Hull Safeguarding Children Board

ANNUAL REPORT

2016/17

Contents

2. Foreword

4. The Role of the LSCB

5. LSCB Partners

8. How the Board undertakes its work

13. Growing up in Hull

22. The child's journey through the safeguarding system

37. The effectiveness of safeguarding arrangements in Hull

42. Serious Case Reviews and Other Learning

47. Reviewing child deaths

51. Managing allegations against people who work with children

54. Partner compliance with statutory safeguarding requirements

57. Holding partners to account for safeguarding practice

58. The effectiveness of the LSCB and progress against priorities

62. Conclusions and challenges the LSCB is setting itself for 2017-19

Foreword

Welcome to the Hull Safeguarding Children's Board annual report. This report 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, together with capturing learning and improvement activity undertaken by the Board itself.

The analysis of the children's safeguarding system demonstrates a significant increase in child protection activity and increased numbers of children who are looked after by the local authority. A rise in contacts and referrals to children's social care demonstrates the continued pressure on the system and the continued need to work together to improve the multi-agency "Early Help" offer across the partnership. This is an area of practice the board has supported in development and applied its authority in holding agencies to account in respect of the pace of development of the EHASH (Early help and Safeguarding Hub).

Our current partnership as a board continues to be a strength with appropriate representation and good attendance to board and subcommittee meetings.

In consultation with agency leads we agreed and refreshed our approach to the conduct of the full board meetings, by identifying greater time to focus upon priority area which analysis indicated may place children at risk, together with future themes in relation to the inspection process.

For example, our "deep dive" to review the impact of Domestic Abuse upon children was used to test the effectiveness of current systems and how evident learning from Serious Case Reviews was embedded in front line practice. This led to challenges in relation to the use of evidence based risk assessment tools and informing the development of the Hull Domestic Abuse Strategy.

Following the Wood review of Local Safeguarding Children's Boards and consideration of the Children and Social Work Act in relation to Safeguarding Children arrangements, it is essential as a board we look ahead and consider how partnership future arrangements may look together with supporting the 3 identified statutory partners (Local Authority, Humberside Police, Hull Clinical Commissioning Group) in developing those discussions.

In support of this I personally believe where an evidence based compelling case exists, we should seek out opportunities for greater co-production and collaboration across partnerships and boards, to maximise impact, reduce duplication of effort, and by doing so improve outcomes for the vulnerable within our city.

On a final note I would wish to place on record my thanks to my vice Chair Kate Munson, my board manager Neil Colthup and the

remainder of the staff employed at the board for their outstanding support throughout this year.

Rick Proctor

Independent Chair

Hull Safeguarding Children Board

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 their 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.

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 2015/16 Annual Report identified continuing strong partnership engagement, albeit with a small number of 'gaps' which needed to be addressed:

- During this period (2015/16), due to major internal reorganisation and personnel changes, Humberside Police had been unable to provide a consistent representative for most of the period. This issue was addressed by the Board Chair with the Police & Crime Commissioner and senior officers. During 2016/17 there was a much improved consistency of engagement with the Board itself, the Board's Business Group and its various sub-committees and work streams.
- Whilst the Hull and East Yorkshire Hospital Trust was represented at each of the Board meetings (in 2015/16), each time this was by a deputy rather than the designated senior Board member. The trust reviewed its safeguarding lead

arrangements and has been consistently and appropriately represented by a newly designated lead in 2016/17

- There is strong and consistent representation from the primary schools sector in Hull, but replacement representatives from the secondary and special schools sectors were not identified in 2016/17.
- There has been no representation from Adults Social Care during the period. This remains a significant gap, particularly in the context of learning from the section 11 audits and emerging learning from a current serious case review. This issue is being addressed by the Chair with the Corporate Director.

A ‘core budget’ of £417,281 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
NPS & CRC	£ 4,731
Cafcass	£ 550
Total	**£417,281**

The Integrated Inspection of services (Nov/Dec 2014 – published February 2015) had helped the partnership to develop a shared understanding about where improvement was most 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) were:

- 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.

These headline inspection outcomes, together with some specific areas of development for the Board, helped to shape the work of the Board and the Board’s development priorities. The priorities identified in the immediate aftermath of the inspection (June 2015)

continued to drive the work of the Board in 2016/17, albeit with adjustments to the ways in which this work was undertaken (pages 8 - 12).

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.

Based on our analysis of the 'safeguarding system', local learning, including from serious case reviews, and the joint targeted area inspection programme, the 2015/16 Annual Report identified a need to focus on:

- Reducing the harm to children from domestic abuse
- Reducing the harm to children from neglect
- Reducing the harm to children from sexual exploitation and from going missing
- Improving agency and practitioner engagement with men and fathers
- Continuing to strengthen the city-wide early help offer

An assessment of progress, and the work undertaken by the Board on these priorities during 2016/17, is described on pages 59 - 62.

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 identified priorities.

How the Board undertakes its work

The full Board is a large partnership, bringing together a range of senior managers and leaders whose services have a key role in safeguarding children. In March 2016, the Board as a whole considered how best to maximise the strength of this partnership.

Prior to this meeting the full Board had met six times a year for three hours each time. Meetings were structured so as to 'create space' for a more in-depth conversation about a key theme or issue each time, alongside a full agenda of 'core business'.

Despite the efforts made it was felt that this model still did not fully engage all members nor generate the level of shared understanding of key issues and priorities that was needed to drive improvement.

The development discussion in March 2016 considered proposals to change the frequency, duration and style of Board meetings, 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 (or themes), 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, learning from serious case reviews etc.) would be aligned to the forthcoming themes to ensure that as much 'intelligence' as possible could be gathered to inform understanding.

Members 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 2016) and the 'front door' and early help (November 2016).

It was agreed that the effectiveness of these arrangements would be reviewed in March 2017.

The Business Group (comprising the Board's main funding partners, (local authority, police and CCG), the Chair and Vice-Chair and a Lay member) met on seven occasions during the period.

Key issues of focus for the Group included:

- Consistent updates on progress in developing the Early Help and Safeguarding Hub (EHASH) – including challenge, to the PCC and others, about the pace of development

- Consistent oversight of progress in respect of various post-inspection improvement plans, including the local authority "getting to good" plan and HMIC action plan.
- A focus on the key outcomes of the CQC and HMIC safeguarding inspections (which had been undertaken but not formally reported by the end of the period)
- Consideration and approval of the HSCB Annual Report
- Forward planning and review of the Board's "deep dive" days (July and November 2016), including identification of key actions which needed to be taken forward
- Formulation and endorsement of key processes, e.g. the section 11 audit process and the arrangements for joint evaluation (multi-agency audit) of cases.
- Identifying and agreeing key pieces of development work, for example in relation to neglect
- Updates and oversight of the work of key subcommittees, for example, SCR, CSE and Guidelines and Procedures
- A focus on how to strengthen the Board's overall performance management framework which was hampered by a lack of capacity in some partner agencies.

The Board's 'engine room' remains its sub-committees, 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.

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 February 2017 the Business Group agreed a need to review governance arrangements to ensure that these support the necessary focus on the Board's priorities, alongside its key statutory functions.

This review will be undertaken in 2017/18 and will also take account of the 'Wood' review and any new guidance which is issued about future safeguarding partnership arrangements.

Significant work in 2016/17

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

- Three full day Board meetings with a "deeper dive" into: domestic abuse; early help and the 'front door; and domestic abuse re-visited and provision for vulnerable young people
- 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." This is a statutory function of the Board which we have continued to fulfil this year by, for example: updating and re-issuing the Board's escalation policy, following learning from SCRs; updated CSE guidance to reflect the revised definition and to provide guidance on MACE and the revised CSE Risk Indicator Tool; updating e-safety (online safety) guidance; and producing new practice guidance on safe sleeping (linked to learning from child death reviews).

- Joint evaluation (multi-agency audits) of 'front door' and domestic abuse cases, with the learning from these feeding into Board "deeper dive" days and establishing this important activity on a more routine basis.
- Ongoing development and refresh of the Board's training courses and programme, including new courses on 'becoming culturally competent', 'responding effectively to disclosures' (the need having been identified from case review) and a re-design of online safety training. The inspectors found that *"training is well delivered, well received and highly rated by professionals."* The Board's training continues to reach over 5,000 practitioners each year.
- Continued effective multi-agency work on reviewing all child deaths (see pp 47 - 50 for more detail). Inspectors found that local arrangements were *"highly effective."*
- Undertaking a full section 11 audit process with all of the Board's partners.
- The development and publication of FGM pathways and practice guidance, informed by learning from a review of an FGM case
- Finalised 'unborn' procedures and pre-birth vulnerability pathways, work which was identified as being needed from the Child T SCR. The procedures and pathway were launched In October 2016. The 'pathway group' is reconvening in 2017/18 to audit practice and assess impact. The pre-birth vulnerability identification work in midwifery was highlighted as good practice in the recent CQC inspection.
- Continued strengthened arrangements and multi-agency practice in relation to child sexual exploitation, including the introduction of pre-MACE meetings (see pp 33 - 35) and leading on the development of a revised pan-Humber CSE risk identification tool, based on learning from the 'Jay report' and letter to Directors from the Chief Social Worker.
- Further work on private fostering, based on learning from section 11 audits and private fostering case audits, including a revised cascade briefing and one-minute guide.
- Work (commenced in January 2017) on developing a neglect strategy, useful evidence-based neglect tools for practitioners and their supervisors and new training (for more detail see page 59)
- Significant work on how all services and practitioners engage with men and fathers, following learning from a number of local serious case reviews (see pages 60 - 61).

- 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 the police and local authority in relation to strengthening work on missing children
- 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), therapeutic support for victims of CSE and police commitment to provide additional resource for the EHASH.
- To the police and local authority with regards to the provision of accommodation for children detained after charge and development of the 'concordat'
- To the PCC in relation to plans for the provision of a regional Sexual Assault Referral Centre (SARC) for children.
- To the local authority in relation to assessment timescales and the provision of performance information.
- To all key partners about the provision of performance information and the development of a Board performance framework.
- To all key partners (following the Board day in November 2016) about their commitments to the EHASH.
- To Humberside Police in relation to the need to ensure that the impact of domestic abuse incidents on children is consistently captured on '913' reports.

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 and learning from serious case reviews. The narrative also shows where the Board has focused attention and sought to exert influence and developments in relation to important multi-agency work (e.g. the development of the EHASH, response to domestic abuse, practice in relation to neglect, pre-birth vulnerability pathways etc).

The new approach to full Board meetings (the "deeper dive" days) was kept under review by the Business Group during the period and also at the final Board meeting of the period.

Generally, feedback was positive. The approach was seen as successful in terms of developing a deeper shared understanding of key issues. Board members particularly valued the opportunity to hear directly from practitioners. In March 2017, the Board agreed to continue with the approach (for 2017/18) but also wanted a stronger connection with the work of the Business Group.

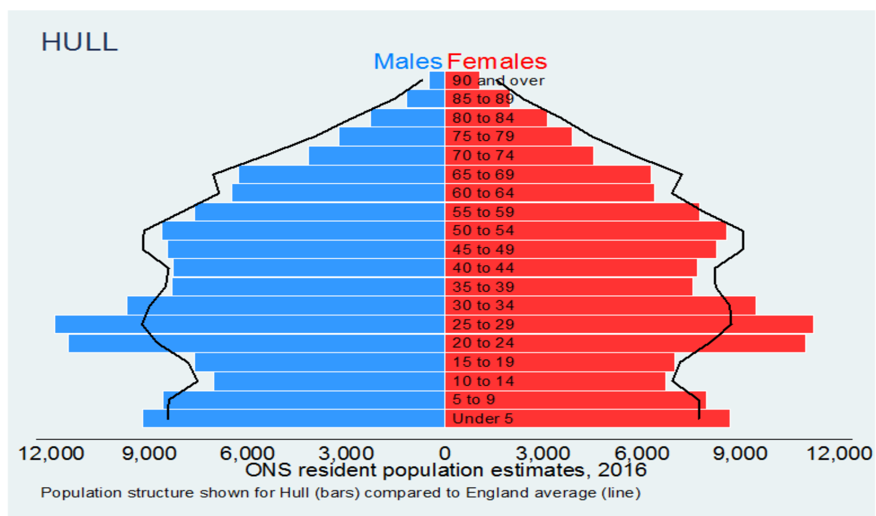
Some progress has been made in relation to most of the priorities identified, but further focus is needed to accelerate the pace of change and development in some key areas:

- Despite the efforts made, at the end of the period the Board still did not have an agreed and established performance framework with which to monitor quality and impact and influence continuous improvement.
- 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 multi-agency work in relation to children who go missing.

Growing up in Hull

Population and ethnicity

Based on the most recent estimates (2016), 260,240 people live in Hull, including 62,875 children and young people aged 0-19 years. To mid-year 2016, there were 3,552 births, and an estimated 17,868 children aged 0-4 years, 16,592 aged 5-9, 13,788 aged 10-14, and 14,627 aged 15-19 years.

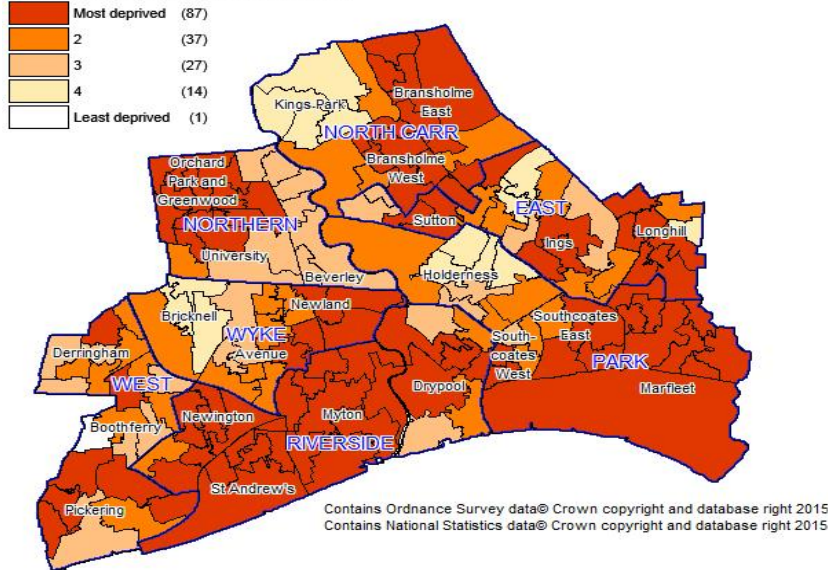


According to the Office for National Statistics (2016) between 2014 and 2020, it is estimated that the number of 0-4, 5-9, 10-14 and 15-19 year olds will change by –5%, +6%, +18% and –9% respectively.

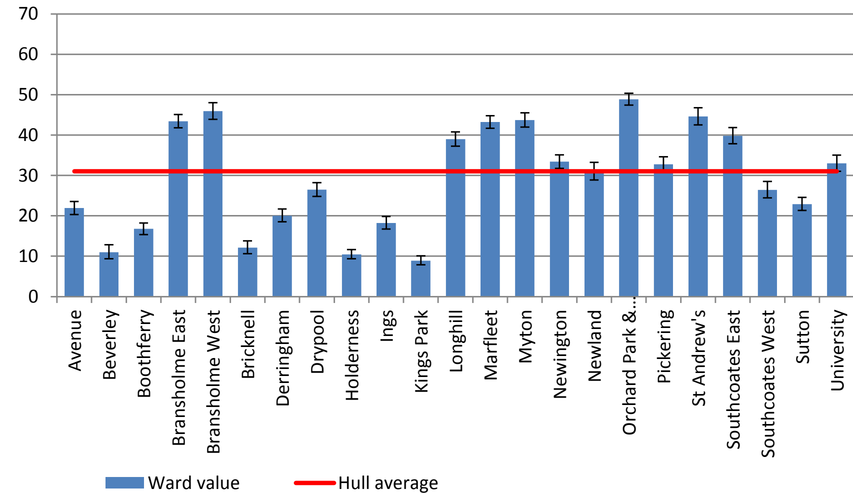
From the 2011 Census, Hull's population remains predominantly White British (89.7%). Whilst the percentage of the Black and Minority Ethnic (BME) population in Hull is still relatively low compared to many other areas, it does vary significantly across Hull's wards and the overall rate has tripled between 2001 and 2011. Hull's BME population is also diverse, with relatively small numbers of people from a wide range of BME groups. From the Child Health Profile 2017, in 2016, 5,400 (17.3%) of school children in Hull were from minority ethnic groups having increased from 9.1% in 2010.

Deprivation and child poverty

Based on the Index of Multiple Deprivation 2015 score, Hull is the third most deprived local authority in England (out of 326) with 17 of Hull's 23 wards amongst the most deprived 20% nationally (fifth).



Child poverty (children living in households where income is less than 60% the median household income before housing costs) is high in Hull. For 2014, 31% of dependent children aged 0-19 years lived in relative poverty compared to 20% across England, and rates differed substantially across Hull's wards from 9% in King's Park to 49% in Orchard Park and Greenwood. In total, it is estimated that there are 18,455 (out of 59,455) dependent children living in poverty in Hull.



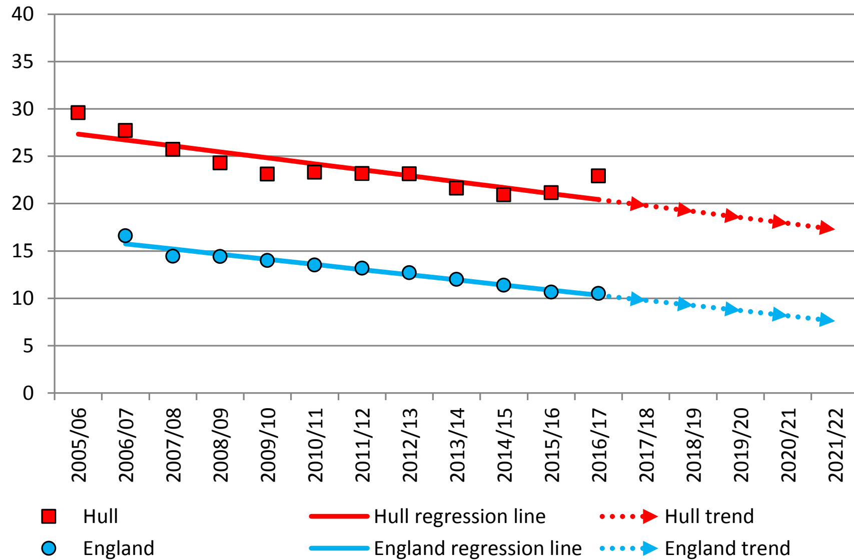
Risk factors for poor child development

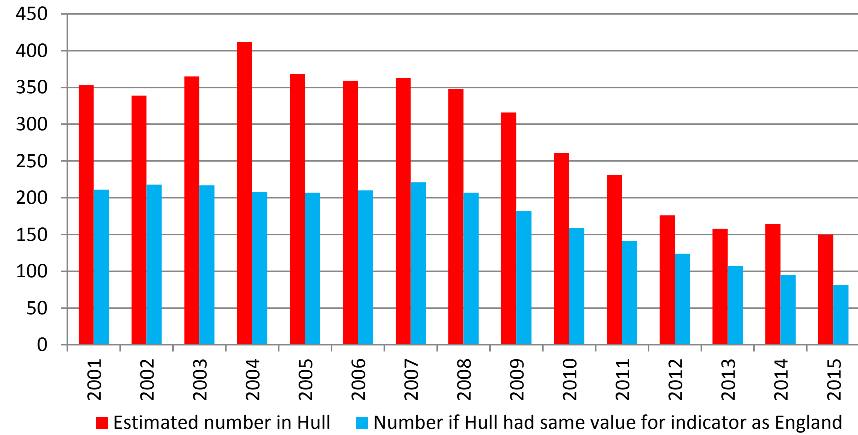
Due to the high levels of deprivation in Hull, the prevalence of the risk factors for poor child development is generally higher than in England.

In 2015/16, 66.9% of the working-age population were in employment in Hull compared to 73.9% for England.

In 2015/16, there were 24.8 domestic abuse-related incidents and crimes recorded by the police per 1,000 population in Hull compared to 22.1 for England.

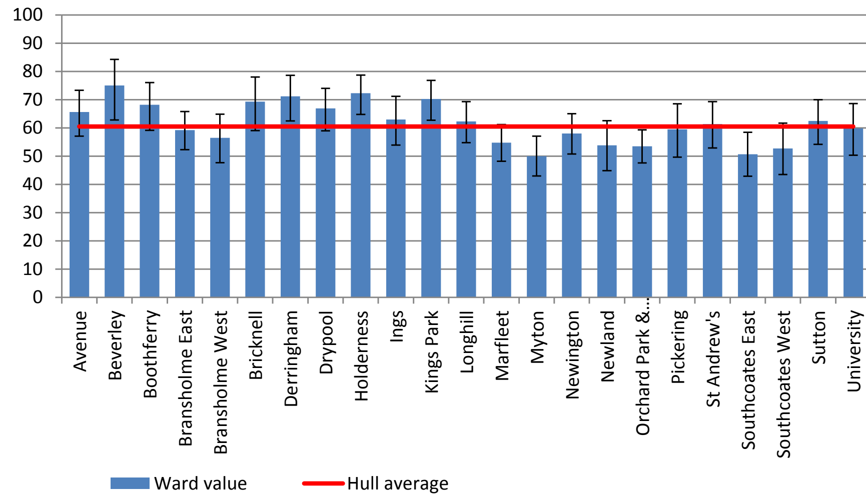
In 2016/17, 878 out of 3,834 women (22.9%) were known to be smokers at the time of delivery, compared with 10.5% for England.

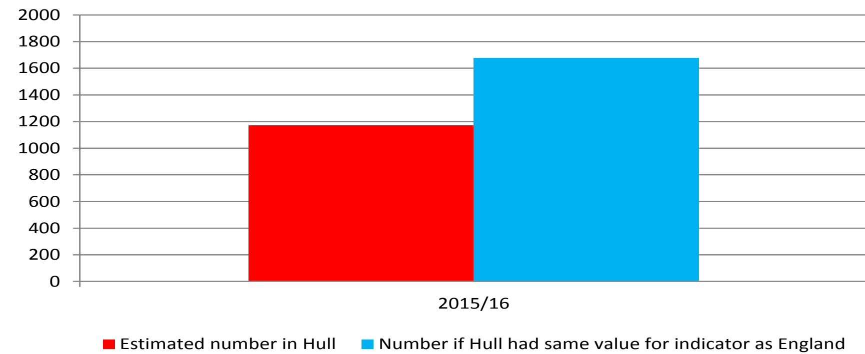




The rate of under-18 conceptions is 38.4 per 1,000 women aged 15-17 years in Hull for 2015 is still much higher than the England average (20.8), even though the rate has fallen at a significantly higher rate locally over the years.

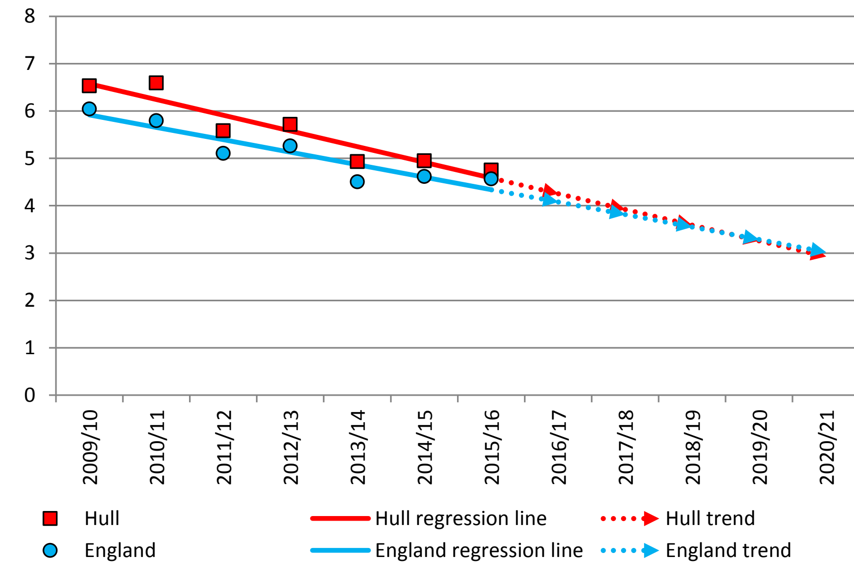
The percentage of children who had achieved a good level of development by the end of Early Stage Foundation Years was only slightly lower in Hull (65%) compared to England (69%) for 2015/16, and higher among free school meal children (58% versus 54%). Variations at ward level are given here for 2014/15.





Other risk factors are also higher in Hull:

- Breastfeeding rates were lower in Hull (both initiation 62% versus 74% for 2014/15, and at 6-8 weeks 30% versus 43% for 2015/16).
- School pupil absence rates were higher in Hull (4.75% versus 4.57% half-days missed for 2015/16)

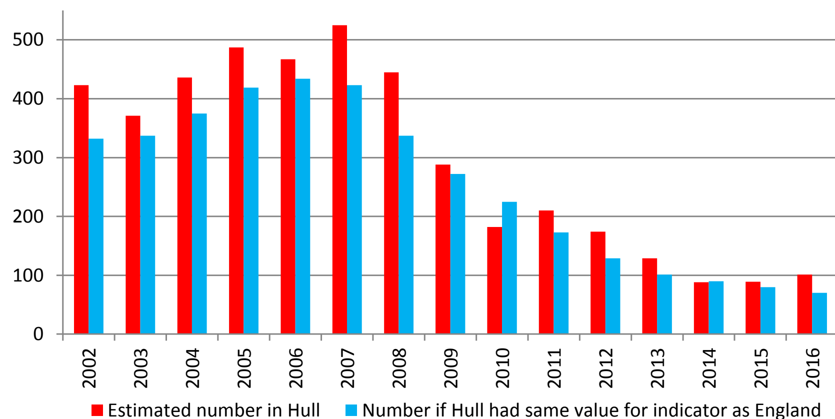


- First time entrants into youth justice were also higher in Hull (471 versus 327 per 1,000 people aged 10-17 years in 2016) with 101 first time entrants into the youth justice system in Hull, although the number and rate of first time entrants has reduced substantially over the last decade and is now much closer to average.

The total number of young people in Hull is currently estimated to be 21464

This plot gives the estimated number of young people entering youth justice system in Hull

In general, as a decrease in the indicator denotes an improvement and as the average difference is negative, Hull is worse than England

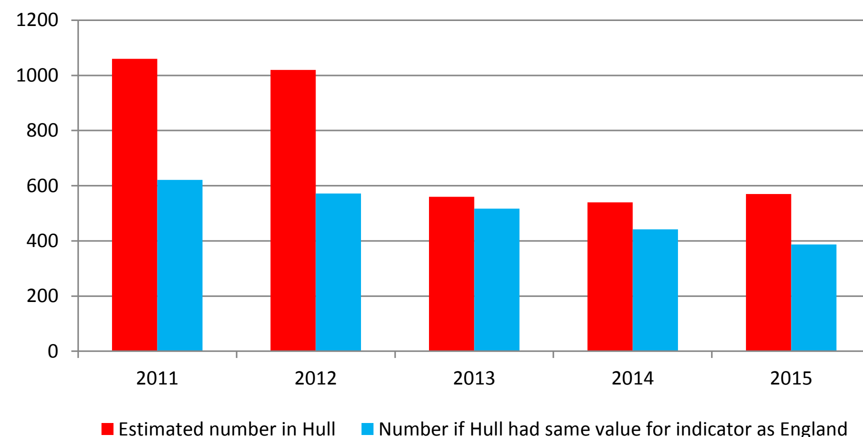


- The percentage of 16-18 year olds not in education, employment or training (NEETs) was 6.2% in Hull compared to 4.2% for England in 2015, with 570 NEETs in Hull.

The total number of young people in Hull is currently estimated to be 9260

This plot gives the estimated number of young people not in education, employment or training in Hu

In general, as a decrease in the indicator denotes an improvement and as the average difference is negative, Hull is worse than England

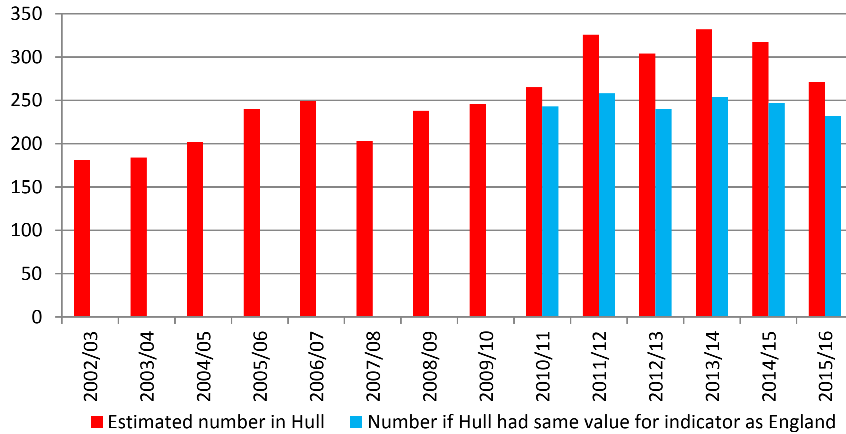


- During 2015/16, there were 637 hospital admissions of children and young people aged 0-14 years caused by unintentional and deliberate injuries (a local rate of 134 compared to a national rate of 104 per 10,000 children). This was also the case for children aged 0-4 years (151 compared to 130 per 10,000 children) with 271 admissions in total for Hull, and among young people aged 15-24 years (145 compared to 134 per 10,000 population) with 555 admissions in total for Hull.

The total number of children in Hull is currently estimated to be 17898

This plot gives the estimated number of admissions for injuries in Hull

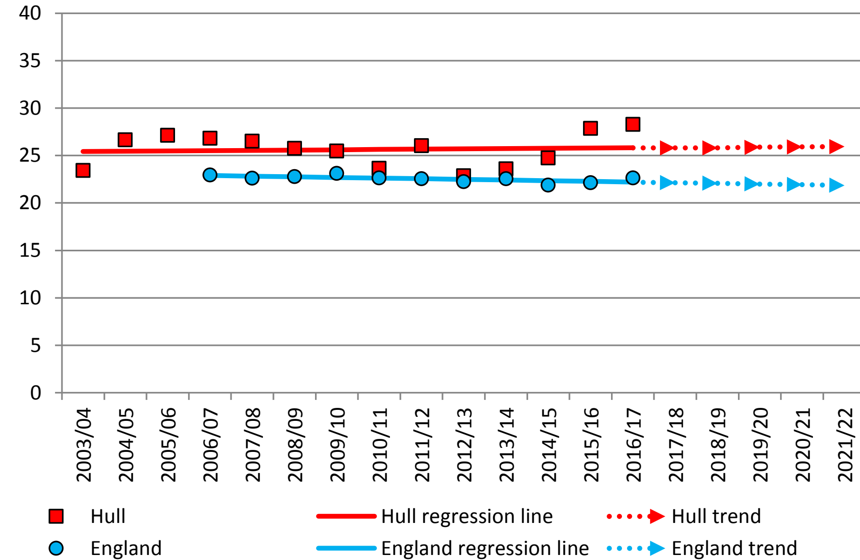
In general, as a decrease in the indicator denotes an improvement and as the average difference is negative, Hull is worse than England



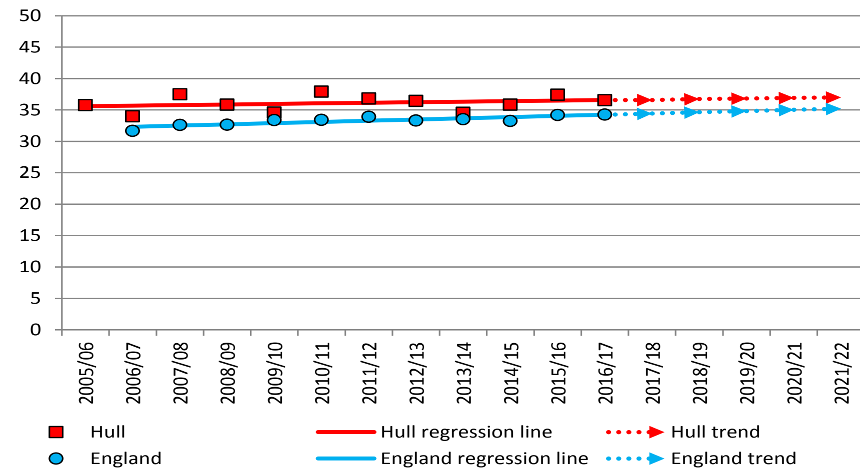
NB. The estimated number of children referred to above is the estimated number of children aged 0-4.

Prevalence of lifestyle and behavioural risk factors among young people in Hull

From the National Child Measurement Programme (NCMP), in 2015/16, 27.9% of 4-5 year olds were overweight or obese compared to 22.1% for England.

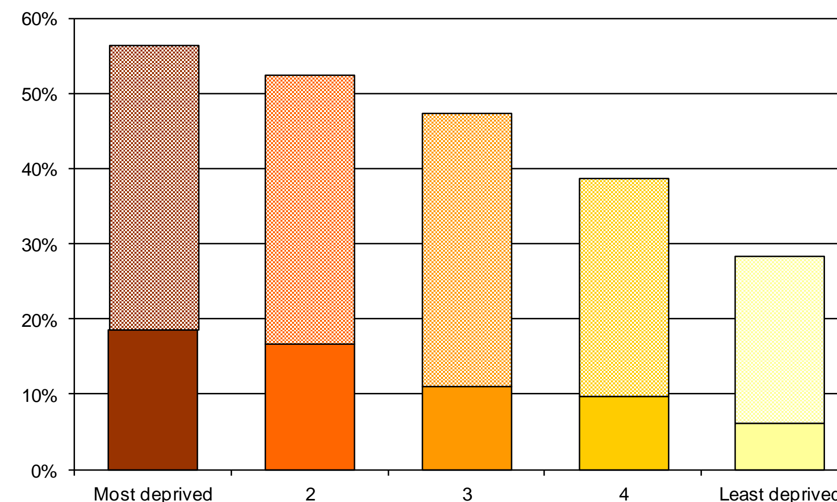


Among 10-11 year olds, 37.4% were overweight or obese in Hull compared to 34.2% for England.



In the latest Young People Health and Lifestyle Survey conducted in 2016, one in three secondary school pupils (years 7 to 11, aged 11-16 years) participated in the survey giving results broadly representative of Hull's young people. In general, the prevalence of lifestyle and behavioural risk factors among young people in Hull has decreased over time, similar to patterns observed nationally.

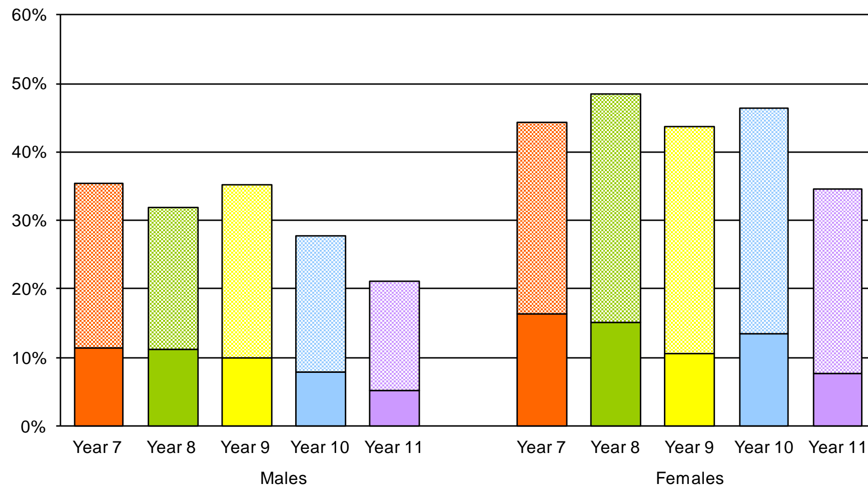
- More girls smoked (9.1% overall, and 21.1% in year 11) compared to boys (5.9% overall, and 11.7% in year 11).
- Just under half (43% of boys and 47% of girls) reported that someone living in their house smoked regularly and overall 30% of boys and 34% of girls reporting that the regular smoker(s) smoked inside the house. This was much higher for young people living in the most deprived fifth of areas of Hull (57% lived with a smoker and one-third of these (or 19% overall) smoked within the home).



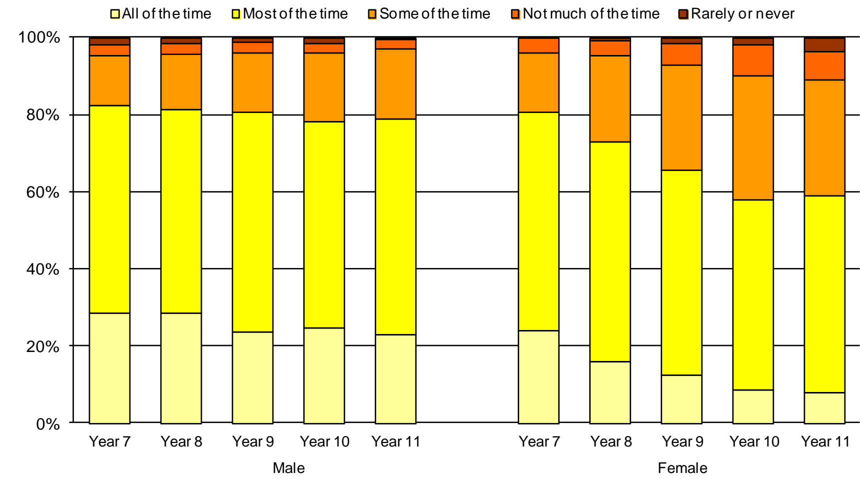
Solid bar = smoke inside the home; dotted bar = smoke but not in the home

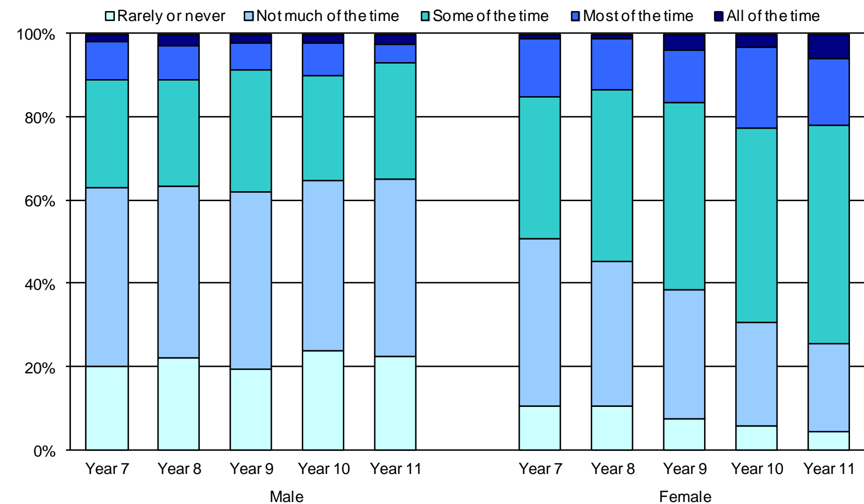
- Three quarters of pupils had never been drunk, while in year 11 one in six boys and one in three girls got drunk at least once a month. One in twelve boys (8%) and one in twenty girls (5%) in year 11 reported drinking more alcohol than the maximum amount recommended for adults (14 units).
- Few pupils in years 7 and 8 had used or tried drugs, although by year 11, 23% of girls and 18% of boys had used or tried drugs. The most commonly used drug by pupils was cannabis (15% of girls and almost 10% of boys in years 9-11).
- Overall, 42% of boys and 41% of girls reported eating 5-A-DAY fruits and vegetables daily.
- Overall, 44% of boys and 34% of girls engaged in at least 1 hour of physical activity per day on average, although this was much lower (24%) among year 11 girls.

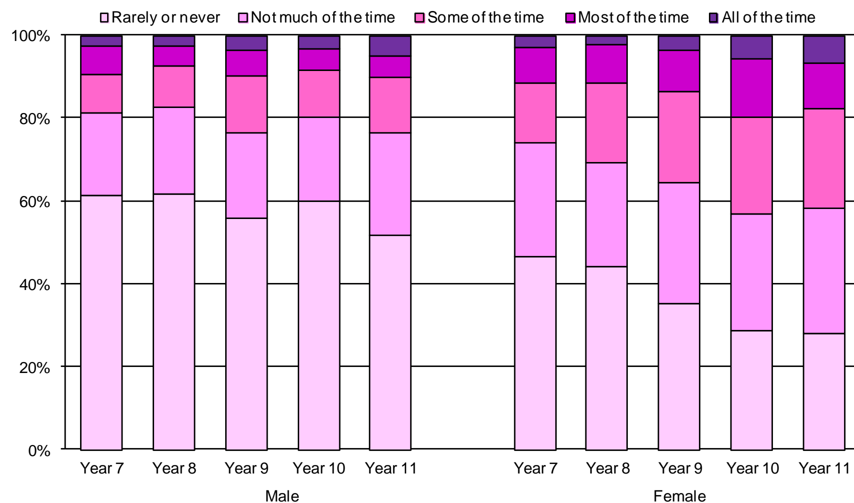
- Around one in ten (9% of boys and 13% of girls) reported that they had been bullied at school in the last month, with the percentages reporting they had ever been bullied at school more than three times higher.



- Eight out of ten boys and two out of three girls were happy all of the time or most of the time, while one in ten boys and almost one in five girls were sad all of the time or most of the time. One in eleven boys and almost one in six girls felt lonely or isolated from others all the time or a great deal of the time.







Analysis

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 chid, both to their safety and to their development and behaviour".

This context is, predictably, reflected in a local safeguarding system (see next section) which is characterised by high rates of 'children in need, and of looked after children, with enduring and increasing high levels of demand on 'acute' and expensive specialist services, including children's social care.

As indicated in last year's Annual Report, these high rates and continued reliance on social work solutions, are unsustainable in the medium term and in the context of reducing public sector budgets. The analysis in the next section shows how these pressures and demands have increased still further during the intervening 12 months.

Previous annual reports (including last years) have reflected on this context and emphasised the critical importance of continuing to strengthen and develop the whole-partnership targeted 'early help' offer and arrangements, such that children and families can receive the help and support that they need, and before needs become acute or chronic. This stronger set of arrangements is essential, primarily to better meet need and address risk as it emerges, but also to reduce demand on CSC, police and other specialist services.

Subsequent sections of the report comment on progress in this regard and in particular the development of the Early Help and Safeguarding Hub, and the Board's role in supporting developments.

The child's journey through the safeguarding system

Context

The 2015/16 Annual Report (and previous annual reports) included a detailed description, and some analysis, of the local 'safeguarding system'. This description and analysis, together with the key activity data and performance indicators, were used in November 2016 to set the context for the day which the Board devoted to early help, the development of the Early Help and Safeguarding Hub (EHASH) and the 'front door' of services.

In summary, the data for 15/16 appeared to show:

- An 'in year' reduction in the overall number of contacts with (-7.4%) and referrals to (-16%) Children's Social Care compared to the previous year.
- An overall reduction (of 12.7%) in the number of children in need, leaving a CIN rate which was still amongst the ten highest rates nationally.
- Alongside these reductions, a significant increase in core 'child protection' activity: number and rate of section 47 enquiries, number and rate of initial child protection conferences, number and rate of children subject to child protection plans.
- A continuing high rate and upward trend in the number of looked after children
- Evidence that children tend to remain subject to child protection plans or as children in need for longer in Hull compared to relevant comparator averages elsewhere.

One tentative hypothesis as to the reason for the apparent small 'in year' reductions in contacts, referrals and overall numbers of children in need, was that this may have reflected a growing impact of early help services and arrangements in Hull.

Nevertheless, the system overall was characterised by high demand and high caseloads across the partnership, including across children's social care and Humberside Police Protecting Vulnerable People Unit, and reflective 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.

Based on long-term and underlying trends, the 2015/16 report forecast that the number of children subject to child protection plans and the number looked after were likely to continue to increase.

The analysis also reinforced the central strategic importance of ‘early help, 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/acute services in the context of increased 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).*

For these reasons the Board identified ‘early help’ as a key priority and, in particular the establishment of the Early Help and Safeguarding Hub, and devoted a full day to these issues, along with the ‘front door’ in November 2016, with a view to helping accelerate the pace of development. By the end of the period the EHASH development had been ‘signed off’, with an agreed ‘go live’ date in June 2017.

Early Help

More data is available for 2016/17(than was for previous years) in relation to requests made to the early help email ‘box’, their source and the response to those requests. A total of 2038 such requests were received, consistently averaging between 400 and 500 each quarter (with the exception of the first during which an accrued ‘backlog’ was responded to).

Of these, 377 were received from schools, 314 from a range of health providers (including GPs), 240 from children’s social care (either as requests for additional specific support in ‘open’ cases, or passed to early help following assessment) and 177 resulting from police domestic abuse and juvenile report forms. An additional 477 cases were passed on to early help having been received as ‘information shares’ by children’s social care access and assessment services.

A total of 406 of these requests were passed on to children’s centres for additional support and/or further assessment. A further 168 were allocated to early help family workers. 114 were directed to Early Help Action Meetings in order for a multi-agency group of professionals to consider how best to meet the family support needs. In 142 cases an early help social worker visited the family in order to better understand needs and in an additional 42 cases the social worker facilitated a ‘Team Around the Family’ meeting. Other services allocated work as a result of these requests included: family group conferencing (102 cases), parenting support (211) and targeted pregnancy support (174). In a further 246 cases, no early help role was identified and it was judged that the support needs of families could be met by the referring agency. 72 cases were referred on to children’s social care.

A total of 1,078 family star (early help) assessments were completed during the year by local authority early help practitioners.

Whilst the above activity data provides a clearer picture of the demand for early help and requests for support via the early help inbox it:

- Provides an important, but only partial, picture, in that it does not capture requests which may still be being made direct to the early help locality hubs
- Is not yet sufficiently mature or sophisticated to enable an analysis of the impact of early help in appropriately diverting work from children's social care or in enabling appropriate 'step down' from children's social care
- Does not yet help develop a comprehensive understanding of quality and impact.

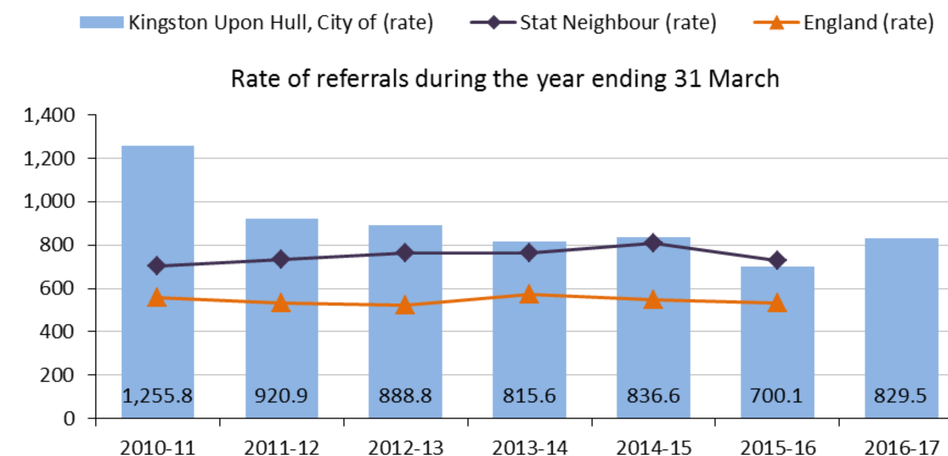
The local authority has invested in a new replacement ICS system (Liquid Logic) which will 'go live' early in 2017/18. Phase two of the implementation includes roll-out of the early help 'functionality' which will allow much greater partner access to a single system and will, over time, help to produce a higher level of analysis of activity, impact and outcomes.

The 'Front Door'

During the year, there were 12,055 contacts made with children's social care in Hull to share information or to discuss concerns about a child. This represents an increase of over 33% on the number (9,031) reported in 2015/16. This number of contacts is more representative of the historical 'norm' in Hull which suggests that a 'health warning' should be applied to the accuracy of the 2015/16 data. The information provided is discussed with the caller by social work staff in order to determine the appropriate response.

4,728 of these contacts (39%) progressed as referrals. The remainder were recorded as 'information sharing' or were referred on to early help services. The number of referrals increased by 21.4% (from 2015/16) and the local referral 'rate' (829.5) is once again significantly higher than the most recently reported statistical neighbour rate (727.0 in 2015/16).

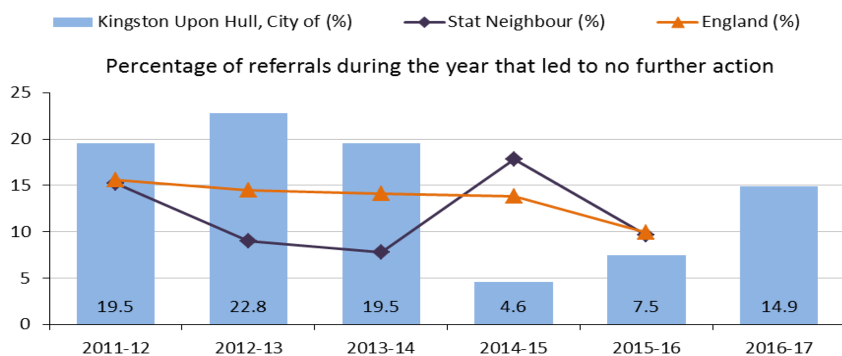
This rate of referral is much more in line with the 'norm' of the last four years.



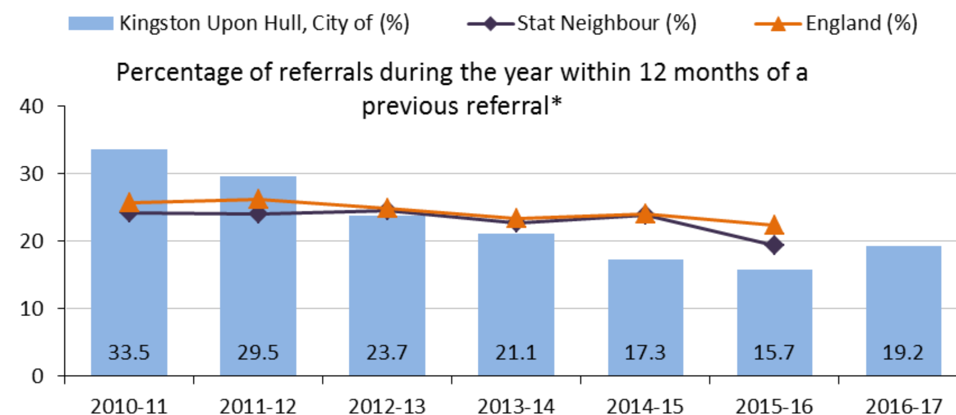
'Referrals' are those contacts which reach the threshold for action by Children's Social Care (CSC). This action includes making further

enquiries, contacting the family and other agencies and holding strategy discussions where a child is considered to be at risk of significant harm.

85.1% of all referrals progressed to a CSC assessment during the year (compared to 92.5% in 2015/16). This means that a higher proportion of referrals resulted in 'no further action' in Hull than had been the case since 2013/14. The number of assessments opened to CSC in 2016/17 (3,897) was higher than the number commenced in 2015/16 (3,600).



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 increased slightly in Hull for the first time in six years, to a rate of 19.2%, similar to the most recent available statistical neighbour (SN) rate but better than the national average rate.

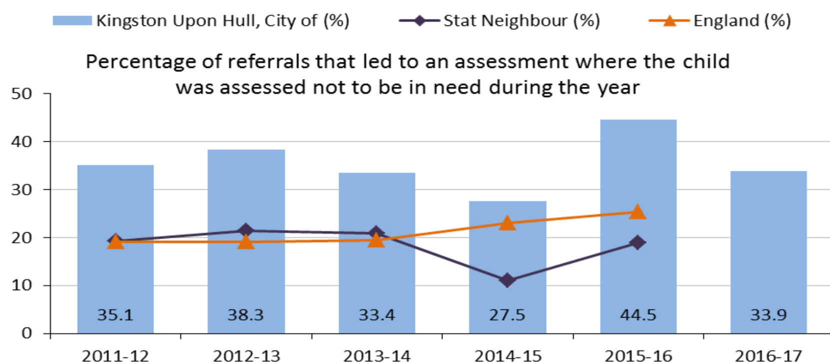


The 'model' for the provision of social work services in Hull means that CSC assessments are completed in Access and Assessment (at the 'front door'), rather than children and families being 'transferred' to locality based services for completion of this work. This 'model' has an impact on the pattern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

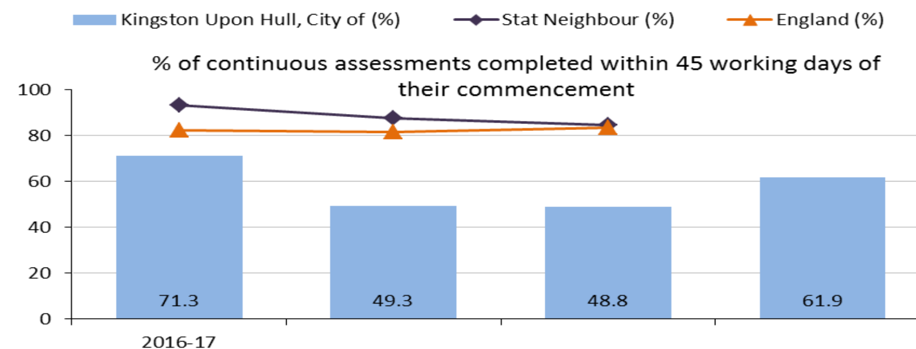
Children's Social Care Assessments

In Hull 33.9% of CSC assessments resulted in the child being assessed as 'not to be in need' of ongoing CSC help and support, compared to 44.5% in 2016/17. This brings the outcome of assessment pattern closer to the last reported national average (25.4% in 2015/16). This means that 66.1% of children were

assessed as being 'in need': 'in need – with a disability' 'in need of protection' or 'in need of being looked after'.



CSC single assessments are expected to be completed within 45 days of their commencement. 61.9% of such assessments were completed within 45 days during 2016/17, a significant improvement on 48.8% the previous year, but still significantly lower than SN and national averages (both over 80%). Further improvement is needed in relation to the timely completion of assessments to ensure that there is no delay in children receiving the help and support they need.



It is worth highlighting that the data on assessment activity captures updated assessments on existing (open) cases as well as assessments undertaken in relation to new referrals.

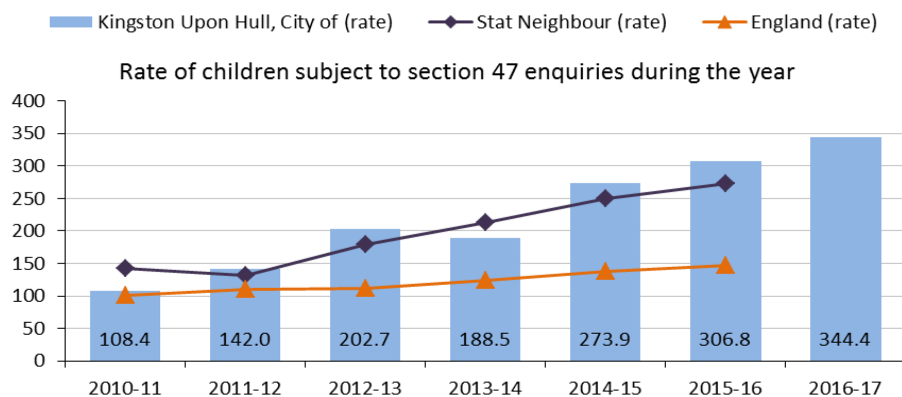
Overall, this data suggests increased pressure on the 'front door' during 2016/17 building on a 'system' which had already been characterised by high demand and high caseloads:

- An increased overall volume of contacts and referrals
- An increase in the number of CSC assessments
- A higher proportion of assessments leading to the provision of social work services

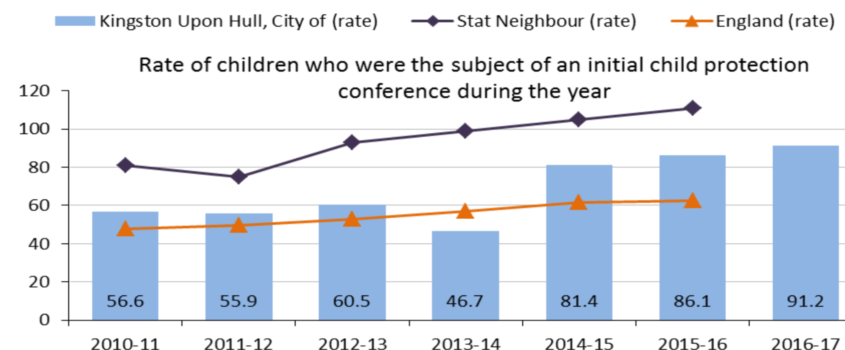
Children at risk of significant harm

At the same time, the number and rate of recorded section 47 enquiries (these are enquiries made where there are reasonable grounds to suspect that a child is suffering or is likely to suffer

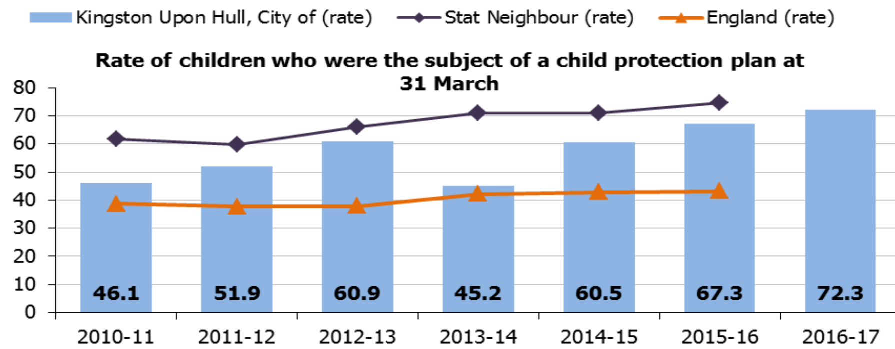
significant harm) continued to show a significant rise. In 2016/17, 1,963 such enquiries were initiated which is a rate of 344.4 per 10,000 child population. The recorded s47 rate in Hull has historically been noticeably higher than statistical neighbour averages (where the rate was 273.2 in 2015/16). The local rate showed an increase by a further 12.3% this year. Some of this increase in apparent s47 work may reflect improved practice and recording over the years. Nevertheless the local rate is high. There is no indication, either from the s47 audit work previously conducted by the Board, from inspection or from single and multi-agency audits of cases, that s47 enquiries are being initiated unnecessarily. Nevertheless, the number of recorded s47 enquiries locally appears to have nearly doubled since 2012/13.

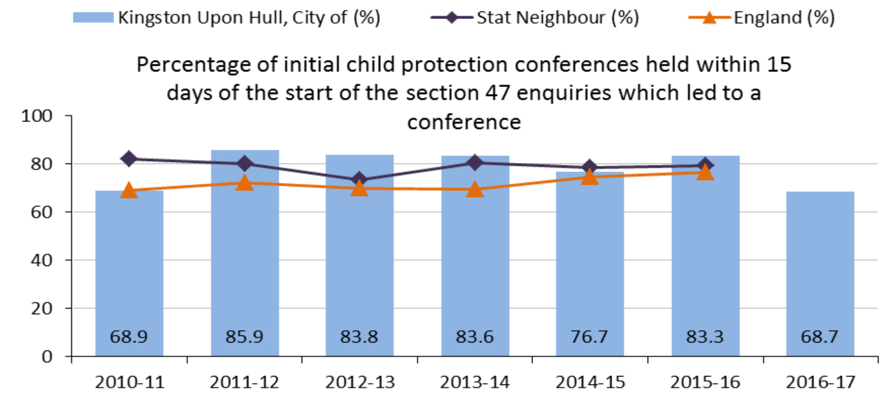


This year-on-year increase in the number of section 47 enquiries is reflected in an increase in the number and rate of initial child protection conferences (ICPCs) of more than 100% since 2013-14 (from a rate per 10,000 of 46.7 to 91.2). The number of ICPCs held in 2016/17 was 520 compared to 256 in 2013-14.



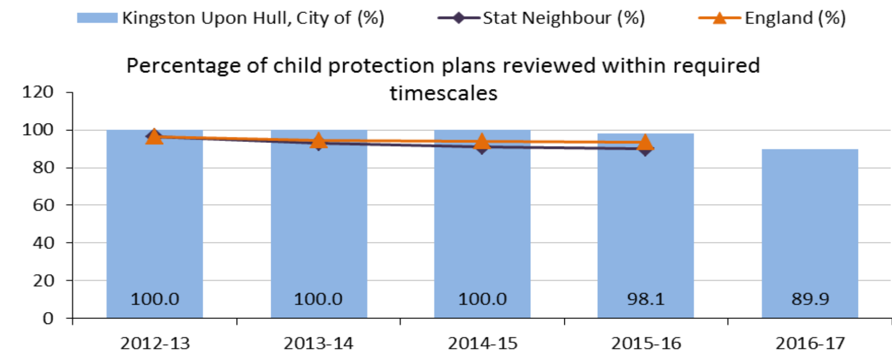
The number of children subject to child protection plans was 412 at 31st March 2017, compared to 330 at 31/03/15 and 248 on 31/03/14 (an increase of 66% over the last three years).



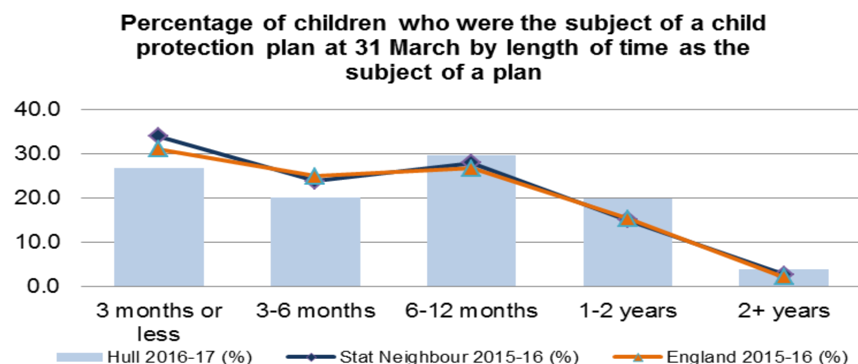


The proportion of initial child protection conferences which were held within 15 days of the start of section 47 enquiries fell significantly during the year, from 83.3% (better than average performance) to 68.7% (worse than average performance). The reasons for conferences being held late are monitored and reflect capacity challenges across the system. These include difficulties for social workers in being 'conference ready' within the timescales and some capacity challenges within the Independent Conference and Reviewing Team (availability of chairs, minute takers and meeting rooms).

Similarly, the performance in relation to reviews being held on time fell from 98.1% to 89.9%. Although this rate is close to average, the reasons for this decline in performance need to be monitored during 2017/18.



23.7% 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 25% in March 2016, whilst the rate of children who became subject to a plan for a second or subsequent time increased from 10.8% to 14.9%.



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 21.5% during the year to a total of 22,809. 809 cases were considered by MARAC during the year, 305 of which were 'repeats'. 843 children were linked to these cases. A total of over 7,000 children were directly involved in the 2,103 referrals received during the year by the Domestic Abuse Project. 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 pattern of child protection plan categorisation in Hull is unusual when compared with the average patterns elsewhere. For example, only 23% of children were on plans under the category of neglect compared to over 50% nationally and 31% were under the category of physical abuse compared to just 9% in England as a whole. Further work is required during 2017/18 to understand this pattern and to address any local 'custom and practice' issues which might explain it.

This continued increase in 'core child protection' activity was forecast in last year's annual report. It reinforces several imperatives:

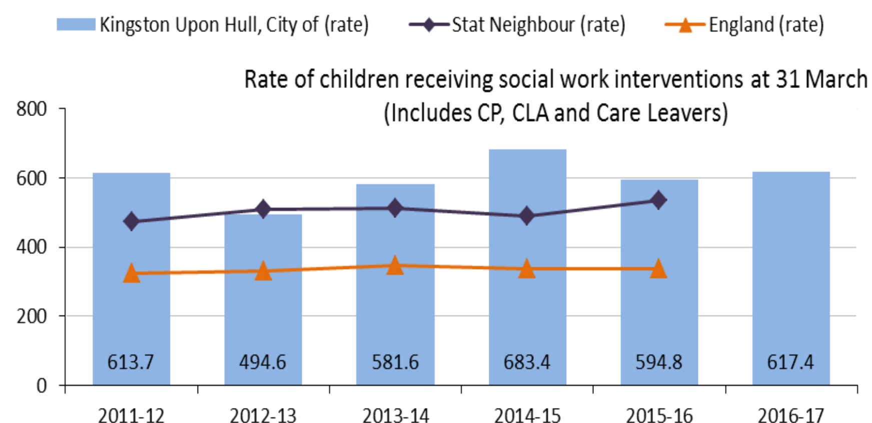
- The need to continue to strengthen the whole partnership targeted early help offer to better meet need before it becomes acute
- The need to develop different and more strategically 'joined up' approaches to tackling issues such as domestic abuse, which causes harm to children and significant demands on police, children's social care and other resources.

In summary, the local child protection system is characterised by:

- Increasing and significantly higher than average rates of section 47 enquiry
- Significantly increasing rates of initial child protection conferences and numbers of children subject to child protection plans
- Declining performance in relation to the timeliness of initial child protection conferences
- Children who tend, on average, to remain subject to child protection plans for longer than is the norm elsewhere.

Children in Need

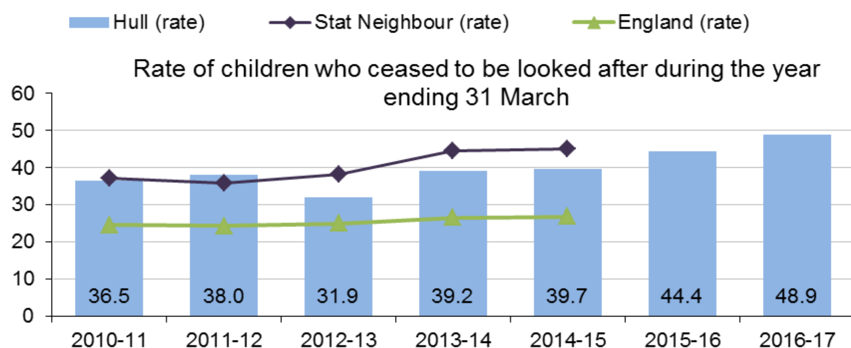
The overall number of children in need in Hull rose in 2016/17 from 3,307 on 31st March 2016 to 3,519 on 31st March 2017 (a rise of 6.4%) following a reported fall of 12.7% the previous year. Comparative information for statistical neighbours is not yet available for 2016/17. However, the Hull child in need rate (617.4) 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 2017, the number of looked after children in Hull had increased by 8% to 694 from 645 on the same date in 2016. Hull's looked after children rate remains high with a long-term underlying upward trend. This number was raised by an additional 14

unaccompanied asylum seeking children who were looked after during the year.



The age profile of the Looked After Child population in Hull shows that just over 50% are aged 11 years or older. This profile shows that a higher proportion of Hull's looked after children are under 10 (compared to averages elsewhere).

At 31st March 2017, 83% of Hull's looked after children were subject of a legal order (Care Order – 62%, Interim Care Order – 14%, Placement Order – 7%) with the remaining 17% being looked after with the agreement of their parents under S 20 of the Children Act 1989.

The 'Safeguarding System' – Analysis

The data 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.

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 implementation of the Early Help and Safeguarding Hub (which subsequently went live in June 2017) 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 high across all parts of the system in Hull and capacity within the Humberside Police Protecting Vulnerable People Unit is stretched to cope with increasing demand. Based on current trends such demand is likely to increase for the foreseeable future.

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 and learning from serious case reviews.

Vulnerable Older Young People

The Board published in December 2015 a Serious Case Review into the death of Child W, a sixteen-year-old girl who was living in local hostel accommodation at the time of her death.

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 monitored and reviewed progress at its meeting in March 2017.

At this point the local authority had commissioned external expertise to assist in the development of a new 'vulnerable young people service model. The development of the proposed model had, at this stage, considered how best to re-shape existing local authority services into an integrated vulnerable young people service model. Further work was needed to identify and engage partner agencies in this development work.

The Board will need to monitor progress during 2017/18 to ensure that the pace of development and implementation is accelerated.

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 increase in the population 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 delivered in 2016-17

The 'pathway' group has now evolved, and is being led by Public Health, with a 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, and at key review points including post-natally prior to discharge; 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.

The pathway, and supporting procedures, were launched in September 2016.

The group of key practitioners and managers which worked together to develop the pathway will reconvene during 2017/18 to monitor and audit practice against the agreed pathway and procedures.

Children at risk of Child Sexual Exploitation (CSE).

Last year's annual report described the significant improvements which had been made during the year in strengthening local multi-agency responses to CSE. These improvements were enhanced and consolidated during the year:

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

- Pan- Humber development and agreement of a revised CSE Risk Indicator Tool, reflecting the advice of the Chief Social Worker, which allows greater scope for professional judgement and less focus on numerical scores
- The establishment of a CSE 'pod' (comprising social workers and youth workers) and co-located with the Police 'Missing and Exploited' Team.

There continued to be strong whole council and wider partnership engagement in the MACE processes. All children referred to 'MACE' were also being managed and supported within existing, established safeguarding policies and procedures. The CSE pod also developed a monthly report (from MACE) which began to identify CSE hotspots and to provide some analysis (profiling) of the children being considered at MACE.

The Board's CSE sub-committee continued to meet regularly to oversee progress and to tackle any barriers to multi-agency working which might arise. A multi-agency Practice Development Group continued to provide more detailed oversight of progress in relation to the Board's CSE improvement plan.

During the year a CSE performance framework was developed by the Practice Development Group and approved by the sub-committee. The framework will be populated and updated on a quarterly basis from the start of 2017/18 and will yield greater intelligence about progress against the three strands of the Board's existing CSE strategy, (Prevention and early intervention, Protection and support, Disruption and effective prosecution)

Some progress was made towards including safeguarding (and CSE) training as part of the licence conditions for Hull's taxi drivers, but no final agreement was reached. This agreement will need to be secured during 2017/18.

No further progress was made during the year in relation to the development of a CSE 'problem-profile' in Hull (to build consistently on the one produced in March 2015). The need to develop such profiles was reflected again in the HMIC inspection of Humberside Police and will receive priority attention during 2017/18.

Progress has been made on developing a CSE training programme for hotels and B&B's and this will be rolled out during 2017/18.

During the period, 56 individual children were discussed at MACE, with a total of 245 discussions (i.e. many children were discussed multiple times). The CSE pod received 66 referrals requesting a consultation for advice or support, 42 of which were allocated a worker from the Pod. Overall, based on the figures held by the pod (including for MACE) 80 children were considered to be at risk of, or vulnerable to, CSE during the year. This figure does not, though, include additional referrals made to the Cornerhouse 'CARE' (Children at Risk of Exploitation) project.

All but four of the children referred to MACE during the period were girls. The majority (42 of the 56) of children discussed at MACE were within the 14-16 age group, although the pod had noticed an increase in referrals for younger children before the end of the period. The 'status' of some young people changes during the period when they are considered at MACE, as known or assessed risk rises or decreases. The 'final' status of the 56 children discussed was: LAC, 26, CPP, 11 and CIN, 19.

The MACE process also discusses suspected CSE perpetrators, in order to share intelligence and identify any additional intervention which can be undertaken to disrupt activity and secure prosecutions. 48 individual suspects were discussed during the period: 8 of these suspects were female, 45 were recorded as being white British and 33 were between the ages of 18 and 21.

According to Humberside Police data there were 39 CSE crimes reported to the police in Hull during the period, 15 of which were still being investigated. Charges were laid in respect of 3 of these reported crimes. There were a total of 748 CSE intelligence reports submitted during the same period. A comparatively low number of Child Abduction Notices (11 in total) were issued in Hull during the period. Humberside Police have been asked to explore further any underlying reasons for this comparatively low usage in Hull.

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 helps inform some targeted action. For example, identified CSE 'hotspots' are regularly visited by community police officers and PCSOs, CSE pod workers and Cornerhouse staff in an effort to reach the most vulnerable young people.

More work is needed on embedding 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:

- Work with Humberside Police on the development of a new 'problem-profile'
- Further 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 accessible for key professionals
- Develop clear plans to deliver the 'Say Something if you See Something' campaign and 'Operation Make Safe' across Hull, with a focus on hotels, licenced premises and taxi drivers

- Refresh the existing CSE strategy and action plan.

Children Who Go Missing

According to Humberside Police data, there were 1,372 cases of children recorded as missing in Hull in 2016/17, involving 404 individual children. This represents an increase in both frequency and the number of individual children compared to 2015/16. 520 (38%) of the missing episodes related to children missing from local authority care.

In addition, there were 175 cases of children reported as missing who were classified by the police as being "absent" (123 individual children). Absent is used in cases where there is "no apparent risk" identified. This classification will no longer be used in future years.

In relation to the 1372 cases, 24 were recorded by the police has having suffered harm whilst missing, including physical injury, sexual assault, emotional harm and self-harming.

The breakdown by gender, age and ethnicity of missing cases (rather than individuals) shows that 921 involved boys and 451 girls. 55 of the cases involved children aged ten or under and a further 305 children aged 11-13. 93% of all missing cases were in respect of white British children.

By the end of 2015/16, the local authority had put in place arrangements to ensure independent 'return interviews' for looked after children and had 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 March 2017, there was still no consistently reliable performance information available indicating that all return interviews were being completed, and in a timely fashion. The lack of reliable performance information in relation to return interviews is partly explained by the difficulty in extracting data from the Care First (CSC) database. This intelligence should be more readily available once the new Liquid Logic system is introduced early in 2016/17. There is still work to be done to be satisfied that all return interviews are being completed as required, and further work beyond that to quality assure the work and ensure that any significant information gleaned from these interviews is fed back in to police intelligence systems. This latter is vital to help find any missing child quickly if there are subsequent missing episodes and also to build a more comprehensive intelligence picture about where children go when they are missing.

The majority of the most frequently missing children are considered within the MACE arrangements as also being at risk of CSE. However, last year's annual report highlighted a need to re-

establish a multi-agency forum to regularly consider the needs of, and safety plans in place for, the most frequent and/or highest risk missing children. The Board has proposed that this cohort could be considered within the existing MACE processes but this, or any alternative, arrangement has yet to be implemented.

Further work is needed to improve responses to children who go missing and to ensure that progress matches the improvements made in relation to CSE. The HSCB CSE strategic group will need to expand its remit to ensure a focus on missing children, so that it has clear oversight and can drive the necessary improvements. It is also recommended that the new CSE strategy becomes a 'CSE and Missing' strategy to ensure that the needs of this significant cohort of children are being met.

The effectiveness of safeguarding arrangements in Hull

Other chapters in this report provide 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 and joint evaluation of cases (multi-agency 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

Humberside Police: HMIC National Child Protection Inspections

HMIC (Her Majesty's Inspectorate of Constabulary) undertook an inspection of child protection services in Humberside Police in November 2016. The report was published in April 2017. The following text describes Humberside Police's contribution to safeguarding children in Hull, together with the key findings of the inspection.

Humberside Police is committed to the strong partnership arrangements within the city, to enhance the response to providing

early help and safeguarding to children, young people and families, ultimately improving the outcomes for children.

Humberside Police co-ordinates safeguarding through a Central PVPU based within Communities Command. Appropriate action is taken against those who offend either by prosecution or civil remedies and where there are areas of concern these are shared with partner agencies to ensure a multi-agency approach is considered.

There is a dedicated detective sergeant working within the Local Authority (LA) who is responsible for the co-ordination of referrals and concerns identified through Police contact. The role of the detective sergeant involves reviewing all safeguarding referrals received from within the Police and providing advice and guidance where necessary. They also attend a range of meetings established within the LA, which include –Early Help and Intervention and strategy meetings and strategy discussions. Appropriate information is shared with partner agencies to safeguard the needs of adults and children. The Force ensures that there is engagement with front line Officers and in particular those who work within Communities to safeguard the needs of the community.

During the year training was delivered to all front-line Officers within the Communities and Specialist Teams to raise awareness on vulnerability across the community. The course was facilitated by Police and colleagues from within the Local Authority and included training focussing on Safeguarding Children, Referral processes and Allegations Management.

Humberside Police has actively engaged in a number of multi-agency audits and disseminated this learning across the organisation where appropriate.

The HMIC inspection identified some key strengths and evidence of improvements across the force since previous inspections in 2015. Inspectors found that:

- The Chief Constable has made child protection a priority for Humberside Police, and there was now an increased focus on improving outcomes for vulnerable children. This included major changes to the way the force provides child protection services across the county supported by an increase in resources for safeguarding.
- The chief officer team and the senior officers responsible for managing the force's public protection teams were comitted to improving services for the protection of vulnerable people.
- The force demonstrated a concerted effort to improve working effectively with the local safeguarding children boards to protect children across the force area
- Within the MASHs (Multi-agency Safeguarding Hubs) inspectors found some good examples of agencies working well together,

identifying risks, making plans to reduce these risks and supporting children and families.

- Staff had a good knowledge and awareness of domestic abuse and understood that this was a priority for the force
- Staff who manage child abuse investigations were knowledgeable, committed and dedicated to providing good outcomes for children identified as being at risk of harm
- Training had been provided to non-specialist neighborhood officers and staff about the identification of, and response to, child sexual exploitation
- Humberside Police had dramatically reduced the number of children it arrested and detained in custody through increased use of alternative resolutions. The Inspectors were pleased to find that in the past year the force had not detained any children in police custody under section 136 of the Mental Health Act 1983.
- The Inspectors acknowledged the chief officers' commitment to developing a culture of continuous improvement.

The inspection report also identified areas for improvement. These included:

- the force's response to child sexual exploitation remains an area for further improvement
- the force needs to do more within custody to ensure that its officers and staff recognise and respond to children who need to be safeguarded
- the standard of recording on police systems across the force,
- a lack of qualitative performance data does not help the force in understanding the nature and extent of the issues it faces

Overall, whilst the inspectors found that improvements had been made since the previous inspection (2014), more still needed to be done to improve safeguarding practice in order adequately protect those children most at risk of harm. Inspectors also found that the response to these findings to date was positive and robust.

Since the Inspection the force has implemented a Vulnerability Board which has oversight of the work being done to improve practice in the areas identified. Progress on improvements against the recommendation from the inspection report are also reported into the Safeguarding Children Board.

Care Quality Commission (CQC) Review of Services for Children Looked After and Safeguarding in Hull.

The CQC commenced this review in January 2017. The focus of the review was on evaluating the experiences and outcomes for children, young people and their families in receipt of health services in Hull, including those commissioned by Local Authority Public Health.

The final report contained a total of 38 recommendations, but also identified a significant number of areas of good practice.

Principal Findings

Early Help: Recommendations centre around HEYHT (Hull and East Yorkshire Hospital Trust) strengthening arrangements within the Emergency Department (ED) and both HEYHT and HFT (Humber Foundation Trust) to develop a greater understanding of the responsibilities of staff working in adult settings in relation to children ('Think Family')

Children in Need: Areas for improvement are in relation to maternity records and the provision of mental health services on paediatric wards.

Child protection: The inspectors raised concern that feedback from children's social care to child protection referrals and case conference/core group minutes were not always evident in records. Processes within sexual health services are to be strengthened. The further development of the role of the Named GP will facilitate enhanced support within general practice.

Looked After Children: The inspectors were assured in relation to the escalation process undertaken by NHS Hull CCG and CHCP (City Health Care Partnership) in relation to the timeliness of health assessments and have recommended that this impetus is maintained. As in previous inspections the CQC recommended that NHS Hull CCG ensures that the role of designated nurse for looked after children is resourced independently of the provider.

Leadership and Management/governance arrangements: NHS Hull CCG was recognised as having effective and visible leaders in safeguarding practice. The inspectors were satisfied that previous inspections had resulted in extensive action plans which provided evidence of improvements in the current inspection. Overall a positive culture among all health service leaders was identified. The developmental role of the relatively new post of Named GP was acknowledged.

Training and Supervision: The inspectors were made aware of recent contractual discussions which had taken place with HFT in relation to level 3 training uptake. Supervision arrangements in both maternity services and CAMHS require additional strengthening.

NHS Hull CCG has submitted a detailed action plan to CQC. The designated nurse has established a Hull looked after and safeguarding (HCLAS) monitoring group, including local authority and public health representation, to monitor actions. The action plan has been shared and discussed with the HSCB Business Group which will monitor progress on a regular basis.

CQC inspectors noted good practice and progress in relation to NHS Hull CCG priorities for 2016/17. Amongst these were:

- Although there remain some issues with initial LAC health assessments taking place late, the numbers are relatively low and the reasons closely scrutinised. CQC inspectors found that: "positively, we have seen evidence of the looked after children health team's proactivity in scheduling priority appointments to see children."
- The Designated Nurse Safeguarding children has been instrumental in the implementation of a process via CHCP, for disseminating police information from attendance at domestic abuse incidents and MARAC within health agencies, ensuring that relevant health professionals, including GPs, are aware of risk.
- The Named GP has provided valuable GP representation and input at Serious Case Review panel meetings and is also now an active member of the Child Death Overview Panel. Further progress has been made in relation to GP level 3 training and a revised form and process to improve GP input into child protection conferences.
- CCG and provider engagement with serious case reviews, learning lessons reviews and multi-agency auditing activity remains consistently high, including various and innovative ways of embedding learning. The CQC report states: "we have seen evidence of responsive leadership by the CCG's safeguarding team following inspections, serious case reviews and lessons learned reviews. We recognise that providers are also active and responsive to audits and reviews…"
- Significant improvement in relation to joint working on child sexual exploitation was noted, including the active involvement of health services in the MACE arrangements and strategic and practice development groups.

Serious Case Reviews and other learning

During the year, the partnership was engaged in a significant volume of serious case review work. The Board Chair took the decision not to publish a review which had been completed (see Baby A below). A further review was completed (Baby J) (and then published in May 2017). Two further reviews were initiated but not concluded within the period.

The Board has continued to pay 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 H

Last year's annual report described this review as being concluded but not yet published. This remained the case in 2016/17. Publication remains deferred so as not to compromise any potential future prosecution(s): a police investigation is ongoing.

Learning from this review was thoroughly explored in July 2016 at the full Board "deeper dive" into domestic abuse, including a particular focus on "coercive control" and on the use of evidence-based tools to assess risk and support professional judgement.

Baby A

The decision not to publish this SCR was taken by the HSCB Independent Chair on the advice of the Board's Serious Case Review sub-committee, as those involved were deeply concerned about the assessed negative impact of publication upon the surviving children and upon ongoing multi-agency work with the family.

In reaching this decision the Chair balanced the need for openness and transparency via publication against the primary role of the LSCB to safeguard and promote the welfare of children.

Advice was sought from the National Panel of experts for serious case reviews. The panel did not agree with the local view that there were substantial grounds for non-publication. This advice was carefully considered but the Chair's decision remained unchanged. In his correspondence with the panel, the Chair undertook to describe the review, and the learning, in this annual report.

Baby A died aged 5 months, of infection as a result of natural causes. His five older siblings were all subject of child protection plans under the category of neglect at the time of his birth. This

was due to longstanding concerns about conditions in the family home, and about the children's attendance at school and engagement with medical appointments and interventions. Baby A was placed on a child protection plan at birth.

Shortly after his birth, the child protection status of the children was changed to 'child in need'. However, the professionals working with the family subsequently became further concerned about progress and consideration was being given to a further period of child protection planning, or possibly legal proceedings, when Baby A died unexpectedly.

Conditions at the family home on the day of A's death raised serious concern, including an unsafe sleeping environment.

The review focused primarily on the challenges facing professionals when working with families where neglect is a concern.

One of the key learning points was that, at the time, practitioners and their managers in Hull were not supported in their work by agreed, evidence-based 'neglect tools' to assist in identification and assessment. Working with neglect is challenging, demanding and difficult for professionals, particularly when parents may not understand the need for change and/or are resistant to it.

In this context, the review found that it is important that assessment:

- Precisely defines neglect and describe the current impact on each child
- Explores the willingness and capacity of parents to change
- Identifies the longer-term impact on children if change cannot be achieved or sustained

The review also highlighted the importance of professionals being supported and encouraged to:

- Arrange for shared reflective and critical thinking time,
- Hold purposeful professionals-only meetings to facilitate this thinking time when needed.

The learning in this case also highlighted:

- A need to ensure that the needs of any child born into a family where there are pre-existing safeguarding concerns are individually assessed
- A need to ensure that, where there is difference of opinion between professionals about what needs to be done to keep children safe, that all involved are supported to be confident to voice their opinion and know how to escalate concerns if they remain dissatisfied with the action being taken.
- That more work is needed on developing guidance about what a 'good' (SMART) children's plan looks like.
- That section 47 enquiries should always be initiated when there are new concerns that a child may be suffering, or at risk of suffering, significant harm.

Learning from this serious case review has led to the identification of 'neglect' as a priority for the Board. The work on this to date is described on page 59.

Baby J

Baby J died in September 2014. His parents took him to hospital stating that he was unresponsive. Hospital scans revealed significant bleeding inside the brain. Medical tests and expert opinion (provided in May 2015) indicated that J's injuries were as a result of head trauma, associated with having been violently shaken.

J's father was subsequently charged and convicted of manslaughter (November 2015) and received a custodial sentence of 8.5 years.

J's father was a known perpetrator of domestic abuse (in a previous relationship), both parents had been referred to mental health services and were open about cannabis use. Father was also known to drink heavily at times, which was known to adversely impact on his behaviour.

In this case, there had been previous involvement with the family and J's older half-sibling by children's social care, given father's history of domestic abuse. A decision was taken to close the case some four months before J's birth. The review found that this decision was reasonable based on the information which was known, understood and considered at the time.

However, the review also found that:

- The police had been called to a significant number of domestic abuse incidents over a 12-month period prior to J's death. Each incident was assessed as 'standard risk' and details of few were shared with partner agencies. Whilst the level of assessed risk was appropriate to each incident in isolation, the systems were not in place at the time to consider any pattern and what this indicated in terms of risk.
- The GPs and other adult services held information about the needs of the parents, but this information was not sought, shared and analysed so that agencies did not have an holistic picture of the family needs and vulnerabilities.
- Father had engaged in an IDAP programme imposed in relation to his previous domestic abuse. An assumption was made that his engagement in the programme in and of itself meant that the risk he posed had been reduced.
- There was a significant level of coercive control within the adult relationship which was not recognised by professionals.
- The case revealed a degree of 'over-optimism' (that behaviour had changed and risk been reduced) and an over-reliance on 'written agreements', without a clear process for monitoring and reviewing these as part of a multi-agency plan.

The learning from this serious case review was explored in detail prior to publication when the Board revisited progress on domestic abuse in March 2017.

Other Serious Case Reviews

At the end of March 2017, the Board was working on a further two serious case reviews which should both be concluded during 2017/18.

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'.

The Board's serious case review sub-committee agreed that it would be helpful to identify independent reviewers to examine multi-agency practice in relation to the sexual grooming and abuse of young girls by a young adult skater. The victims were all skaters at the Hull Ice Arena where the perpetrator also attended for expert coaching. The purpose of the review is to identify whether there was anything more which might have been done to prevent any of this offending.

There were delays in establishing this review. However, suitable independent reviewers have now been identified and the review commenced formally in May 2017. It will be concluded in 2017/18, with the intention that the findings will be published.

In addition, the Board asked children's social care to undertake a 'management review', following the conviction of a former foster carer who had sexually assaulted looked after children placed with him. The purpose of the review was to examine the fostering assessment and approval process and practice, and to examine the response to any complaints or issues of concern which may have been raised in relation to the foster household and whether there were missed opportunities in any of this to safeguard the children.

No such opportunities were identified but there was learning in relation to steps which could be taken to strengthen practice in relation to support to foster households. The Board's SCR sub-committee will monitor the improvement activity during 2017/18.

Other Board learning activity

In addition to serious case reviews and other specific 'learning lessons reviews', the Board has led on the following learning activity:

- A programme of joint evaluation (multi-agency audit) of cases. This included three domestic abuse cases, prior to the Board's domestic abuse "deep dive" in July 2016, so that Board members could consider the learning and hear directly from the practitioners involved. A further 10 cases were evaluated prior to the November "deep dive" focusing on the "front door" and multi-agency responses to referrals. Learning from these cases was also fed into the Board day. Six further domestic abuse

cases were jointly evaluated prior to the March board day, so that the learning from these could be considered by Board members when they re-visited progress on domestic abuse. There is an explicit focus in this work on learning from serious case reviews: for example, in exploring how well the role of men and fathers is considered in CSC assessments.

- The multi-agency professionals involved in the MARAC (Multi-Agency Risk Assessment Conference) arrangements were all asked for their perspectives on the strengths of these arrangements prior to the Board day in July 2016. The learning from this exercise was, again, fed into the Board day.
- Following learning from the section 11 audits, existing and recent private fostering cases were audited (only 3 cases in total) in order to identify what more could be done to raise awareness of private fostering across the professional community.
- A multi-agency audit of 5 'open' cases to children's social care, using a locally agreed tool specifically designed to evaluate how agencies engage with men and fathers in the work that they do with children and families. This audit was undertaken to inform the Board's work on engagement with men and fathers. The work, and some of the learning from the audit, is described in more detail on pages 60 - 61.

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 27 child deaths during 2016/17. With the exception of 2008/09 (when there were 42 notifications) the number of deaths notified during any year has ranged from 19 to 27. 21 (of the 27 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 five times during the period and reviewed the deaths of 29 children. 9 of these deaths were treated as 'unexpected'. The Rapid Response process was initiated in 6 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) (15 cases) and infancy (28 days – 1 year) (6 cases) reflecting mortality associated with prematurity, genetic, chromosomal or congenital disorders as well as sudden infant death.

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, but two reviewed during the year were as a result of suicide or deliberate self-inflicted injury.

27 (of the 29) deaths reviewed during the year had occurred during 2015/16 (18 cases) or 2016/17 (9 cases). 21 reviews were ongoing as at 31st March 2017, 18 of which occurred during 2016/17. The other three reviews were all on hold pending the conclusion of serious case reviews.

In seven of the 29 cases reviewed the panel identified modifiable factors which may have contributed to the death of the child (see below).

Learning from reviews

- The panel reviewed 2 deaths of cases where a child died at their own hands. One had been the subject of a Serious Case Review and the CDOP did not identify any additional learning to that previously identified through the SCR. There were no modifiable factors identified from the 2nd case and there were no prior indicators from agency involvement or from the family that the child had wanted to harm themselves. Following this review CDOP members were recommended to review their use of recording that a child had not attended an appointment, to a preferred "was not brought" way of highlighting a parent's responsibility in bringing children/young people to health and social care appointments, and consider the implications on children when they are not brought. CDOP members also received regular updates on the development of the local authority's young people's emotional health and wellbeing strategy and plan.
- The CDOP again identified 'modifiable factors' in relation to a parent/s lifestyle choice 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 unsafe sleeping environments. 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.
- 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 2017. Since April 2008, 18 local child deaths have featured factors relating to some element of unsafe sleeping practice or environment. 13 of these cases also featured parental use of alcohol, drugs or cigarette smoking.

- Safer sleep training has been provided to Early Years managers and the safety messages and risk factors are cascaded through training to local providers.

- The importance of removing babies' outdoor clothing when indoors and not leaving babies too long in their car seats has been emphasised in the local safe sleep training for professionals to share with parents.

- The Lullaby Trust has offered to fund and help CDOP facilitate a safer sleep conference for professionals next year.

- The local child death notification process has been improved to ensure the children's disability team are notified in a timelier manner i.e. as soon as the CDOP co-ordinator becomes aware, to enable the team to respond to the family appropriately.

- There does not appear to be an identified process for accessing funding for help with transport to hospitals out of area and falls between gaps in the provision of services from health and social care - CDOP are in the process of preparing a list of charities that can be referred to for support, for sharing with health colleagues to share with families.

- Sunshine House is a local resource for some children receiving palliative care and this provision is being promoted amongst local doctors and regional specialist hospitals where it is appropriate and beneficial for families to use this provision closer to home.

- CDOP learned that although an emergency response for a child was not a contributory factor to that child's death, it might have had more serious implications in different circumstances. A Clinical Case Review was undertaken by the Ambulance Service and an action plan and learning for staff was undertaken and completed.

- A number of cases identified the lack of information about mother's partner/child's father held by hospital and community health and in one case this meant a key carer for a child was not included in meetings and given the same feeding /medical care advice as mother. CDOP members learned that the LSCB is undertaking a lead in the locally and nationally identified theme of 'improving engagement with fathers/men' and significant others in the family.

- CDOP learned of some areas of good practice by schools in supporting students, parents and staff following a student's death and an example of good joint working and planning to return the child to Hull from an out of area hospital to be with family and allow parents' wishes and religious beliefs to be accommodated.

- Local Ambulance Service and Hospital Emergency Department consultants have been reminded about the importance of transferring / receiving all child deaths so that the appropriate process/tests can be undertaken in a timely manner.

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: 61 professionals from health, the police and children's social care attended training in 2016/17, bringing the total number of people trained to 554 since 2008.

- The CDOP welcomed membership from the local Named GP for safeguarding, who has provided valuable insight into the role of GPs and has been instrumental in disseminating learning to GP colleagues.

- The publication of a quarterly e-bulletin containing articles of local and national significance relating to preventing childhood accidents, deaths and supporting bereaved families.

Managing allegations against people who work with children

The local authority has a single designated Local Authority Designated Officer post (established in May 2015). This post was made substantive during the period and a permanent appointment secured. This arrangement (following a period of time during which the LADO function had been carried out by the manager of the Independent Conference and Reviewing Team) also ensures that the LADO has 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, 58 cases were deemed to meet the allegations management threshold (compared to 55 in 2015/16). During the same period the LADO undertook 328 consultations on concerns about professional conduct which did not meet the threshold. This compares to 210 such consultations in 2015/16. In these cases, the LADO still provides employees with advice about how to respond to, and manage, the concerns. The underlying reasons for this increase in consultations are difficult to identify and explain: a small proportion may be attributed to the loss of the Education Officer (Safeguarding) role in October 2016, which had previously provided safeguarding advice and support to all Hull schools. It may also reflect a wider awareness of the LADO role and increased availability and ease of access to the post holder to provide such advice.

The current LADO database does not allow for differentiation between LADO referrals and consultations in terms of source (of referral or contact) or the employment 'sector' of individuals referred. Sources are of referral and consultation are varied, and predominantly come from children's social care (164), education (69), fostering services (19) and the police (32). Approximately one third of referrals to and consultations with the LADO, related to education settings (104), with an additional 43 relating to foster carers and 51 to children's social care staff (including residential care staff). 26 allegations (referrals and consultations) related to staff working within the health sector.

Physical (129 cases) and sexual abuse (70 cases) remain the primary categories of harm referred to the LADO. During the year, there was an increase in the number of allegations of emotional harm (67). Neglect remains the least predominant primary category of abuse (18 cases). This category also includes allegations of a failure to safeguard or act.

58 LADO cases were concluded during the period (conclusion means the final decisions rather than the conclusion of any police investigation). 21% of the LADO cases concluded during the year were 'substantiated', 31% 'unsubstantiated', 33% 'unfounded' and 15% 'false'. A total of 10 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. This is a reduction on the 23 people who did so during 2015/16. The data for 2016/17 (of concluded cases) shows a significant decline in the proportion of cases with a substantiated outcome, though it should be noted that, in relation to ongoing cases, charges or criminal trials are pending in seven, there are two ongoing police investigations and four ongoing disciplinary investigations.

Other LADO themes and issues

- The LADO continues to deliver allegations management training. This was reviewed in 2015 and delivered to a total of 53 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.
- The LADO has provided 38 '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).
- The LADO plays a key role in identifying and highlighting cases which may attract local and national media attention, in order that the Board and its partners can proactively plan media responses and wider communication.
- The LADO works closely with the local VCS safeguarding support service (provided by ERVAS) in helping to manage allegations within the sector, including within some faith settings and small organisations that may be without robust management structures.
- There continues to be a relatively high number of cases involving the misuse of computer equipment and information technology, such as the making or sharing of child abuse images. Effective early notification by the police enables early suspension and safeguarding arrangements to be implemented in tandem with arrests and the execution of warrants. These

cases almost invariably result in dismissal, conviction and disqualification or barring from working with children.

- This year saw a significant increase in Freedom of Information (FOI) requests pertaining to the children's workforce, which is probably a reflection of an increased media attention upon historic sexual abuse, particularly in relation to sports organisations. A total of 10 FOI requests were made and responded to in 2016/17.

Areas for development and action in 2017/18 and beyond

- 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, once updated '*Keeping Children safe in education'* guidance is published.
- A review of the intelligence/information-sharing protocol between the LADO and Humberside Police
- Based on the learning from LADO cases this year and the analysis of patterns of referral and consultation, the LADO will:
    - Seek to further develop awareness and understanding of the role within the Humberside Police Protecting Vulnerable People Unit by providing briefings
    - Approach the head teachers' forums in Hull to ensure open dialogue and a shared understanding of roles and responsibilities in relation to allegations and to seek representation at the Designated Officers Forum.
    - Invite a representative of Active Humber to join the Designated Officers Forum to enhance representation of sports providers
    - Undertake a series of targeted briefings to social workers in the city due to the high numbers of referrals from CSC.

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 were 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 conducted 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.

During 2016/17, the Board carried through on its commitment to re-visit the section 11 audit process with all other key safeguarding partners. Relevant providers and commissioners of services were asked to complete and return section 11 self-assessments. This included some key providers not captured in the previous process (for example, Hull Culture and Leisure services (HCAL) and local authority public health (as key commissioners).

Each safeguarding partner was then invited to attend a “challenge panel” meeting with the Independent Chair, Board manager, professional practice officer and Board member, to talk through their self-assessment and the improvement actions identified.

The process was time-consuming but received as valuable. It helped to develop a deeper understanding of safeguarding across organisations and systems, providing a snapshot of safeguarding across the whole system, significant reassurance about the safeguarding systems and processes in place and direction as to what actions might need to be taken to improve in some cases.

This year the Board staff team built some specific additional questions into the process in order to better understand:

- Understanding, and application, of thresholds
- Knowledge and experience of early help
- Referrals, including quality assurance arrangements, and feedback on the outcomes of referrals
- How agencies deal with disagreements and their awareness and use of the Board's escalation policy.

These additional areas were identified in order to test out learning from serious case reviews and also to provide intelligence to help inform the Board's day in November on early help and the 'front door'.

There were improvement actions identified by individual safeguarding partners and the Board will seek progress updates in relation to these during 2017/18. Additionally, there were some recurring themes identified where a broader partnership approach to improvement was identified as helpful:

- Private fostering: Knowledge and understanding remains inconsistent across the partnership about private fostering and responsibilities for identifying and reporting arrangements. Further work on this is being led by the Board's private fostering work stream, which includes a revised approach to private fostering briefings and the production of a 'one-minute' guide.
- Dissemination of learning from local and national serious case reviews: There was evidence of developed practice for disseminating and embedding learning from SCR's in many organisations. In some, this was less well developed. The Board's staff team will work on updating SCR briefings in a way which can be cascaded in organisations.
- Supervision: progress has been made in many organisations in embedding reflective supervision but this is not yet fully developed across the partnership. The Board will produce guidance on good practice principles.
- Voice of the child: the process yielded good evidence of services seeking feedback from children and young people but less evidence of this feedback being collated and used consistently to inform service delivery and development. The Board will consider having this as a theme for a future development day.
- Thresholds of need: it is acknowledged that the existing thresholds of need guidance requires updating to capture and describe the continuum of response to need. Work on this needs to be aligned with the development of the EHASH and early help arrangements.
- Training; some partners described difficulty accessing some of the Board's training in sufficient numbers. The Board staff team will review the allocation process for places, ensure that access arrangements are 'fit for purpose' and explore the possibility of a more 'blended' approach in the future.

Future plans

The Board will ask partners to provide an update on their section 11 action plans during 2017/18.

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 include:

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

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.

At the end of the period, this deficit had still not been satisfactorily resolved. The 'scorecard' had not been agreed and developed and used routinely to understand performance and impact and to agree improvement actions.

The new approach to Board meetings partially compensated for this deficit. For example, a domestic abuse performance scorecard was produced for the domestic abuse "deep dive" in July 2016. This "deep dive" (and the return to the theme in March 2017) was also informed by learning from case audits and local serious case reviews. Similarly, the "deep dive" into early help and the 'front door' (November 2016) was informed by detailed data in relation to the local safeguarding 'system', emerging information relating to early help activity and learning from section 11 audits.

Nevertheless, despite this increase in focused learning activity, the Board will still need to enhance its collective performance management capacity and capability in 2017/18.

The effectiveness of the LSCB & Progress against priorities

The work of the Board during the year continued to focus on core statutory functions and on sustaining the existing strengths identified in the inspection of the LSCB in November/December 2014 which 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 2015/16 annual report identified five new and refreshed priorities for the Board. These priorities were identified and agreed (confirmed) by the Board and are informed by our understanding and analysis of the local safeguarding system and from key learning from serious case reviews. The Board has confirmed the same priorities for 2017/18. The following describes the work to date (up to end March 2017) in relation to each priority:

1. Reduce the harm to children from domestic abuse

The Board conducted a full day "deeper dive" into the impact of domestic abuse on children in July 2016. This included:

- An overview of current domestic abuse levels in the city and of the specialist services available currently
- Consideration of learning from the triennial analysis of serious case reviews and from local SCRs (including Child H)
- An evaluation of the current MARAC arrangements
- The learning from joint evaluation of four domestic abuse cases and direct conversations with the core groups of practitioners involved in these

The Board revisited progress in March 2017 and used learning from the Child J SCR and joint evaluation of a further six cases to inform this.

As a direct result of this work, and development work arising from previous SCRs and from inspection, the following actions have been taken (or identified):

- The establishment of a cross-partnership strategic group to review the local strategy and approach to domestic abuse, with a focus on strengthening early help. The need for a group of this nature came from a collective recognition of the need to develop new approaches to tackling domestic abuse, given high and increasing incidence across the city. This was agreed in March 2017.
- A need to review the partnership training offer in relation to domestic abuse to ensure that it is current, accessible and relevant. The HSCB domestic abuse training programme has already been reviewed and updated by the Board's 'Children Living with Domestic Abuse' work stream.
- An increased use of the DASH (Domestic Abuse, Stalking and Honour Based Violence) assessment tool. By March 2017, family nurse partnership practitioners had all received training and were using the tool. 61 social workers and 28 additional health practitioners have attended DASH training.
- Support for the roll-out of Operation Encompass (police domestic abuse information sharing process with schools) which will 'go live' in 2017/18
- 17 additional schools and 60 early years coordinators have received 'Expect Respect' training so that they can use the resources to educate children about healthy relationships.
- A new three year domestic abuse strategy has been agreed, which includes a clear focus and actions in relation to the impact of domestic abuse on children.
- The establishment of a process for disseminating police domestic abuse incident notifications with health providers, including GPs.

The emerging EHASH model is designed to improve information sharing and collation. The model should ensure that the weaknesses identified in some reviews (here and elsewhere) whereby domestic abuse incidents are dealt with in isolation are addressed, so that any patterns and history are properly taken into account when assessing risk.

2. Reduce the harm to children from neglect

'Neglect' was identified as a Board priority relatively late into the period, primarily from learning arising from the Baby A SCR, and the development work required commenced in January 2017.

The Board was updated on progress in March 2017. By this date there had been significant progress on developing a neglect observational tool and neglect assessment framework. An initial draft strategy had been produced and work had started on developing a work force (training) plan to support the work.

The Board agreed to the joint evaluation of neglect cases prior to devoting the day in July 2017 to a "deeper dive" into neglect, with the understanding that the development work would be sufficiently developed by then for presentation to members.

3. Reduce the harm to children from child sexual exploitation and from going missing

Further progress has been made during the year to strengthen multi-agency working in relation to child sexual exploitation. Insufficient similar progress has been made in relation to children who go missing (see pp 33 - 36).

Whilst CSE and missing remain priorities, the Board has agreed that there needs to be a heightened focus on missing to accelerate progress during 2017/18.

4. Improve engagement with men and fathers

This priority has been identified from learning from a number of local serious reviews and other learning lessons exercises. Local serious case reviews over recent years have been clear in their recommendations that improvements need to be made in the way in which practitioners/agencies/organisations remain curious about, engaged with and assess the role of men and fathers within families, including those who may be violent. This work also recognises the evidence pointing to the crucial role which men can play in healthy child development.

The national analysis of serious case reviews identified professional cultures in some organisations which militated against effective safeguarding.

A multi-agency steering group was convened late in 2015 to consider how the necessary culture change could be achieved.

Members of the steering group attended a 'research in practice' workshop delivered by Professor Gavin Swann. He had completed research and led a project which had supported culture change within children's social care in his own local authority area. The model and approach yielded positive results, including substantial evidence that engaging positively and consistently with men and fathers improves outcomes for children.

During the year, the steering group has:

- Secured strategic leadership for this work (the City Safeguarding Children Manager).
- Consulted widely with practitioners to establish a baseline of local good practice and areas for development.
- Gathered feedback from a small group of men, via the Strength to Change programme, about how well engaged they felt with services providing help and support to their children
- Jointly evaluated five 'open' children's social care cases to assess how well agencies currently engage with men and fathers.

- Invited Professor Swann to host a workshop in Hull in February 2017. He commended the work already undertaken, and the ambitious multi-agency, rather than single agency, approach to the work and recommended the development of a 7-point strategy as a framework for a whole system approach to father inclusion.

This work will be taken forward by the steering group in 2017/18, together with a number of 'small change' ideas which were taken away from the workshop by managers and strategic leads.

5. Support and monitor the development of the EHASH and early help offer

The Board continued to recognise and acknowledge the critical importance of early help and the implementation of the Early Help and Safeguarding Hub to better meeting the needs of children and reducing the high, and unsustainable, demand on acute services.

The Board is not directly responsible for either, but has a clear role in monitoring and overseeing the effectiveness of arrangements. In respect of EHASH it carried out this responsibility via consistent challenge about the pace of progress. EHASH and early help were also the main focus of the development day in November 2016. This focus was successful in:

- Securing a greater shared understanding about EHASH and what it was being designed to achieve
- Securing whole partnership engagement and commitments from various partners to contribute resources
- Securing agreement that all of the EHASH development work needed to be concluded and 'signed off' by 31st March 2017.

EHASH was re-visited at the Board day in March 2017 to ensure that progress was on track and that all necessary commitments had been secured. Members were informed that EHASH would 'go live' in June 2017.

Conclusions and Challenges the LSCB is setting itself for 2017/19

The report describes the work of the Board during 2016/17. It describes an enduringly strong partnership which remains collectively committed to safeguarding children and promoting their welfare.

During the year the partnership strengthened arrangements for developing a better shared understanding of the quality of multi-agency practice and of the improvements needed to achieve better outcomes and address key priority issues.

During the second half of the period (from October 2016 onwards) a new approach to joint evaluation of cases (multi-agency auditing) was developed with a commitment to establish this as a more structured and routine, and less ad-hoc, activity. A thematic approach was taken, aligned to the Board's priorities, learning from local SCRs and Joint Targeted Area Inspection themes. The learning from these audits was fed into the Board's 'deeper dive' days in July & November 2016 and March 2017.

A new approach to full Board meetings was also agreed and implemented during the year. The approach was designed to better engage all Board members in developing a deeper understanding of priority safeguarding issues. We held three, less formal, full Board days (instead of six half-days) and on each occasion had a 'deeper dive' into key themes, informed by: learning from SCRs; learning from joint evaluation of cases; learning from section 11 audits; specific performance and activity data relevant to the 'theme'; and, an opportunity for Board members to engage directly with front-line practitioners and their managers. Board members valued, in particular, this direct engagement with the 'front-line'.

Whilst these focused learning and improvement activities, supplemented by learning from section 11 audits, inspection outcomes, case reviews and other bespoke audit activity helped to develop a better, and more rounded, shared understanding of activity and performance, nevertheless the continued lack of routine data and analysis continues to limit the Board's ability to have fully effective oversight of how the system works to safeguard children. This is a deficit which must be addressed in 2017/18.

Similarly, the work of the Board is not routinely informed by the views and experiences of children and young people. As with performance data, the Board is primarily reliant on combining the 'intelligence' gathered by partner agencies, and so closing this 'gap' will require collective consideration and action.

During the year we made progress on key commitments set out in the conclusion to last year's annual report, including:

- Continued progress in responding to child sexual exploitation
- A different approach to Board meetings, with an explicit focus on 'learning' and improvement
- Oversight of the development of the EHASH – exerting influence to quicken the pace of development and implementation
- Progress in relation to the ways in which services engage with men and fathers
- Progress between Jan-March 2017 on developing a neglect strategy and tools for professionals.

As indicated elsewhere, insufficient progress has been made on strengthening joint agency practice in relation to children who go missing and on developing a consistent and helpful partnership performance framework.

The Board's priorities for the next period were re-visited at the full Board meeting in March 2017. Members agreed that the priorities are to:

- Reduce the harm to children from domestic abuse
- Reduce the harm to children from neglect
- Reduce the harm to children from sexual exploitation and from going missing
- Improve the engagement with men and fathers
- Continue to strengthen the city-wide early help offer

Our analysis of the local 'safeguarding system' provides evidence of enduring, and increasing, high demand for social work services, increasing complexity of need and workloads across the system which are consistently higher than recommended levels. Children also tend to remain 'in need' of social work intervention for longer than average.

One respondent to the ADCS survey (*'Safeguarding Pressures Phase 5', December 2016)* 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.

All of which reinforces the imperative of continuing to strengthen and develop effective, whole partnership, early help services, capable of better meeting the needs of children and families before those needs become acute, and of managing the demand on specialist/acute services in the context of increased pressure and reduced resources.

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 Board will need to continue to focus on improving the way in which it delivers its full range of statutory functions, whilst ensuring progress in respect of its priorities. At the same time, the Board is well placed to provide advice and support to the three accountable statutory partners (the local authority, CCG and police) as they go about designing and agreeing a replacement set of ‘multi-agency safeguarding arrangements’ from April 2019 onwards.