the pattern of outcomes of assessment locally.

In Hull 55.5% of CSC assessments resulted in the child being assessed as ‘not to be in need’ of ongoing CSC help and support, compared to only 25.4% for England as a whole. The remaining 45% were assessed as being ‘in need’ (27%), ‘in need – with a disability’ (2%), ‘in need of protection’ (13%) and ‘in need of being looked after’ (3%). Further work is needed to better understand this outcome pattern, but the current local analysis suggests that the help and support provided and accessed for children and families during a single assessment at the ‘front door’, results in fewer children being defined as ‘in need’ than would be the case under a more traditional model of ‘quick’ assessment and transfer to longer-term CSC teams for more in-depth assessment.

Overall, the data suggests an increasingly effective and efficient multi-agency ‘front door’ over time:

- A reduced overall volume of contacts and referrals, suggesting a reduction in inappropriate contacts with CSC.
- A much higher proportion of referrals progressing to CSC assessment than before
- Reducing rates of ‘repeat referrals’, indicative of progress in getting it right first time for more children and families.

Children at risk of significant harm

Whilst the overall number of referrals to children's social care reduced during the period, the number and rate of section 47 enquiries (these are enquiries made where there are reasonable grounds to suspect that a child is suffering or is likely to suffer significant harm) continued to rise significantly. In 2015-16, 1706 such enquiries were initiated which is a rate of 306.8 per 10,000 child population. The s47 rate in Hull has historically been noticeably higher than statistical neighbour averages (where the rate was 249.6 in 2014/15). The local rate increased by a further 12% this year. There is no indication, either from the s47 audit work previously conducted by the Board or from inspection, that s47 enquiries are being initiated unnecessarily.

This year-on-year increase in the number of section 47 enquiries is reflected in an increase in the number and rate of initial child protection conferences (ICPCs) of more than 80% since 2013-14 (from a rate per 10,000 of 46.7 to 85.3). The number of ICPCs held in 2015-16 was 474 compared to 256 in 2013-14. The number of children subject to child protection plans was 374 at 31st March 2016, compared to 330 at 31/03/15 and 248 on 31/03/14 (an increase of just over 50% over the last two years).

7.5% of children subject to a child protection plan at the end of the period were from a BME background. This is a marked increase compared to previous years, reflecting Hull's changing population and new challenges facing safeguarding partners locally.

25% of children subject to a child protection plan at the end of the period had been on a plan for 12 months or more, compared to only 14% in March 2015, whilst the rate of children who became subject to a plan for a second or subsequent time reduced from 15% to 10.8%.

The number and rate of children in Hull who are subject of a child protection plan was historically lower than would have been expected, given high levels of deprivation, referral rates, s47 enquiries and high overall numbers of children in need and children looked after. Indeed, the local rate in 2013-14 was similar to the England average rate. The local rate now is closer to the 'expected' rate given all of the other indicators and activity levels, but is anticipated to continue to rise over the next few years.

Police activity data, and children's social care data on 'factors' identified during assessment, provide a wider context for this increase in 'core' child protection activity and tend to support research from elsewhere which, for example, identifies a 'panoply of interlocking factors which are becoming more complex and more prevalent' (including the effects of the "toxic trio" of domestic abuse, parental mental health and parental substance misuse, neglect and poverty).

For example, the number of domestic abuse incidents reported in Hull increased by 22% from 2014/15 to 2015/16 to a total of 7,423 nearly 20% of which involved repeat victims. Domestic abuse featured as a factor in a significant proportion of children's social care assessments (approximately 30%). According to the DfE (DfE, 2016) half of all children in need have experienced or witnessed domestic abuse. Respondents to the ADCS research cited domestic abuse reaching 'epidemic' proportions as a reason why children are referred to children's social care. This continuing rapid increase in incidents locally, together with a growing understanding of the impact of domestic abuse on children, is one of the factors which will continue to place growing demands on local child protection systems.

The Board did not lead on any specific multi-agency audit work on the quality of child protection conferences or plans during the period, having implemented and comprehensively evaluated the 'Strengthening Families' model for conferences in 2014. New Board training on Child Protection Conferences was delivered and refined during the period, and feedback from participants used to inform improvements. The Board also addressed attendance issues at Initial Child Protection Conferences (ICPC) with Humberside Police. Police attendance rates at ICPCs declined significantly in May 2015 following a reorganisation and introduction of a new shift pattern. By the end of the period, the attendance rate was consistently back up to 100%.

Sustained improvement was made during the period in the proportion of statutory visits to children on plans made by social workers within timescales (on average about 90% by the end of the period) and, despite the significant increase in volume, strong performance was sustained on reviews held on time (98.1% for 2015-16).

Children in Need

The overall number of children in need in Hull fell from 3,787 on 31st March 2015 to 3,307 on 31st March 2016 (a fall of 12.7%). Comparative information for statistical neighbours is not yet available for 2015-16. However, the Hull child in need rate (594.8) is still amongst the ten highest rates in the country and is the highest in the Yorkshire & Humber region (similar to the North East Lincolnshire rate). Children also tend to remain 'in need' for longer on average in Hull than elsewhere.

Looked After Children

At 31st March 2016, the number of looked after children in Hull had actually fallen slightly (by 2.6%) to 646 from 663 on the same date in 2015. However, the trend remains upward and by 31st October 2016, the number had risen sharply to 710. Hull's looked after children rate remains high but is broadly similar to the rates of its deprivation neighbours.

The age profile of the Looked After Child population in Hull shows that just over 50% are aged 11 years or older. At 31/03/16, 165 young people were receiving services as care leavers, with 184 more due to become eligible over the next four years.

Based on a sample of 142 children who were newly looked after in 2016, the average number of days of children's social care involvement prior to the child becoming looked after was 338. This is indicative of the priority and focus given to supporting children to continue to live with their families and the use of alternative care only where this is clearly essential to safeguard the child.

At 31st March 2016, 81% of Hull's looked after children were subject of a legal order (Care Order – 63%, Interim Care Order – 12%, Placement Order – 6%) with the remaining 19% being looked after with the agreement of their parents under S 20 of the Children Act 1989.

In relation to children defined as looked after in foster placement, Hull has a very low proportion (8%) in private provision, compared to an England average of 31%, and by far the lowest rate amongst its deprivation neighbours. Similarly, at 50% the proportion of looked after children living in local provision was the 24th highest (out of 151 local authorities).

From September 2015, the Independent Reviewing Officers (IROs) have routinely been undertaking basic 'quality audits' as part of the Looked After Children review process. All looked after children in Hull have an allocated social worker.

Based on this audit work, the following key findings have emerged:

- Not all looked after children have an up-to-date child's plan or pathway plan, but the proportion who have has improved to 75%
- The proportion of looked after children with an up-to-date social care assessment or pathway needs assessment improved over the period but is still only 48%
- There was improvement during the period in the proportion of looked after children visited by their social worker within statutory timescales and for whom a PEP (Personal Education Plan) meeting was held within timescales but there remains scope for further improvement.

The 'Safeguarding System' – Analysis

The reduced overall volume of contacts and referrals to children's social care, together with an overall reduction in the number of children in need are, at least plausibly, indicative of the impact of the developing early help arrangements locally and improving 'systems' for transitioning support for children and families from children's social care to targeted early help.

However, the data also shows a continuing significant increase in 'child protection' activity (section 47 enquiries, initial child protection conferences, children subject to child protection plans) and an underlying trend of increased numbers of children entering the looked after system.

The local 'system' reflects the conclusions of the extensive national research undertaken by the Association of Directors of Children's Services (ADCS) (*'Safeguarding Pressures Phase 5, December 2016)* which found that children's needs are becoming more complex at a time when specialist interventions and services are depleted. The root causes of why children are suffering abuse and neglect, or require additional specialist support for reasons such as domestic abuse, continue unabated. The level of risk and vulnerability of children, particularly in areas of acute deprivation such as Hull, is likely to increase further due to the impact of social and economic pressures on families.

Research into children's services spending and delivery conducted by the DfE (DfE, 2016) concluded that budgets were decreasing against rising demand with the main strategy identified to manage demand being investment in early help.

In a local context, this reinforces the imperative of 'investment' in targeted early help. There is an urgent need to complete the design of the Early Help and Safeguarding Hub and to implement it and to identify and strengthen the 'whole partnership' commitment and contribution to 'early help', so that it becomes less reliant on local authority provided or commissioned services.

Such 'investment' is essential, but not in itself sufficient, to manage demand. Social work caseloads are already comparatively high in Hull and capacity within the Humberside Police Protecting Vulnerable People Unit is stretched to cope with increasing demand. Whilst it is possible to forecast that overall numbers of children in need might remain quite stable over the next three years or so, the underlying trends suggest that, even assuming the continued development of a stronger multi-agency targeted early help 'offer', the number of children subject to child protection plans and the number looked after might increase by a further 30% and 15% respectively.

One respondent to the ADCS survey described a "perfect storm of increased need, expectations and reduced resources" and the research overall presents a much clearer picture of reducing budgets, increasing and more complex needs of children and their families together with a growing sense that a "tipping point" is being reached.

In this context, continuing to improve the quality of help and support to children and their families and maintaining a 'safe' system, will require strong and focused political and strategic leadership which effectively engages the whole partnership.

The Ofsted report on 'Social Care' (2016) concluded that neither deprivation nor funding levels are, on their own, causes of 'failure'. Authorities which provide 'good' quality help and support to children and families, despite the underlying contexts, are characterised by local political and strategic leadership which:

- Prioritises children's services
- Provides a high level of support and scrutiny to senior managers and practitioners
- Demonstrates the highest levels of ambition for children
- Shows a willingness to take difficult decisions

Vulnerable Groups

During the period, HSCB had a specific focus on improving multi-agency working in respect of specific groups of children: this focus was informed, variously, from the outcome of self-assessment and inspection, learning from serious case reviews and emerging safeguarding issues arising from Hull's changing population.

Vulnerable Older Young People

The Board initiated a Serious Case Review into the death by hanging of Child W, a 16 year old girl who was living at the time of her death in local young people's hostel accommodation. The review was published in December 2015.

The review identified that, in the context of the need to redesign and remodel services for children generally, given funding cuts, that there had been less specific attention paid to the needs of vulnerable young people. Learning from Child W's tragic death identified that she had found many services accessible to her, and valued the help and support she received from many individual workers, but that service provision could and should have been better coordinated and Child W's needs more explicitly considered within a risks framework, continuous with the wider local system for help and safeguarding.

The Board considered the key learning from this review in March 2015, focusing on the identified need for a fundamental 'whole system' review of support arrangements for vulnerable young people in Hull. This review was initiated by the Children, Young People and Families Board during 2015-16 with a target completion date of 30th June 2016.

In the interim, improvements had been made by the time of publication, including:

- Stronger alignment between targeted youth support provision and children's social care to improve the management oversight of the safeguarding of vulnerable young people (with CSC leading on assessment and

assuming case responsibility in some cases, based on assessed need)
- Commissioning work to increase the range and choice of accommodation options for young people.

Nevertheless the progress of the 'whole system' review has been slower than first anticipated and the Board will need to monitor and review progress during 2016-17 to ensure that the learning from this SCR is reflected in improved and better coordinated services for vulnerable young people.

Adolescent emotional and mental health and wellbeing

The Board identified and considered a range of 'intelligence', learning and issues relating to adolescent emotional and mental health and wellbeing, from 'early help' to identify and respond to lower level needs through to the provision of specialist Child and Adolescent Mental Health Services (CAMHS). These included:

- Learning from the Child W SCR which highlighted a need to better equip frontline practitioners with the skills and confidence to work effectively with young people with emotional and mental health needs.
- A noticeable 'spike' in admissions to hospital of young people due to self-harming behaviour
- Feedback from Hull schools (as part of the Board's section 11 audit work in 2014-15) of a growing incidence of self-harming behaviour
- The outcome of the CQC inspection (2014) which highlighted lengthy waiting times for CAMHS.

The Board maintained a focus during the year on this issue, including on progress in developing and implementing the Children and Young People's Health and Wellbeing joint commissioning strategy and associated delivery plan and also on the work being undertaken to 're-shape' CAMHS services, including improving accessibility and reducing waiting times. Members recognised that these need to be seen as 'whole system' developments: a significant proportion of CAMHS referrals were deemed 'inappropriate', reflecting a need to develop better 'upstream' support for young people, and that this demand had an impact on waiting times.

Improvements were noted during the period, informed by extensive consultation with children, young people, parents, stakeholders and partners, and these included:

- Considerable investment in workforce development to enable skills development and capacity building in Universal and Targeted/Early Help services designed to increase the number of brief interventions and improve partnership working through shared and consistent training, knowledge and practice.
- Piloting of a range of universal and targeted provision across schools, community and family for children aged 10-14 under the 'Headstart' programme.
- The development of digital tools for young people

- The commissioning of a community based counselling service for 10-19 year olds (launched in September 2015)

Within CAMHS the newly established Crisis Intervention Team received 96 referrals between November 2015 and March 2016 (across Hull and East Riding). The Board has also monitored CAMHS 'waiting times' as part of its 'Drift and Delay' scorecard and whilst there has been improvement overall, at the end of the period fewer than 50% of children whose needs were assessed as either 'urgent' or 'routine' were seen within the local service target timescales.

Whilst significant improvement is evident overall in the range of responses to the emotional and mental health needs of young people, the Board will need to devote time in 2016-17 to revisit this theme and satisfy itself that the work being undertaken is having a positive impact.

Female Genital Mutilation

During the period the Board continued to focus on FGM, building on the extensive awareness raising work in previous years. FGM is a recently emerging safeguarding issue in Hull, reflecting an influx of families from countries with high FGM prevalence rates.

Development work was driven by a multi-agency FGM 'pathway' group. Progress over the period included:

- The development of a multi-agency FGM pathway, reflecting national guidance, including the mandatory reporting requirements from October 2015. The pathway and guidance was published and launched by the Board in July 2016.
- A 'lessons learned' reflective discussion in relation to one specific case which helped to inform the final pathway and guidance.
- The development of bespoke HSCB FGM training, ready to be delivered in 2016-17.
- Regular joint meetings between the Named Safeguarding Midwife and colleagues in children's social care to discuss and jointly plan responses to FGM 'cases' identified at the acute trust.

During the year, there were 42 cases of FGM recorded (and reported to the DoH), one of which was in relation to a child. All of these cases were identified and reported by staff at the Hull and East Yorkshire Hospital Trust (HEYHT), the majority from midwifery, a small number from gynaecology and one from a general surgical ward.

More widely, and building on learning from the Board's Diversity Conference (February 2015) and elsewhere, there was an acknowledgement of a need, particularly in a city like Hull with only a recent history of 'cultural diversity', to ensure help and support across the workforce to develop the confidence of practitioners to engage effectively with children and families from BME backgrounds. The Board

commissioned ‘Becoming Culturally Competent’ training, on an initial pilot basis, and has added this to its programme for 2016-17.

The ‘pathway’ group will now evolve, and be led by Public Health, and will focus on the development of an FGM strategy and on identifying service development needs.

Unborn Babies

Learning from both published (Child T – 2014) and ongoing serious case reviews, inspection (CQC – 2014) and other local learning lessons reviews, highlighted a need to improve multi-agency practice in the early identification of vulnerability, and multi-agency assessment and planning in relation to the risk of harm to unborn babies. This need was reinforced by an audit of over 50 referrals to children’s social care from midwifery over a two month period.

Significant work continued during the year, led by the Board, on developing a comprehensive pre-birth vulnerability pathway. The ‘pathway’ and supporting ‘unborn’ procedures set out the agreements reached for ‘best practice’ locally including: vulnerability screening of all pregnant women by midwives at the point of first booking; clear referral pathways into children’s social care or early help services based on assessed need; early (20 weeks) multi-agency meetings to share information and inform an early assessment; clear arrangements for ‘transition’ between early help and children’s social care services.

The bulk of the work on the ‘pathway’ had been completed by the end of the period, and midwives had started to routinely use the ‘vulnerability assessment’. A small number of key strategic decisions were still needed prior to launch and publication, which was planned to take place in September 2016.

The group of key practitioners and managers which had worked together to develop the pathway will continue to meet together to monitor and audit practice against the agreed pathway and procedures.

Children at risk of Child Sexual Exploitation (CSE).

Significant progress has been made during 2015-16 on strengthening local multi-agency response to CSE, building on the learning from ‘self-assessment’ and inspection in 2014. The primary focus on improvement and development work during this period has been upon identifying and supporting young victims and disrupting perpetrators.

Key developments and improvements during the period included:

- Embedding the now 6 weekly Multi-Agency Child Exploitation (MACE) meetings to discuss those children identified at highest risk of sexual exploitation and where wider partnership services can add to existing victim safety plans and perpetrator disruption tactics

- Introduction of a Pre-MACE meeting (2 weeks prior to the main MACE meeting) where all the Risk Indicator Tools (RITs) submitted are scrutinised, their risk assessment reviewed and further information held by agencies added and consideration for the child being placed on the full MACE agenda for discussion. Both meetings take place within a 6 week period to ensure all information for each child/young person discussed remains as up to date as possible
- More consistent use of the agreed 'Risk Indicator Tool' (RIT) as a standard tool to assist in the identification of risk which has recently been amended and improved to allow professional risk assessment judgement
- A monthly CSE report has been designed to illustrate data trends and analysis in relation to children deemed at risk of sexual exploitation in Hull. The data is gathered and recorded from discussions held at both the Pre-MACE and full MACE meetings. Information from the police and the RITs highlights areas of Hull frequented by suspects ('hotspots')
- Good engagement and involvement from across the whole council and wider partnership in the process
- Similar MACE arrangements in place to focus on suspected perpetrators and consider all available measures to disrupt activity which are held at the same time
- The establishment of a CSE sub-committee, chaired by the HSCB Independent Chair, and with senior strategic membership to provide oversight on progress
- The establishment of an HSCB CSE Professional Practice Group to monitor the operation of the MACE arrangements and lead on the implementation of the CSE strategy
- All children identified as at risk of CSE are managed in accordance with established safeguarding policies and procedures
- The development of an initial 'CSE Problem-Profile' for the city
- The appointment of an HSCB CSE & Missing Coordinator to add capacity to progress the wider strategy and coordinate the ongoing development of multi-agency practice
- Agreement to establish a CSE 'pod' (comprising social workers and youth workers) to be co-located with the Humberside Police 'Missing and Exploited' Team
- Work initiated to adapt the risk assessment tool (RIT), building on the learning from the 'Jay' report and subsequent letter from the Chief Social Worker, to develop a tool which allowed greater scope for professional judgement and less focus on numerical 'scores'

During the period 54 individual children were discussed at MACE, with a total of 206 discussions (i.e. many children were discussed multiple times).

Analysis of information relating to children discussed at MACE was increasingly used during the period to identify particular patterns and trends, demographic information and 'hotspots'. This helped inform some targeted action, for example, in relation to 'hotspots' and supporting schools which had a particular concentration of victims.

More work is needed though on further developing a comprehensive performance framework for CSE, which captures the quality and impact of partnership work and on developing a more 'organic' problem-profile which can help inform specific interventions and longer-term 'commissioning' decisions.

Whilst significant progress has been made, the priorities for the next period will be to:

- Continue to refine the MACE arrangements for both victims and perpetrators to ensure that they add maximum wider partnership value to existing plans
- Refine the risk assessment tool (RIT) in partnership with Humberside Police and the three neighbouring authorities
- Work with Humberside Police on the development of a new 'problem-profile'
- Develop the CSE performance framework
- Continue to raise awareness of CSE across the partnership
- Ensure that HSCB 'impact of sexual harm' and CSE training is accessed by key professionals
- Develop clear plans to deliver the 'Say Something if you See Something' campaign and 'Operation Make Safe' across Hull, with an initial focus on hotels, licenced premises and taxi drivers

The partnership as a whole will also need to consider the short-term (interim) funding arrangements in place for two key CSE specific 'services': the children's social care CSE 'pod' is funded until 31st March 2017 and the funding (local and Children in Need) for the Children at Risk of Exploitation (CARE) project (local VCS provision run by Cornerhouse) extends until 31st March 2018.

Children Who Go Missing

According to Humberside Police data, there were 1,080 cases of children recorded as missing in Hull in 2015-16, involving 307 individual children. A number of individual children were reported as missing on multiple occasions, including 29 who were missing on ten or more occasions. Of these 29, 17 were looked after children. Nearly 30% of the missing cases in total related to looked after children.

In addition, there were 426 cases of children reported as missing who were classified by the police as being "absent" (183 individual children). Absent is used in cases where there is "no apparent risk" identified.

In relation to the 1080 cases, 25 were recorded by the police has having suffered harm whilst missing, including physical injury, sexual assault and self-harming.

The breakdown by gender, age and ethnicity of missing cases (rather than individuals) shows that 638 involved boys and 442 girls. 31 of the cases involved children aged ten or under and a further 237 children aged 11-13. 96.6% of all missing cases were in respect of white British children.

The Ofsted inspection of November/December 2014 found that not all children going missing from home had robust risk assessments and plans and identified, as areas for improvement, the need to ensure that all children who go missing from care are interviewed by an independent person when they return, and the need to systematically collect and analyse data to help influence the shape of services and target interventions.

By the end of the period, the local authority had put in place arrangements to ensure independent 'return interviews' for looked after children and developed plans to enhance the quality and consistency of 'return interviews' in respect of children 'not known' to children's social care and those (not looked after) with an allocated social worker.

These plans were supported by the development of Board training on return interviews which was delivered to a number of 'champions' across children's social care for cascading to social workers and others.

However, by the end of the period, there was still no consistent mechanism in place to monitor practice and assure quality. Very little information from 'return interviews' was being fed back to the police to form 'intelligence' which might reduce future risk and identify patterns and trends.

The lack of a multi-agency forum to regularly consider the needs of the most frequently missing and/or highest risk missing children remains a gap, although the majority of the most frequently missing children are considered within the MACE arrangements as also being at risk of CSE. Further work is needed to improve responses to children who go missing. The HSCB CSE strategic group will need to expand its remit to ensure a focus on missing children capable of ensuring the improvements needed.

The effectiveness of safeguarding arrangements in Hull

Other chapters in this report have provided some analysis of the safeguarding system in Hull and some description about the range of ways in which the Board as a whole approaches the task of ensuring effectiveness and influencing improvement. This includes:

- Learning from both internal and external reviews and inspections
- Section 11, Children Act 2004 audits and self-assessments
- Learning from practice audits
- Learning from child deaths
- Learning from serious case reviews and other specific case reviews
- Performance management and quality assurance work

This section of the report provides a summary of key external inspection activity not already captured elsewhere.

External Inspections

OfSTED Inspection of Arrangements for Supporting School Improvement

Ofsted carried out this 'whole system' inspection in December 2015, confirming their findings in a letter to the Director of Children, Young People and Families Services in January 2016.

The key findings included:

- The local authority and partners have implemented a successful strategy to improve the quality and take-up of free early year's provision. 78.3% of children access provision (against a national target of 80%) and 90% of providers are rated 'good' or 'outstanding' by OfSTED.
- As a result, the proportion of children making expected gains at the Early Year's Foundation Stage has improved rapidly, although the gap between children from the most disadvantaged communities, compared to the least, has widened significantly.
- The proportion of primary schools judged to be good or outstanding has improved to just below the national average.
- There has been a rapid improvement in the proportion of children at Key Stage 2 (year 6) gaining level 4 in reading, writing and maths combined from below, to above, the national average.

However, these significant improvements pre-school and at the primary school stage have not yet been reflected in equivalent improvement at secondary school and beyond:

- Over a third of secondary-aged pupils attend schools or academies which are not yet good
- Although improving, the proportion of year 11 pupils gaining five good GCSEs remains “stubbornly low”
- 99% of young people move on to training or education at 16 but the proportion who remain engaged drops below average by the age of 18
- The proportion of young people gaining level 2 & 3 qualifications post-16 is below average.

Securing improved outcomes for young people at age 16 and beyond has long been recognised as critical to helping break the cycle of deprivation and poverty locally and is, therefore, also important in addressing, in the longer term, some of the conditions which create and sustain the high level of demand for help and support services in Hull.

Police Effectiveness, Efficiency and Legitimacy (PEEL) Report

PEEL is the programme in which HMIC draws together evidence from its annual all-force inspections. The Humberside Police effectiveness report was published in 2015. The overall report drew upon more detailed thematic inspections, including one in relation to ‘vulnerability’, based on the question, ‘How effective are forces at protecting from harm those who are vulnerable, and supporting victims?’ This question was inspected in Humberside between June and August 2015 and the findings published in December 2015.

The inspection identified some key strengths and evidence of improvement since previous inspections in 2014:

- The chief officer team has made protecting vulnerable people a clear priority for the force, and police officers understand and share this commitment
- The force is generally successful in identifying repeat and vulnerable victims at the initial point of contact.
- The force investigates crimes committed against the most vulnerable victims well, applying the right level of expertise to the more complex investigations, and this shows progress since 2014
- The police response to the missing children assessed as high risk is good
- The force has made a good start in tackling child sexual exploitation and must build on this initial approach.
- Officers attending domestic abuse incidents have a good knowledge of how to assess risk and keep victims safe and this is a good example of progress made since 2014.

However, the overall assessment was that the force still needs to improve because:

- It still needs to address the consequences of its new way of working, the new operating model, to ensure that the right resources are deployed to the right incident at the right time.
- There are some delays to answering calls, although the force is closely monitoring and managing this, resulting in a reduction in the number of abandoned calls
- The force's ability to respond is undermined by its current staff allocation, processes and shift patterns, which are not adequately aligned with demand.
- Although crime is mostly investigated well, some vulnerable victims are not receiving a good level of service.
- Response to 'medium' and 'low' risk missing cases, and 'absent' cases needs to improve

One of the early outcomes from this inspection was the identification of additional resource for protecting vulnerable people, reflecting the judgement of HMIC about the need to better align resources with demand.

HM Inspectorate of Probation: '*Transforming Rehabilitation: Early implementation'*

In May 2016 HMIP published the fifth and final report on a series of inspections on 'Transforming rehabilitation'. The focus of inspection was on work undertaken at the point of sentence and allocation by the National Probation Service (NPS) and the work undertaken by the Community Rehabilitation Companies (CRC) and NPS to manage offenders. Six NPS local delivery unit clusters and the associated CRCs were visited, including Hull and East Riding.

The published report is thematic and does not provide an overall judgement of quality in relation to individual services. Nevertheless the report contains frequent and highly positive references to the quality of the work undertaken locally, and particularly by Humberside NPS. Of particular note was the excellent work identified in Hull where NPS administrative and court staff had extremely effective systems in place for initiating children's services and domestic abuse checks for offenders appearing on the overnight list. Staff were observed to be proactive and with a good level of information provided by children's social care and the police.

These arrangements, together with the comments of inspectors highlighting excellent local practice in undertaking Risk of Serious Harm assessments and producing pre-sentence reports provides a high level of reassurance that work with offenders at this critical point has an appropriate and consistent focus on keeping children safe.

Serious Case Reviews and other learning

During the year, the partnership was engaged in an unprecedented volume of serious case review work: one serious case review was published: a further review was completed, but could not be published due to an ongoing criminal investigation; one review was ongoing; and a further review was initiated but not completed within the period.

The Board has paid close attention to the methodology and approach to serious case reviews and other learning, ensuring that reviews focus on understanding what happened and why, and that the professionals involved with families are fully involved and can contribute their experiences and perspectives without fear of being blamed for actions they took in good faith. Families are also routinely invited to contribute to reviews.

Child W

The Board published its review into the death of Child W in December 2015. Child W died, aged 16, by hanging in November 2013. Born in Barnsley, Child W had a troubled early childhood, experiencing abusive and neglectful parenting, leading to her (and her younger sibling) becoming looked after by Barnsley MDC.

Child W and her brother were adopted by carers in Hull after a period of time with them as foster carers.

The review identified learning in relation to post-adoption support and access to specialist therapeutic support to help Child W and her sibling form strong attachments.

The main focus of the review, however, was upon the last six months of Child W's life, during which time her relationship with her adoptive parents was breaking down and she was living in hostel accommodation in Hull. She had also been the victim of an alleged rape.

The review found that a significant number of people from a range of agencies and services had worked hard to try to help and support Child W during this period: there was evidence that she had formed strong and important relationships with many of these professionals and had generally found services accessible and welcoming.

There were, though, significant learning points for the partnership as a whole:

- A need to ensure that vulnerable young people have their needs considered within a safeguarding system and context and that mechanisms to enhance joint working are used effectively.
- A need to ensure that professionals across the partnership working with vulnerable young people are better trained

and equipped to recognise and respond to self-harming behaviours and emotional wellbeing needs
- A need to review the way in which the partnership as a whole comes together to support Hull's most vulnerable young people.

The need for this more fundamental review was identified and agreed by the Board as a whole in March 2015, when the emerging learning from this review was considered at a full Board meeting, some nine months before publication. The Director of Children's Services undertook to initiate the review, under the auspices of the Children, Young People and Families Board. After some delay, an independent expert was commissioned to lead on this piece of work, which had commenced before the end of 2015/16. The Board will monitor progress during 2016/17.

Child H

This review has been concluded but not yet published. Publication has been deferred so as not to compromise any potential future prosecution(s): a police investigation is ongoing.

In October 2015, the Board convened a special, additional meeting specifically to consider the learning from this review and, thereby, to ensure that improvement action would commence immediately.

Other Serious Case Reviews

At the end of March 2016, the Board was working on a further two serious case reviews which should both be concluded during 2016/17.

Other 'Learning Lessons' Reviews

In addition to statutory serious case reviews, the Board also identifies cases which may not meet the criteria requiring a serious case review but which, nonetheless, may lead to important learning about the way in which local agencies work together to keep children safe or are cases of 'special interest'.

Four such cases were identified during the year:

- The death by overdose of a 17 year old, where there was no evidence of abuse or neglect, but the Child Death Overview Panel and SCR sub-committee jointly felt that a 'learning lessons' review would be helpful in understanding how agencies had responded to emotional and mental health needs over a prolonged period of time, in order to identify any improvements needed.
- The death of a six week old baby in December 2014. There was no conclusive evidence of abuse or neglect as factors in the death of this child, but, via the child death review process, information emerged about a significant amount of agency involvement ante-natally and post-birth,

which informed a decision to undertake a ‘learning lessons’ review.

- The sexual grooming and abuse of a number of young girls by a young adult skater. The victims were all skaters at Hull Ice Arena where the perpetrator also attended for expert coaching. The young adult was convicted and sentenced in July 2015. It was agreed by the SCR sub-committee that it would be helpful to identify independent reviewers to examine the circumstances and whether there was anything more which might have been done to prevent any of this offending. The review had not started by the end of the period, but will commence during 2016/17.

In addition, a ‘learning lessons’ review was agreed in relation to a case of suspected female genital mutilation. The review took place in April 2016 and helped to inform the development of the FGM pathway (see pages 22 & 23).

‘Learning lessons’ reviews are proportionate approaches to learning in specific cases: there is no ‘one’ model for undertaking these reviews, but each always follows the same key principles of seeking to involve, and learn from, the practitioners involved and to ensure that families are given the opportunity to contribute to the learning.

Reviewing child deaths

The Hull Child Death Overview Panel (CDOP) has been undertaking its statutory role to review the death of every Hull child, including neonatal and perinatal deaths, since April 2008. The CDOP is a multi-agency panel, chaired by the City Manager for public health. A multi-agency case review sub-group reviews each case in detail, based upon information of involvement from all agencies, allowing the CDOP itself to identify key learning and take a strategic view on what action can be taken to reduce the risk of future deaths. The inspection of the LSCB in 2014 concluded that "highly effective arrangements for the review of child deaths are in place."

The CDOP was notified of 21 child deaths during 2015/16. With the exception of 2008/09 (when there were 42 notifications) the number of deaths notified during any year has ranged from 19 – 27. 15 (of the 21 deaths) were of children aged less than one year old.

Where the death of any child is 'unexpected' or 'unexplained' a multi-agency rapid response meeting is convened (usually within 24 working hours of the death). Each such meeting includes professionals/agencies known to and/or involved with the child and family. The purpose is to share information about the circumstances leading up to the death, the emergency response to the death, previous agency involvement with the family and to consider support arrangements for the bereaved family and wider network. Information captured via this meeting helps to assist the Coroner with their investigation/inquest (if any) and contributes to decision-making in relation to the need for any serious case review and to the CDOP review itself.

The CDOP met four times during the period and reviewed the deaths of 23 children. Nine of these deaths were treated as 'unexpected'. The Rapid Response process was initiated in 8 of these cases. None of the deaths remained unexplained at the time of the review.

The pattern of deaths reviewed locally reflects the national pattern, with relatively higher rates of death in the neonatal period (<28 days) and infancy (28 days – 1 year), reflecting mortality associated with prematurity, genetic, chromosomal or congenital disorders as well as sudden infant death.

The comparatively low number of child deaths each year does not provide a sufficient quantity to isolate or identify any statistically significant patterns or trends from which to design public health initiatives. The Hull CDOP is undertaking an audit of deaths of babies aged less than 28 days, over a seven year period, with a view to identifying, and then targeting, specific 'higher risk' areas of the city or particular maternal characteristics, in order to reduce incidence. Given that nearly 40% of child deaths locally are perinatal or neonatal deaths, any interventions which could reduce the

incidence of these deaths would have a dramatic impact on the total number of child deaths.

No deaths reviewed during the year related to neonatal deaths occurring out of the Hull area due to local Neonatal Intensive Care Unit capacity issues. None of the deaths reviewed involved children who were the subject of a child protection plan – only one child had previously been subject of a statutory order. None of the deaths reviewed was as the result of accidental injury.

Learning from reviews

- As a result of learning from a previous serious case review (Child T) and a 'learning lessons' event commissioned by CDOP following the death of a baby born prematurely and in poor health with medical problems associated with mother's substance misuse, the Board is leading on developing a pre-birth vulnerability pathway (see page 23)
- The panel had reviewed no deaths of cases where a child died at their own hands since 2010/11, but reviewed three such deaths in this period. One of these cases is the subject of a 'learning lessons' review (see page 31). Learning from each is helping to inform the development and implementation of the young people's emotional health and wellbeing strategy and plan.
- The CDOP again identified 'modifiable factors' which may have contributed to a child's vulnerability, ill-health or death. These included parental smoking, maternal smoking in pregnancy (known to be associated with an increased risk of premature birth) and infant safe sleeping. Hull CDOP continues to raise awareness and educate professionals and families about these risks and the prevention measures they can take, through working groups, training, fact sheets and campaigns.
- The Panel learnt directly from one set of parents whose child had died from a life-limiting condition. This feedback has enabled the Children & Families Disablity Team to understand what life was like for that child and their family and to make improvements to the practical and emotional support provided to families in the future.
- A plan to re-promote asthma management with schools and community sports clubs was drawn up and implemented following the death of a child from an acute asthma attack.
- CDOP is represented on the local (joint Hull and East Riding) multi-agency Infant Safe Sleeping Steering Group. This group coordinates the sharing of safe sleeping advice from local and national reviews to support the ongoing safe sleeping campaign and training for professionals. The CDOP supported and promoted key messages on infant safe sleeping and the risks of co-sleeping during the national campaign in March 2016. Since April 2008, 15 local child deaths have featured factors relating to some element of unsafe sleeping practice or environment. 12 of these cases also featured parental use of alcohol, drugs or

cigarette smoking. None of the deaths recorded 'overlay' as the cause of death.

Other Work of the Panel

Additional development work undertaken by the CDOP during the period included:

- Ongoing 'rapid response' training for professionals who may be involved in responding to the unexpected death of a child: 73 professionals from health, the police and children's social care attended training in 2015/16, bringing the total number of people trained to 493 since 2008.
- Ongoing discussions with NHS Hull CCG to secure GP representation on CDOP, most likely via the Named GP for safeguarding. The role will contribute expertise to case reviews and disseminate learning to GPs.
- The publication of a quarterly e-bulletin containing articles of local and national significance relating to preventing childhood accidents and deaths and to support bereaved families.
- Representation on the Child Bereavement UK local advisory group. A local directory was developed and circulated to GPs, schools and local authority children's services.
- The SUDI (sudden unexpected death in infancy) box, used by doctors responding locally to unexpected deaths, won a national award.
- CDOP members discussed their response to the consultation questions as part of the 'Wood Review' into LSCBs.

Managing allegations against people who work with children

In May 2015, the local authority took the decision to establish, initially on an interim basis, a substantive Local Authority Designated Officer (LADO) role. Previously, for many years, the LADO function had been carried out by the manager of the Independent Conference & Reviewing Officer Team (ICRO). This decision reflected acknowledgement that the combination of the roles, in the words of Ofsted, "adversely affects the capacity of the LADO."

One of the key benefits of this development has been that the LADO has had the capacity to chair all strategy and professionals' meetings relating to allegations management, bringing a greater consistency to the process and to the provision of advice.

Local guidance, consistent with statutory guidance, defines that the LADO should manage allegations against those working with children who have:

- 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 he or she may pose a risk of harm to children (including children both in and outside of the workplace)

During 2015/16, 55 cases were deemed to meet the allegations management threshold (compared to 54 in 2014). During the same period the LADO undertook 210 consultations on concerns about professional conduct which did not meet the threshold. This compares to 93 such consultations in 2014. In these cases the LADO still provides employees with advice about how to respond to, and manage, the concerns.

51 LADO cases were concluded during the period (conclusion means the final decisions rather than the conclusion of any police investigation). 24 of the 51 cases were recorded as substantiated, 15 as unsubstantiated (insufficient evidence to either prove or disprove), 9 as unfounded and 1 as malicious. A total of 23 people left their roles in the children's workforce locally as a result of the investigations during the period, either because they ceased to undertake their role, were dismissed, de-registered (foster carers) or resigned.

Other LADO themes and issues

- The LADO continues to deliver allegations management training. This was reviewed in 2015 and delivered to a total

of 52 professionals during the year. Feedback on content and delivery continues to be very good.

- Meetings of the Designated Officers across the partnership continue to be held twice a year. These are well-attended and provide a forum for sharing updates, issues in cases and as a means of keeping local practice strong.
- On-line abuse. There continues to be a relatively high number of cases involving misuse of ICT, such as downloading indecent images of children. Effective early notification from the police enables early suspensions and safeguarding arrangements to be implemented in tandem with arrests. These cases almost invariably result in dismissal, conviction and disqualification or barring from work with children.
- The LADO has provided 31 'intelligence reports' to Humberside Police. This helps the police in applying their risk assessment tool to determine the priority of response (for example, when there are suspicions about downloading indecent images of children).

Areas for development and action in 2016/17 and beyond

- The development of a substantive full-time permanent LADO post
- The construction of a business case for the purchase of the allegations workspace within the new children's social care ICS. The current stand-alone LADO database is unstable and no longer supported.
- The consideration of information governance, and legal advice, regarding the retention of records that do not reach the LADO threshold, and the development of a local policy on this.
- The further consideration, within the Council and wider partnership, relating to the recording of 'unsubstantiated' allegations in references, balancing the guidance in 'Keeping children safe in education' and the legal advice of the Council.

Partner compliance with statutory safeguarding requirements

Working Together 2015 requires LSCBs to "assess whether LSCB partners are fulfilling their statutory obligations (to keep children safe)". These duties are set out under section 11 of the Children Act 2004. Most Boards use annual 'section 11 audits' as one of the main means of making this assessment.

In Hull, an annual programme of section 11 audit work was re-established in 2012. All key LSCB partners were required to complete a section 11 self-assessment and action plan and then to attend a 'challenge panel' chaired by the HSCB Chair to talk through their assessment and identified areas for improvement. In 2013, each of these partners was invited back to a similar panel to report on progress.

In 2014/15, the Board conducted a similar exercise with Hull's schools. A small number of schools was randomly selected to present to a 'challenge panel' and a series of workshops were held to share learning, including the many examples of good safeguarding practice which had been identified during the process.

The Board decided to conduct a similar exercise in 2015/16 with early years settings and childminders. 64 of Hull's 68 early years settings completed and returned a section 11 self-assessment, supported by the local authority's early years quality assurance officers.

The emerging themes and issues from the self-assessments were identified and 'learning and feedback' sessions held in January 2016 (and attended by representatives of 39 settings). This presented an opportunity not only to consider common safeguarding issues and challenges but also to identify and promote particularly good safeguarding practices identified during the process.

In general, nurseries had found the self-assessment helpful as a process for evaluating practice and setting improvement targets. Amongst the 'system-wide' developments informed by the process are:

- The establishment of half-termly meetings with QA officers, as an additional vehicle for discussing safeguarding themes and issues
- Cascade training for settings (via QA officers) in relation to FGM.
- A reinforcement of the important role of safeguarding lead within each setting – and that the duties and expectations of the role are reflected in job descriptions and properly supported, including by accessing training.

- Enhancements made to the ‘form’ for transferring information from early years settings to schools to ensure that safeguarding information is routinely communicated.
- A reinforcement of the key role played by early years settings in keeping children safe from harm, given the amount of time staff spend with children.
- The re-circulation of the Board’s ‘escalation policy’ so that early years settings are aware and confident about how to resolve disagreement in relation to individual children.

Amongst the challenges and issues fed back by early years providers included:

- Difficulties in recruiting suitably qualified and competent staff across the sector to respond to the need to increase capacity
- A felt lack of information about ‘early help’ and about the change to the ‘pod’ structure in children’s social care, and some recurring difficulty in contacting social workers for individual children.
- Some settings reported really positively about the role of their nominated health visitor – other settings did not know that this role exists.
- Some difficulties experienced in releasing staff, often at short notice, to attend child protection conferences, but a general view from early years staff that they are able to contribute when they do attend.

Future plans

The Board will re-visit the section 11 audit with its main partners in 2015/16, taking the opportunity to ask specific additional questions which can help inform its wider ‘learning programme’ for the year.

Holding partners to account for safeguarding practice

There are a range of ways in which Board partners hold each other to account for safeguarding practice. Many of these have already been described elsewhere in this report and these include:

- Section 11 auditing
- Tracking progress on post-inspection improvement plans
- 'Learning lessons' exercises in relation to particular cases
- Monitoring improvement actions arising from serious case reviews
- Progress updates on specific themes and issues at Board meetings and the Business Group
- Specific 'challenge' by the Chair on individual improvement priorities.

In addition the Board leads on multi-agency case auditing. Examples of this during the period include audits of referrals from maternity services to children's social care to help inform the development of the 'pre-birth vulnerability pathway' and of FGM 'referrals' to help inform the development of the FGM pathway.

Whilst these exercises are helpful and informative, and used effectively to develop improved joint agency practice, nevertheless they remain somewhat 'ad-hoc' in nature. There remains a need to develop a more regular, routine process for joint evaluation (multi-agency auditing) of practice. This will be developed and implemented in 2016/17.

An acknowledged area for further development by the Board was in respect of the development of a 'balanced scorecard' of data and performance information from across the partnership. Deficits in relation to the routine availability of meaningful performance information were identified in the respective inspections of both the local authority and the police. These deficits in turn limit the Board's ability to maintain a clear picture of performance, including quality and outcomes, across the partnership.

In July 2015, the Board took the strategic decision to develop a performance framework in a 'bite-sized' way by developing a 'drift and delay' scorecard, given that this was an issue identified in a number of inspection reports, affecting a minority of children, but at key points in their lives. Key partners were asked to identify a small number of relevant indicators and provide data on progress at quarterly intervals. Indicators included: waiting times for CAMHS, timescales for completion of CSC assessments and delays in the secondary risk assessment of domestic abuse incidents.

This initiative was partially successful, but the process of capturing reliable and updated performance data was time-consuming and often problematic. Whilst improvement was noted across some indicators (CAMHS waiting times and secondary risk assessments, for example), the work did not progress beyond 'activity data' to quality and impact.

The Board still needs to develop enhanced ways of understanding the effectiveness of the work being undertaken across the partnership, including in relation to early help, to keep children safe and promote their welfare.

To this end, Board members held a development discussion at the meeting in March 2016, to consider proposals to change the frequency, duration and 'style' of Board meetings in 2016/17, explicitly to create opportunity for the partnership as a whole to take a "deeper dive" into specific priority themes and issues, with the aim of developing a greater shared understanding of performance and where improvement is needed.

It was agreed that the Board would meet as a whole partnership three times a year. Meetings would be less formal, creating an environment for greater engagement. Each meeting would have an identified 'theme', with as much relevant 'data' and performance information as possible collected in advance to help inform discussion. Front-line practitioners would be invited to attend and talk to Board members about their work on specific cases. Other 'learning activity (joint evaluation of cases, section 11 auditing, Board member 'walking the floor', learning from serious case reviews) would be aligned to the forthcoming themes to ensure that as much 'intelligence' from across the partnership as possible could be gathered to inform understanding.

The Board also agreed to take into account the Joint Targeted Area Inspection programme when determining the 'themes' for these days. It was agreed that the first two themes would be: the impact of domestic abuse on children (July 2015) and the 'front door' (including early help) (November 2015).

The effectiveness of the LSCB & Progress against priorities (2015/16).

The inspection of the LSCB in November/December 2014 confirmed a number of existing strengths in relation to statutory functions. These included:

- Multi-agency policies and procedures which are "fit for purpose", reviewed effectively and updated appropriately to incorporate statutory responsibilities and changes to practice.
- A developing culture of "challenge" through a range of activities including section 11 audits.
- Mostly effective partnership working, with most services well-coordinated and targeted.
- Appropriate decision making in relation to serious case reviews, with well-established learning and methods of dissemination of local and national learning.
- Clear learning pathways and a comprehensive training programme – training which is well delivered, well received and highly rated by professionals
- Highly effective arrangements for the review of child deaths.

The Board was assessed as still needing to improve in a number of key aspects of its work and these informed the improvement priorities for the year agreed by Board members at a development day in June 2015. The challenge for the Board, and partners, was to improve on performance where this was not yet 'good' whilst sustaining strong performance as described above.

The priorities agreed, and the progress made, are described below:

- Monitoring and evaluating the effectiveness of services and the quality of inter-agency practice and influencing continuous improvement.

Some progress on this has been made during the year, via the development of the 'drift and delay' scorecard, having identified this as a key theme from inspection. Nevertheless, gathering consistent performance 'data' for this scorecard was not straightforward – and the data itself was not fully supported by analysis of quality and impact. The establishment of a reliable and helpful 'balanced scorecard' will remain a priority.

The activity described above is supplemented by the work the Board does routinely – SCRs, child death reviews, learning lessons reviews etc – and more episodically ('audits'), and

plans to do in 2016/17 through 'themed' Board meetings (e.g. domestic abuse, 'front door' etc) and to some extent 'walking the floor' and section 11 audit.

Despite the progress made, there is further work to do, within individual agencies and as a Board, to develop a more consistent shared understanding of quality and impact.

- Lead on ensuring that the partnership work to tackle child sexual exploitation and children who go missing is consistently 'good' or better.

There has been good progress made in relation to the whole partnership response to CSE. Further work is required to quicken the pace of improvement in relation to children who go missing (see pages 23-26 for more detail)

- Ensure that the learning from local 'learning from practice' exercises leads to sustained improvements in safeguarding practice

There are some good local examples of Board-led improvement resulting from serious case reviews, child death reviews and other 'learning from practice' activity. These examples include: the development of the pre-birth vulnerability pathway, FGM pathways and progress on developing a 'whole system' approach to securing better engagement with men.

Partner agencies have also developed different and determined approaches to disseminating learning across their work force – for example CSC held lunch-time briefings on learning from (local) SCRs.

More still needs to be done to evaluate the impact of learning (especially) from SCRs and to ensure that agreed actions are implemented in a timely fashion.

- Develop mechanisms to consistently capture the views and experiences of children and young people and their families and use these to improve services and outcomes

There are examples of progress in relation to this: the Board consistently aims to capture the direct views and experiences of children and young people into case audit activity and has also led on the redesign of child protection processes and referral forms which explicitly require professionals to describe what life is like for the child.

There is evidence too, from audit activity and inspection, of significantly improved recording of children's views in CSC records. Children and young people were also widely consulted as part of the development of the emotional health and wellbeing strategy.

Weaknesses remain, however, for individual agencies and the Board as a whole, in terms of mechanisms for capturing and aggregating the views and experiences of children, and using these to quality assure services and inform service

development. More work is needed on this which will remain a priority for the Board.

- Improve the way that the Board effectively communicates, across a range of audiences

The Board communicates in a range of ways across the partnership audience. Weekly safeguarding bulletins are produced and widely disseminated – feedback from the section 11 audit (2016) shows that these are highly valued and actively used across a range of settings and services. The Board also communicates consistent safeguarding messages via its extensive training programme which reaches thousands of practitioners each year. Specific targeted safeguarding messages (for example, on safe sleeping) are delivered to coincide with national campaigns.

Further work is still needed to strengthen communication, for example by re-designing the current web-site to ensure that it is more helpful and informative for professional and public audiences alike.

Summary

Progress has been made during the year, but more is needed in respect of each of the priorities during 2016/17. The agreed changes to the way in which the Board as a whole approaches its business are intended to develop a better shared understanding of quality and outcomes. The Board will also need to consider during the year, whether further adjustments to governance arrangements might be needed to create the partnership capacity for a sharper focus on performance.

Conclusions and Challenges the LSCB is setting itself for 2016/18

The report describes the work of the Board during 2015/16. It describes an enduringly strong partnership which remains committed to safeguarding children and promoting their welfare, and identifies where improvement is evident (for example, in relation to pre-birth work, FGM and CSE). The report outlines the work undertaken to sustain existing good performance in relation to some of the Board's statutory functions and the progress made in improving on areas for development.

Our analysis of the 'safeguarding system' in Hull overall mirrors the conclusions of national research which found that children's needs are becoming more complex at a time when specialist interventions and services are depleted as a result of public sector funding cuts. Whilst there was a small reduction in the volume of contacts and referrals to children's social care, plausibly attributable to the continued development and impact of targeted 'early help' arrangements, nevertheless there was a continued significant increase in core 'child protection' activity combined with an underlying upward trend in the number of children needing to be looked after by the local authority. Other indicators of increased 'demand' included a 22% increase in reported incidents of domestic abuse in the city which required a police response.

Predicting future patterns of demand is difficult, but based on current trends and given no immediate prospect of a reduction in socio-economic pressures on many Hull families, it is likely that the numbers of children subject to child protection plans, and the number needing to be looked after, will continue to rise, placing additional demand on acute and specialist services and on budgets.

The challenges for the Board encompass both a need to continue to improve in relation to some of its core statutory functions, but also to both provide and help to foster the "strong, focused strategic leadership which engages the whole partnership" identified in the Chair's foreword, that would enable some of the essential developments (a stronger whole partnership early help offer, the implementation of the Early Help & Safeguarding Hub, greater integration (service provision, commissioning, performance management)) to progress at the pace which is required to meet need and manage demand.

This will also mean grasping the opportunities which the Wood Review presents for greater shared accountability between the police, health (CCG) and local authority, but

increased flexibility as to what local safeguarding arrangements may look like.

It is important that the Board identifies the right priorities and is realistic about what can be achieved, focusing on those things which will make the most difference to children and families.

Our existing five priorities (pages 42-44) will continue. We need to ensure that the progress made on child sexual exploitation is sustained and mirrored by similar progress in relation to children who go missing. Further work is still needed on performance frameworks across the partnership, so that we know better and more routinely the quality and impact of joint working. We will adopt a different approach to this in 2016/17 by holding focused 'learning Board' meetings on particular themes. We will also establish a more routine approach to joint evaluation of cases (multi-agency auditing) linked to these themes, using the learning to improve practice.

In addition, the Board will have an ongoing focus on the development of early help provision and on the implementation of the EHaSH, recognising the critical importance of these, and using its role of influence and challenge to ensure that all partners contribute and full implementation is accelerated.

The Board will also continue to lead on changing the 'culture' across services and contexts (from universal to safeguarding) in the way in which we engage with men and fathers.

Evidence shows that doing this differently, and doing it well, has a significant impact on outcomes for children.

Finally, we know from learning from a current serious case review that we need to develop and improve the way in which we work with neglect. During the period (up to 2018) we will develop a partnership neglect strategy and adopt neglect tools for practitioners to use, supplemented by multi-agency training.