HULL
SAFEGUARDING
CHILDREN
BOARD
2017/18
ANNUAL
REPORT
FOREWORD

Welcome to the Hull Safeguarding Children’s Board annual report 2017/18. The report provides an analysis of the work conducted by agencies to demonstrate the effectiveness of the child safeguarding system in Hull, how the partnership is working together to promote the welfare of our children and captures the learning and improvement activity undertaken by the Board itself.

The analysis of the children’s safeguarding system demonstrates continuing high demand upon the “front door” (EHASH) of children’s social care demonstrated by a significant increase in the number of contacts and referrals being made. However, the analysis demonstrates a high proportion of these following assessment identify the child not to be in need. The consequence being social work time and expertise is spent reviewing cases which require in most occasions an “early help” form of intervention. The board, where the partnership comes together, will continue to track this concern and apply influence where necessary to assist with improving this current position.

Our strength in partnership as a board continues to be an asset with appropriate representation and good attendance at board and subcommittee meetings.

During the year we sought out opportunities to work collaboratively with the Hull Safeguarding Adults Partnership Board and Community Safety Partnership to address the challenges faced regarding the impact of domestic abuse upon the community, including children and families. This saw us involved in the consultation and development of the new Hull Domestic Abuse strategy, together with holding a joint conference with these partners, in sharing learning from recent Serious Case Reviews, where Domestic Abuse as an issue of concern strongly featured.

The report evidences significant progress and improvement activity with regards to all the boards identified priorities, where the development of new strategies and toolkits for example in relation to “Neglect” I am confident will pay dividends in helping improve how we keep children and families safe in our City.

It will be a priority, in the future, that the newly formed local Multi Agency Safeguarding Partnership (when established following the introduction of the Children and Social Work Act 2017 that removes the statutory requirement to have a Local Safeguarding Children’s Board), maintains the progress and level of work that is currently undertaken by the Board.

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
Hull Independent Safeguarding Children’s Board Chair.
CONTENTS

About the Annual Report 1
The City of Hull 3
City Safeguarding Snapshot 2017/18 4
Safeguarding context 5
Contacts, Referrals & Assessments 5
Child Protection Activity 9
Children in Need 11
Children Looked After 12
Domestic Abuse 13
Child Sexual Exploitation 13
Missing Children 14
Elective Home Education 14
Private Fostering 14
Youth Offending 14
Children’s Mental Health 15
MAPPA 15
Progress in Hull 17
Neglect 18
Domestic Abuse 20
Child sexual exploitation and missing 21

Engaging men and fathers 23
EHASH & the Early Help Offer 25
Private fostering 27
Online safety 28
Female Genital Mutilation 28
Children with disabilities and complex health needs 29
The Management of Allegations against Staff and Volunteers Working with Children 30

Learning & Improvement 32
The child’s voice 33
The voice of parents 34
The community voice – VCS sector 35
Reviews of practice 35
Disseminating & embedding learning from SCRs 37
Multi-agency case auditing 38
Single agency case audits & other learning 44
Performance data 44

The Child Death Overview Panel 46

Training & Development 50

Business Plan 2018/19 58

Appendix A 60
Pages 5 to 18 describe the context for safeguarding children and young people in Hull, highlighting some of the particular challenges which need to be addressed across the partnership to secure further improvement in outcomes for children and young people.

Pages 19 to 33 describe the progress made by the partnership during the year in relation to the priorities which had been locally agreed.

Pages 34 to 51 describe the learning which the Board has identified through specific case reviews and multi-agency practice auditing and what has been done to disseminate and embed that learning, including within this section the work of the child death overview panel and of the local authority designated officer (LADO).

Pages 52 to 59 describe the range and quality of the multi-agency safeguarding training delivered by the partnership.

Pages 60 to 61 set out the priorities for the next period.

Appendix 1 sets out the governance and accountability arrangements for the HSCB and provides information about the structures in place which support the Board to do its work.

In line with statutory requirements and best practice, the HSCB annual report has been sent to and discussed with the following:

- The Leader of Hull City Council
- The Chief Executive of Hull City Council
- The Chair of the Health and wellbeing Board
- The Lead Member for Children’s Services
- The Chair of the Early Support and Lifelong Learning Overview & Scrutiny Commission
- The Humberside Police and Crime Commissioner
THE CITY OF HULL
Approximately 56,600 children and young people under 18

- 0-19 year olds make up 24.2% of the total population
- 27.6% of children (under the age of 16) living in poverty
- 22.1% of primary school pupils and 21.6% of secondary school pupils with free school meal entitlement (compared to 13.7% and 12.4% nationally)
- 84% education settings graded good or outstanding, with 17% requiring improvement and 0% inadequate for overall effectiveness
- 16.2% primary school pupils whose first language is other than English
- 1747 referrals to local authority early help services during the year
- 45 children and young people at risk of CSE being monitored through the Multi-Agency Child Exploitation meetings (during the year)
- 395 children missing from home, 987 episodes of children going missing from home
- 67 children missing from care, 777 episodes of children going missing from care
- 14836 contacts to Hull children’s social care – EHASH

5205 referrals to children’s social care
19% re-referrals to children’s social care
57 days average timeliness of assessments
54.8% assessments judged the child not be in need
2566 child protection investigations
521 initial child protection conferences
20.3% child protection investigations led to an ICPC
432 children on a child protection plan
3987 open children in need cases (at 31/03/2018) (incl. CP Plan & LAC)
523 children in need with a disability
763 children looked after (at 31/03/18)
904 ‘high risk’ domestic abuse cases discussed at MARAC meetings during the year
544 children involved in domestic abuse cases supported by the Hull Domestic Abuse Partnership at 31st March 2018
73 allegations against people working with children and a further 331 contacts with the Local Authority Designated Officer
Hull Basic Demographics

According to the most recent Child Health Profile (Child Health Profile, June 2018, Public Health England) there are 62,900 0-19 year olds living in Hull. Of these, 17,900 are aged less than five years old.

The diversity of Hull’s population has changed significantly over the last decade but remains predominantly white British. At the time of the last census (2011), 89.7% of Hull residents were white British. The most recent data (Child Health Profile, 2018) shows that this demographic change has continued, with 18.4% of school children being from minority ethnic groups.

Hull is ranked as the third most deprived local authority area out of 326. It is estimated that 27.6% of children under the age of 16 are living in poverty, compared to 19.0% regionally and 16.8% nationally (Child Health Profile, 2018).

CONTACTS, REFERRALS & ASSESSMENTS

“Contacts and referrals are progressed in a timely manner. In all cases seen, relevant information, including historical information, was gathered and considered and the decision to progress was appropriate, with clear management oversight.” Ofsted 2018

The Early Help and Safeguarding Hub (EHASH) receives all “contacts” about concerns for the safety or welfare of children and young people in Hull. Any of these contacts can progress to a referral and, if appropriate, an assessment, if the concerns are such as to meet the threshold for the statutory involvement of children’s social care (CSC). If the threshold is not met, then the EHASH ensures that, where necessary, children and families receive early help support. Ofsted found that the co-location of early help within the EHASH “supports the timely progression of work to those services”.

In 2017/18, EHASH received 14,836 contacts from a range of sources, of which 5,205 (35%) progressed to a referral to children’s social care. This represented a 27.7% increase in the volume of contacts and a 10.2% increase in the number of referrals compared to 2016/17.

The rate of referral per 10,000 0-17 population increased in Hull from 842.4 in 2016/17 to 927.8 in 2017/18. This rate is considerably higher than the statistical neighbour (754.2) and England (548.2) rates for 2016/17. The volume of both contacts and referrals have increased significantly over the last five years.
The EHASH went ‘live’ in Hull in June 2017. As part of the system design, referrals which previously were made directly to locality based and citywide local authority early help services were now made via the ‘single front door’ (EHASH) and recorded as “contacts”. This provides some context for the 27.7% increase in contacts, but not for the increase in referrals.

Re-referrals within 12 months of a previous referral

The percentage of re-referrals increased slightly during the year from 19.2% in 2016/17 to 21% in 2017/18. Local re-referral rates have been historically slightly better (lower) than statistical neighbour and England averages. Re-referral rates are generally seen as a ‘proxy’ indicator for the effectiveness of social work support. Comparator data is not yet available for 2017/18.
Children’s Social Care Assessments

Once a contact has been made with EHASH, social workers and their managers decide whether the child’s circumstances meet the threshold for statutory assessment. These contacts are progressed as referrals. Social workers undertake assessments to determine what services (if any) to provide and what action to take.

5,144 CSC assessments were completed in 2017/18 – a 31.9% increase from 2016/17. The local rate of assessment per 10,000 population in 2016/17 was 695.2 which was lower than the statistical neighbour rate (728.8). The figure for completed assessments includes updated assessments on already ‘open’ cases, but nevertheless the increase mirrors the increase in referrals and reflects growing pressure at the front door of children’s social care.

Assessment Timeliness and Quality

The maximum timeframe for social work assessments to conclude should be no longer than 45 working days from the point of referral (Working Together 2015). The timeliness of assessment completion has been has been significantly lower in Hull than elsewhere for a number of years. The proportion completed within 45 days had improved to 61.9% in 2016/17 but this still compared unfavourably to statistical neighbour average rates of 83.3%.

The reported outturn figure for 2017/18 shows slight further improvement in performance to 62.8%. However, this final annual figure masks an underlying recent more significant trend of improvement and is distorted by a focused effort to finalise ‘overdue’ assessments during the last quarter of the period. Ofsted found that “there is inconsistent practice in the quality and timeliness of assessments. Too many assessments are not completed in a timely way, although available performance information does indicate that this is improving.” Of the cases sampled by Ofsted that were out of the 45-day timescale, “children were not seen to be in situations of unacceptable risk”.

Whilst Ofsted found inconsistent practice in the quality of assessments the inspectors also saw examples of “good, thorough assessments, encapsulating effectively the voice and experiences of the child, and appropriately balancing and analysing risk and protective factors to underpin decision-making and future planning.”

The local authority launched a significant new audit programme in January 2018 with 50 or more ‘open’ cases audited each month. The findings of these audits mirror the Ofsted findings, with most assessments completed requiring some improvement.

Assessment Outcomes

During the year 98.8% of referrals led to a CSC assessment. However in 54.8% of those referrals which led to an assessment, the child was assessed not to be in need. In other words there was no assessed role for CSC at the conclusion of the assessment.
Analysis of Contacts, Referrals and Assessments

- The high volume of contacts to EHASH needs to be addressed. The current arrangements mean that social work time and expertise is spent making decisions on cases which are clearly ‘early help’ cases.

- In addition, Ofsted found that “referrals from partner agencies do not consistently deliver clear information and succinct direction on what services or intervention are being requested.” This results in front-door (social work) staff having to spend unnecessary time on gaining clarification before contacts can be progressed.

- The data and findings suggest that more work is needed to improve partner understanding and consistent application of thresholds and to improve the quality of contacts to EHASH.

- The sharp increase in the volume of contacts also indicates a need to re-visit the current front-door system design so that, where it is clear that the needs of children and families can be met by early help services, these can be directly accessed rather than via contact with EHASH.

- Given the high proportion of assessments completed which conclude that there is no ongoing role for CSC, more work is needed to better understand the application of thresholds within EHASH.

- Given the significant increase in activity at the ‘front-door’ it is not surprising that Ofsted found that the “capacity of consultant social workers and their teams to work effectively is compromised by high workloads”. By 31st March 2018, the local authority had taken steps to address this issue, by increasing social work and management capacity.

- The overall improvements needed will require a whole partnership approach with a focus on limiting contacts to EHASH to those children and families who may need a targeted early help or specialist (safeguarding) response and ensuring high quality contact/referrals which facilitate threshold decision-making.

Improvement Activity 2018/19

- The Board has launched revised ‘Thresholds’ guidance supported by a significant programme of briefings and training.

- The EHASH Management Board has launched a regular programme of audits of contact/referral quality – the learning and actions from which will be fed back into the Board

- The ‘front door’ system has been re-designed so that clear referrals for early help services are no longer made via EHASH.

- The Board will monitor impact via its safeguarding performance report.
CHILD PROTECTION ACTIVITY

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving children’s social care, the police, health and other bodies (such as the referring agency). Ofsted found that “immediate risk of harm to children is promptly identified and responded to” with strategy meetings involving CSC, police and health held in a timely way ensuring that information was shared and children seen promptly.

One of the potential outcomes of a strategy discussion is a decision to undertake child protection enquiries under s 47 of the Children Act 1989 (known as s47 enquiries). There were 2605 strategy discussions in the year, 73.1% of which led to a s47 enquiry. The number of s47 enquiries undertaken during the year increased by 27.2% to 2225.

However, only a comparatively small proportion (20.3%) of these s47 enquiries led to an initial child protection conference (compared to ‘conversion rates’ elsewhere which more typically exceed 40%). This is an issue which has been highlighted at the Board and also raised in the Ofsted focused visit. Whilst Ofsted found that “overall decision-making on cases seen was appropriate” they also recommended this as an area of practice that senior managers should keep under review “given the high percentage of s47 enquiries which do not progress to initial child protection conference”.

Changes are to be made to the Liquid Logic system and practice guidance to address this issue.

Children on Child Protection Plans

Where, following a child protection enquiry, concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm, social workers and their managers should convene an initial child protection conference (ICPC). An ICPC brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child’s future safety, health and development. If the ICPC considers that the child is at continuing risk of significant harm, they will be made subject to a child protection plan (CPP). 87.1% of ICPCs during the year resulted in the child being made subject to a CPC.

521 ICPCs were held during the year (compared to 551 in 2016/17). The 2016/17 local rate of ICPCs was in line with statistical neighbour rates, but has doubled from a very low ‘base’ since 2013/14.

The ICPC should take place within 15 working days of the strategy discussion at which s47 enquiries were initiated. Local reported performance on timeliness deteriorated significantly during the year with only 50.9% of ICPCs recorded as taking place within 15 working days. Whilst by the end of July 2018 performance had improved to 74.2%, further detailed analysis is required to understand the various
causes of these delays so that additional targeted action can be taken to improve performance.

Since 2012/13 there has been a significant increase in the number of children subject to CPPs in Hull. Historically, compared to other indicators (volume of referrals, assessments and s47 enquiries) Hull had a disproportionately ‘low’ number of children subject to CPPs but by 2016/17 the local rate was similar to statistical neighbour rates. The number of children subject to CPPs increased by 20 during the year, to 432 by the 31st March 2018.

Children Subject to a Child Protection Plan (31st March)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>330</td>
</tr>
<tr>
<td>2013/14</td>
<td>248</td>
</tr>
<tr>
<td>2014/15</td>
<td>335</td>
</tr>
<tr>
<td>2015/16</td>
<td>374</td>
</tr>
<tr>
<td>2016/17</td>
<td>412</td>
</tr>
<tr>
<td>2017/18</td>
<td>432</td>
</tr>
</tbody>
</table>

Duration and Repeat Child Protection Plans

Two sets of data are used as ‘proxy’ indicators to assess the effectiveness of child protection work. The first of these is the length of time during which children remain subject of child protection plans. Lengthy periods of time subject to CPPs suggest slow progress in improving safety for children. Data for 2017/18 shows that 4.5% of CPPs which ended during the year had lasted for 2 or more years.

The second indicator is the proportion of children made subject to CPPs who have previously been subject to a CPP. Whilst children’s circumstances can change, in general we would expect that a period of time subject to a CPP would secure long-term safety for children. Over the previous five years, the percentage of children subject to “repeat” CPPs in Hull fluctuated between 6.5% and 15.0%. This was generally “better” than performance elsewhere. Data for 2017/18 suggests that this proportion has increased slightly to 16.9%.

Categories of Abuse

The Board considered the local pattern of categories of abuse for children subject to CPPs at its ‘neglect deeper-dive’ day in July 2017. The local pattern differed markedly compared to patterns elsewhere: 22.8% of CPPs in Hull under the category of ‘neglect’ (in 2016/17) compared to 53.1% (statistical neighbours) and 47.7% (England).

Given Hull’s high levels of deprivation this pattern raised questions as to how well ‘neglect’ was being identified locally and whether a cultural reluctance to use the term may have developed.

As part of the Board’s development work on ‘neglect’ during the year (see pages 20 - 22), focused work was undertaken with conference chairs to ensure more consistent and appropriate use of categories. The early indications are that this work, together with the wider work to improve awareness and identification of neglect, has had a positive
impact: 37.9% of new plans during the year and 39.5% of ‘latest’ plans were under the category of neglect.

Analysis of Child Protection Activity

- Joint CSC and Humberside Police management action is needed to address any system and decision-making weaknesses in s47 processes which may contribute to the high volume and low conversion rate to ICPC
- Action is needed to fully understand and address the causes of poor performance on timeliness of initial child protection conferences
- Audit activity during the year should include a focus on children who have been made subject to CPP for a second or subsequent time to understand and address any practice issues which may have contributed to the high rate.
- The Board will continue to monitor categories of abuse as one indicator of the work undertaken to improve practice on neglect.

Improvement Activity 2018/19

- An initial audit of s 47 decision-making and processes has been undertaken. Early data suggests that the volume of s47 enquiries is starting to fall and the proportion proceeding to ICPC starting to rise.
- Ongoing audit of s 47 with a focus on enquiries commenced in respect of already open cases.
- Action has been taken to identify the causes of ‘late’ ICPCs. This has led to improved timeliness (70.1%) for the most recent three-month period.
- Further progress in relation to these issues will be monitored via the Board’s performance report.

CHILDREN IN NEED

At 31st March 2018, there were a total of 3987 ‘children in need’ in Hull (including children subject to CPP and children looked after). These are children receiving multi-agency help and support, described in a child’s plan and with a social worker acting as the lead professional.

This is a further significant increase in the number of children in need during the year from 3507 in 2016/17. It shows an increase in the CIN rate from 625.3 (rate per 10,000 0-17 population) to 710.7. The 2016/17 local rate of 625.3 was already significantly higher than the statistical neighbour average rate of 525.97.

523 (13.1%) of the 3987 children in need as at 31st March 2018 are recorded as having a disability. Children in need with a disability are supported by social workers in the Children and Families Disability Teams.

Previous reports and external inspection have indicated that some children are remaining ‘in need’ for too long and in circumstances where their needs could be met by targeted ‘early help’ multi-agency help and support not requiring social work input.
‘Children in Need’ panels have been meeting regularly in each locality since the turn of the year to identify those children and families who can be appropriately ‘stepped down’ to targeted help. This work has been supported by clear guidance on ‘stepping down’ drawn up as part of the Board-led work on thresholds (see pages 27 & 28).

This work is starting to have a real impact and the outcome should be that social work caseloads are reduced, allowing more social work time and expertise to be devoted to those children and families who are most vulnerable and most in need. By early July 2018, there were 3378 children with an open episode of need.

Analysis of Children in Need

- The Board will continue to monitor the number of open CIN cases, support the work being undertaken to further develop a stronger targeted early help offer and that being developed to track outcomes for these children.

CHILDREN LOOKED AFTER

A child who is ‘looked after’ is in the care of the local authority. They may be placed in local authority care by parents who are struggling to cope or they may be unaccompanied asylum seekers. The vast majority are children who are looked after following statutory intervention because the child is suffering, or at risk of suffering, significant harm.

The number of children looked after in Hull continued to increase significantly during 2017/18 to 763 on 31st March 2018 from 695 a year earlier (an increase of 9.8%). After four years of relative stability, the last two years have seen significant increases in the number of children looked after. At 124 (CLA rate per 10,000 population) the local rate was already higher than the statistical neighbour average. The most recent available data shows that the number of CLA has now reduced to 740.

As at 31st March 2018, 78.9% of children looked after were subject of full (62.9%), or interim (16.0%), care orders. A placement (for adoption) order was in place for 6.4% of CLA. A further 14.4% were accommodated under s20 Children Act 1989 (i.e. with the voluntary agreement of their parent(s)). The proportion of children accommodated under s20 has reduced significantly in recent years due to the impact of case law.

54.7% of CLA were male. The age analysis of the CLA population indicates that numbers are growing in the 11-16 age groups.
CLA rate per 10,000 children

<table>
<thead>
<tr>
<th>Year</th>
<th>Hull</th>
<th>Statistical Neighbours</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>116</td>
<td>98</td>
</tr>
<tr>
<td>2013/2014</td>
<td>116</td>
<td>101</td>
</tr>
<tr>
<td>2014/2015</td>
<td>112</td>
<td>102</td>
</tr>
<tr>
<td>2015/2016</td>
<td>115</td>
<td>106</td>
</tr>
<tr>
<td>2016/2017</td>
<td>124</td>
<td>110</td>
</tr>
<tr>
<td>2017/2018</td>
<td>136</td>
<td>110</td>
</tr>
</tbody>
</table>

Placement and Location

A high proportion of Hull’s CLA (76%) are looked after by foster carers, with 73% cared for by in-house provision. The proportion of CLA placed in private provision (16.6%) increased slightly during the year.

Although 33% of Hull CLA are living outside of the Hull boundaries, 83% are living within 20 miles of the city which is “good” performance. This reflects the fact that Hull has recruited and supports a significant number of foster households in the East Riding of Yorkshire.

DOMESTIC ABUSE

Taking action to reduce the impact on children of domestic abuse is a key priority for HSCB. This reflects recognition of the scale of the problem in Hull and the impact which living with domestic abuse has on children.

- Humberside Police responded to 9,701 reported domestic abuse incidents during the year (up 7.9% on 2016/17)
- At the end of March 2018, the Hull Domestic Abuse Partnership was supporting 366 victims of domestic abuse
- 544 children were involved with the 366 victims being supported.
- 906 cases of ‘high risk’ domestic abuse were considered at the Multi-Agency Risk Assessment Conference (MARAC) meetings during the year
- 330 (38%) of these cases were repeat referrals
- 1024 children were involved in the MARAC cases discussed

CHILDREN AT RISK OF SEXUAL EXPLOITATION

Ensuring that child sexual exploitation is tackled is a priority for the HSCB. The multi-agency element is coordinated by the HSCB Professional Practice Group, overseen by a CSE Strategic Group.

Further detail about progress is described later in the report. During 2017/18 45 children and young people identified as being at highest risk of CSE were monitored through the Multi-Agency Child Exploitation (MACE) meetings.
CHILDREN MISSING FROM HOME, CARE & EDUCATION

Alongside CSE, children who go missing are a priority for the HSCB. Progress in relation to this priority is described later in the report.

- 395 children were reported missing from home during the year
- 987 episodes of children going missing from home
- 67 CLA went missing from care
- 777 episodes of children going missing from care

ELECTIVE HOME EDUCATION

Similarly to elsewhere in the country, the number of children who are electively home educated has increased significantly in recent years. The number of new registrations during 2017/18 was 241, compared to 121 in 2015/16. As at 31st March 2018 the number of children on the local authority maintained EHE register was 325.

This cohort of children will include many who are receiving a suitable education at home. However, the significant increase suggests that amongst this cohort are some of the city’s more vulnerable children who may also be the least ‘visible’ to local services.

PRIVATE FOSTERING

A child under the age of 16 (or under 18 if disabled) who is cared for by someone other than a parent, person with parental responsibility or a close relative for a period of 28 days or more is privately fostered.

During 2017/18, 19 children were identified as living in a private fostering arrangement.

Private fostering has been the focus of specific attention during the year and progress is described in the next section of the report.

YOUTH OFFENDING

The young people supported by the Hull Youth Justice Service often have complex needs requiring significant support both in and out of custody.

- In the calendar year 2017 there were 121 first time entrants to the youth justice system compared to 103 the previous year
- The service worked with 155 children and young people on ‘out-of-court’ disposals and 164 on community order during 2017/18, compared to 172 and 166 respectively the previous year.
- The most recent data shows a reduction in both the overall re-offending rate and the number of further offences committed compared to the previous year.
CHILDREN’S MENTAL HEALTH

The Child and Adolescent Mental Health Services (CAMHS) in Hull are provided by the Humber NHS Foundation Trust.

During 2017/18 there were 3705 referrals to CAMHS, of which 1632 were accepted as appropriate by the service. This was a significant increase on the 1957 referrals received in 2016/17 (of which 1566 were accepted). The data is not directly comparable between the periods – data for 2017/18 includes referrals for crisis, eating disorders, children’s learning disability and autism from September onwards.

Data for March 2018, shows that 85.7% of children overall had their needs assessed within the 18 week target from referral, with 50.5% responded to within 6 weeks. For the same month, crisis response was good with all but one child requiring emergency treatment receiving this within 4 hours and all children needing urgent treatment receiving this within four weeks.

There has been considerable local investment in ‘Headstart’ and the development of a more complete ‘end to end’ response to children and young people’s emotional well-being. Further work is needed to build a more complete picture of service and impact.

CHILDREN & YOUNG PEOPLE AT RISK OF RADICALISATION

In Hull a multi-agency Channel referral process and panel is in place which works at the pre-criminal stage to support vulnerable individuals where a risk of radicalisation is assessed and a plan of action devised. The panel in Hull is chaired by the local authority youth justice lead who is also an HSCB member.

Two young people were referred to the Channel panel in the last six months of the reporting period.

MAPPA

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders (MAPPA-eligible offenders) under the provisions of sections 325 to 327B of the Criminal Justice Act 2003.

They bring together the Police, Probation and Prison services in each of the Divisions in England and Wales into what is known as the MAPPA Responsible Authority.

A number of other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Children’s Social Care, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities.
Within Hull, MAPPA arrangements are managed to a rigorous standard which are fully audited throughout the year to ensure high quality arrangements are in place.

During 2017 / 18, there have been no MAPPA Serious Case Reviews required.

In Hull, as at 31st July 2018, there were 252 Category 1 ‘Registered Sex Offenders’ (jointly managed by Police and Probation), 427 Category 2 ‘Violent Offenders’ and 3 ‘Other Dangerous Offenders’. Humberside Police were managing an additional 372 registered sex offenders on a single agency basis. Further information will be available in the MAPPA Annual Report.

**ALCOHOL AND SUBSTANCE MISUSE**

The ‘Refresh’ service in Hull provides specialist treatment and interventions for children and young people whose alcohol or substance use is a cause for concern. 473 children and young people received brief interventions, a further 146 were provided with extended support and 99 entered treatment during the year.
PROGRESS IN HULL
The Board identified five priorities for 2017/18. This section of this chapter briefly describes the progress made during the year in relation to each of these priorities.

**Priority 1: Reduce the harm to children from neglect**

Why was ‘neglect’ a priority for the Board in 2017/18?

Neglect was identified as a priority for the Board due to learning from a local serious case review which was finished late in 2016. ‘Neglect’ was a feature in this case. The review highlighted a need to raise awareness and understanding of neglect and the impact on children and to provide professionals across the system with evidence-based tools to support identification, assessment and planning.

What has been achieved during the year?

The work on ‘neglect’ commenced in January 2017 and was driven by an HSCB multi-agency working group.

In July 2017, the Board devoted its full-day development meeting to a ‘deeper dive’ into neglect. Members:

- Considered the draft ‘Neglect Strategy’ which had been developed
- Heard directly from professionals who had been involved in the development of local neglect tools and who had tested them in practice.

- Undertook some neglect case auditing in order to hear directly from practitioners about some of the challenges involved in working with neglect.

The Board also chose ‘neglect’ as a theme for two separate rounds of multi-agency case auditing (in June & July 2017 and October-December 2017). This was to identify additional strengths and areas for development when working with neglect (see page 42).

The working group finalised the ‘neglect toolkit’ in September 2017, making small improvements based on feedback from ‘testing’. A ‘Neglect Observation Tool’ and ‘Neglect Assessment Framework’ were launched simultaneously along with simple guidance. The observation tool is designed to help practitioners across the spectrum to identify neglect and record their observations. The assessment framework is designed to help inform assessments in neglect cases and can be used as a supervision and reflective discussion tool.

Briefings on both tools were held separately in October and November 2017. The briefings were designed so that they can be ‘cascaded’ by safeguarding leads and managers in the workplace. By the end of March 2018 over 600 practitioners had had neglect observation tool briefings.

A separate small working group focused on the development of revised HSCB neglect awareness training. A new course was developed and piloted in January 2018. The course has been further refined, based on feedback, and is now offered as part of the Board’s training diary for 2018/19.
The Board’s ‘Neglect Strategy’ and ‘Neglect Toolkit’ were formally launched in April 2018, at a launch day attended by 100 practitioners and managers across the partnership. Six 10-minute workshops were led by practitioners and managers who had played a key role in developing and implementing the tools or attending the training. Practitioners at the event were able to hear at first-hand how:

- The observation tool has been used in a primary school to identify and pull together concerns about neglect, leading to a high-quality contact/referral to EHASH
- The assessment framework was used within CSC to help prepare a report for court in a neglect case
- The assessment framework has been cascaded to staff in one of the early help localities
- The observation tool was developed and tested

Our focus for the year ahead (see below) will be on evaluating the impact of the work described above and the usefulness of the tools. By the end of the period some feedback had already been captured:

**The ‘Neglect Observation Tool’**

“We recently had a neglect concern with a pupil in school. The EWO - Education Welfare Officer consulted the Neglect Observational Tool and from her findings discussed her concerns with myself (Child Protection Officer). We both felt the child was at risk of neglect and submitted a referral to EHASH. The child is now the subject of a Child Protection Plan – under the category of Neglect” – feedback from a Secondary School Child Protection Coordinator

“The tool was discussed and explained during a team meeting where all participants found it clear and easy to understand. The team felt they would be better informed to assess a potential ‘neglect situation’ now than they would have been prior to receiving the training” – feedback from Haven Project

“It’s often difficult to understand how to identify a neglect situation. However, this simplifies the process enabling someone who is not an expert to use a simple yet structured approach” – feedback from Citizens Advice

**The ‘Neglect Assessment Framework Tool’**

Early feedback from managers in CSC:

“We can use this tool in supervision to aid Social work assessments. It provides challenge and is evidence-based”

“Enables you to avoid drift”

“Has given direction to newly qualified social workers”

“Provides a good framework for writing court reports”

**Further work on ‘Neglect’ in 2018/19**

The work on ‘Neglect’ as a priority agreed for 2017/18 has been successfully completed, such that it no longer requires a priority focus in 2018/19.
Ongoing work during the year will focus on evaluating the usage and usefulness of the tools and the impact of the training. A further audit of neglect cases (Jan-March 2019) will seek evidence of improved multi-agency practice and outcomes for children.

**PRIORITY 2 REDUCE THE HARM TO CHILDREN FROM DOMESTIC ABUSE**

**Why was domestic abuse a priority for the Board in 2017/18?**

Domestic abuse has been a factor in a number of local (published and yet to be published) serious case reviews. Each of these reviews identified learning and action needed to improve responses to domestic abuse and the assessment and management of risk. Domestic abuse is also a factor present in over 50% of cases where children’s social care involvement is needed. The number of reported incidents continues to rise in Hull.

**What has been achieved during the year?**

The Board undertook a ‘deeper dive’ into domestic abuse in July 2016, including devoting time to considering the learning (local and national) from serious case reviews. Progress was reviewed at the Board meeting in March 2017.

Members agreed that there needed to be a stronger and better joined up strategic focus on domestic abuse which pulled together the separate work of the community safety partnership, Hull Safeguarding Adults Partnership Board, HSCB and health and well-being board. A cross-partnership Domestic Abuse Steering Group was agreed to lead on this work. This group has been convened and met regularly during 2017/18.

The strategic group has also considered the combined learning from the Joint Targeted Area Inspection ‘impact of domestic abuse’ thematic.

Progress during the year has included:

- ‘Sign off’ of the revised domestic abuse strategy for the city and completion of three-year action plan.
- The production of a set of domestic abuse standards for agencies to adopt and follow.
- DASH (domestic abuse, stalking and harassment) risk assessment training provided to health visitors, social workers and other professional groups. The use of DASH as an assessment tool has been written into social work practice standards.
- A review of the Board’s domestic abuse training offer and revised content with a stronger focus on coercion and control.
- Agreement secured with Hull City Council Housing Services and Hull’s Registered Social Landlords that they will adopt and promote ‘routine enquiry’ practices in their agencies.
- Launch of ‘Operation Encompass’ ensuring that schools receive instant alerts when the police have responded to domestic abuse incidents which involve children in their school.
- An intervention programme for 16/17-year-old perpetrators of domestic abuse is fully operational and involves joint working between targeted youth services, the youth justice service, women’s aid and Hessle Road Network.
- ‘White Ribbon Ambassadors’ helped to deliver a series of ‘These hands are not for hurting’ workshops to 19 primary schools in
November/December 2017. This builds on the ‘expect respect’ toolkit work already in place
- Review of current local perpetrator interventions (voluntary and compulsory) led by the ‘Engaging Men & Fathers’ group.

Domestic abuse was the chosen theme for the Board’s multi-agency audit programme between January and March 2018. Learning about practice from these audits was summarised and widely circulated (see page 43).

A joint HSCB and Hull Safeguarding Adults Partnership conference on ‘domestic abuse’ was successfully held in October 2017 (see page 58).

**‘Domestic Abuse’ priorities for 2018/19**

Despite the activity described, insufficient is currently understood about impact. Prevalence rates remain high and increasing with a significant impact on children living in households with domestic abuse. The Board has therefore agreed that there needs to be a continuing priority focus on domestic abuse.

The priorities include:

- Review of the local domestic abuse training offer
- Continued promotion of the use of DASH and routine enquiry to help identify domestic abuse and assess risk
- Recruitment of DAP (domestic abuse specialist) worker to the EHASH
- Continued effort to improve the consistent quality of initial (police) response and risk assessment of domestic abuse
- Multi-agency auditing of the quality of DASH referrals to EHASH – and work to ensure these are directed appropriately according to level of risk.
- Continued focus on developing skill sets and confidence in early help services to support the earlier identification of domestic abuse and provision of intervention.
- Work with the ‘Place Board’ to secure ‘added value’ from the identification of domestic abuse as a priority for the city.
- Training for social workers and others on assessing risk in domestic abuse. This training has been commissioned by Humberside Police.
- A focus on developing the range of perpetrator programmes available locally and better understanding impact.
- Work with Humberside Police to expand ‘Operation Encompass’ to early years settings
- A focus on developing meaningful ways of analysing the impact of the activity.

**PRIORITY 3 REDUCE THE HARM TO CHILDREN FROM SEXUAL EXPLOITATION AND FROM GOING MISSING**

**Why was this a priority for the Board in 2017/18?**

Local multi-agency responses to CSE have developed considerably since weaknesses were highlighted in the integrated inspection pilot late in 2014. The Board has however agreed that a continued priority focus is needed to make continued progress. Responses to children who go missing have not made the same progress over the period and a sharper focus on improvement here was agreed as an ongoing priority.
What has been achieved during the year?

Strategic planning in relation to CSE and missing continues to be overseen by a strategic board of lead officers from the city council and partner organisations.

Regular Multi-Agency Child Exploitation meetings led by the police and children’s social care continue to be well attended. These are now an established part of the multi-agency assessment of risk and response to CSE. Quarterly reporting (produced by the CSC CSE ‘pod’) provides some analysis of numbers, trends and ‘hotspots’.

A CSE ‘Risk Identification Tool’ is routinely used to inform assessments of risk of CSE. These are currently completed by social workers and routinely quality assured by the CSE pod Team Manager. The processes in place ensure that all children identified as ‘at risk’ of CSE are managed and supported through established safeguarding (child protection, child in need and CLA) arrangements.

Progress, albeit slower than desired, has also been made during the year towards mandating safeguarding/CSE training of taxi drivers as a local condition of licence. Some progress has also been made in training hotel staff in ‘say something if you see something’.

The local partnership has continued to support the ‘Not In Our Community’ project run by Eskimo Soup. This is a multi-media young people’s platform which engages extensively with local children as an interactive source of contemporary information about CSE.

There has been focused activity during the second half of the year to improve multi-agency practice in relation to children who go missing. The existing local arrangements for return interviews following a ‘missing’ episode were not independent, nor sufficiently consistent or effective.

The improvement action taken to address these weaknesses has included:

- The establishment of a ‘Missing Coordinator’ role based in EHASH to coordinate the local authority response to children who go missing
- 19 youth workers have been trained by HSCB to undertake independent return interviews and this new service has commenced.
- Weekly missing meetings are chaired by a CSC assistant city manager to ensure management oversight of practice
- Monthly multi-agency missing meetings have been re-established

Return interview performance improved during the final quarter of 2017/18 with 40% of missing children receiving a return interview. Intelligence gathered from return interviews has also started to be fed back into police systems. This is important to assist in locating children swiftly should they go missing in the future. Although there has been improvement, performance remains poor.

Early in 2018 the Board’s Business Group agreed the need to extend the focus on CSE and missing to include a focus on children who are criminally exploited and those who are trafficked. There is intelligence
locally of some ‘county lines’ activity (children being exploited by gang or groups from outside of the city, to courier drugs).

Whilst progress has been made there is still further work to do, in particular to more fully understand the extent of exploitation in Hull, the impact of the work currently undertaken and to make better use of intelligence to disrupt criminal behaviour.

The Board has agreed that CSE and missing must remain as priorities but with an expanded focus to include CCE and trafficking. Further significant improvement is needed to practice in relation to missing children. A better shared understanding of risks and vulnerabilities is still needed to inform tactical and strategic responses. A more mature performance framework is needed too, so that the impact of the work to reduce exploitation can be monitored effectively.

**PRIORITIES FOR 2018/19**

- Continue to support, monitor and drive forward improved practice, completion rates and quality of return interviews
- Ensure that ‘high risk’ missing children, and those at risk of CCE, are included in the pre-MACE and MACE arrangements
- Ensure that children missing education, and those who are home educated and vulnerable, are considered at weekly and monthly missing meetings
- Quality assure practice in relation to CSE and missing, identifying strengths and areas for development.

- Jointly audit CSE/CCE/Missing and Trafficked cases during July, August and September 2018 to include an analysis of the impact of MACE arrangements
- Produce a new CSE/CCE/Missing and Trafficked strategy, supported by a SMART action plan and robust performance management framework.
- Complete the co-production of a CSE problem profile for the city
- Update the Risk Identification Tool so that it can be used to help assess risk for CCE as well as CSE
- Secure cabinet approval to make CSE training a condition of licence for taxi drivers

**PRIORITY 4 ENGAGING WITH MEN AND FATHERS**

*Why was this a priority for the Board in 2017/18?*

This was agreed as a priority arising from learning from a number of local serious case reviews, child death reviews and learning lessons reviews.

In many of these cases significant males (including fathers) had been largely ‘invisible’ to local services. Their role in caring for children had often not been assessed: it had either been ignored or untested assumptions had been made about them as either potential ‘protective’ factors or as risks to children’s safety.
The Board recognised the research elsewhere that strategies to more pro-actively engage men and fathers contributes to more positive outcomes for children and agreed the need to develop strategies to address a ‘gender bias’ in some service provision in order to better engage men and fathers as important care givers for children. Equally, the Board recognised the need to improve direct engagement with men who may be violent and pose a risk of harm to children.

What has been achieved during the year?

A multi-agency steering group is driving change in relation to how agencies engage with and respond to men and fathers when working to support children and families. A separate task and finish group was set up to explore ways in which engagement with the whole family (including with men and fathers) can be improved when domestic abuse is a feature, by looking at research and emerging best practice from other areas and by making recommendations for changes in Hull.

Changing cultures within organisations and across the partnership is challenging. Small changes can make a significant difference.

Some of the changes made include:

- Changes to the contact/referral form to the EHASH to ensure a focus upon men in households
- Analysis of the quality of CSC assessments under the Board’s multi-agency audit programme always includes the extent to which assessments include men and fathers in households
- Separate workshops held with schools – 2 schools have agreed to hold ‘bring your father-figure to school’ days to promote father’s involvement in children’s literacy and education
- Midwifery systems have been revised to ensure that father/partner details are always captured. Posters and leaflets have been re-designed to show a better gender balance. Fathers are now also able to stay overnight when baby remains in hospital. The ‘HEY baby’ carousel now includes links to support groups for dads and perinatal emotional well-being support to fathers as well as mothers.
- A new leaflet for men and fathers about their rights in relation to child protection planning has been developed
- Engaging men and fathers has been included as a key theme in the review of the parenting strategy.

The ‘task and finish’ group has completed research from within their own agency, professional bodies and national developments in relation to engaging with families where domestic abuse is a feature. Traditional approaches focus primarily on the victim and there has often been insufficient attention paid to engaging with and assessing perpetrators (this is also one of the key findings of the JTAI ‘domestic abuse’ programme of inspections).
Members of the group made a visit to Leeds to learn about how services there are working in a more ‘whole family’ way in relation to engaging with perpetrators of domestic abuse.

The group have started to develop some recommendations for developing practice locally.

Most of the research and development work has now been nearly finalised. It has been agreed too that the ‘engaging men and fathers who may be violent’ strand will be taken forward by the Domestic Abuse Strategic Group, so that this will no longer be a key priority on its own for the Board in 2018/19.

FURTHER DEVELOPMENT WORK IN 2018/19

- Complete and publish the ‘engaging men and fathers’ strategy and toolkit
- Implement the survey which has been designed to capture the views of men about how services can better engage with them
- Separate the ‘engaging men and fathers who may be violent’ strand of the work and task the domestic abuse steering group to assume leadership of this
- Establish a pilot project between ‘Strength to Change’ and CSC to support social workers in assessing suitability for voluntary perpetrator programmes with the intention of reducing waiting times for the programme
- Capture and accurately describe the various perpetrator programmes available locally and make recommendations about their strengths, limitations and impact
- To identify training opportunities to improve practitioner competence in engagement, assessment and planning with families where domestic abuse is present.

PRIORITY 5 SUPPORT AND MONITOR THE DEVELOPMENT OF THE EHASH AND EARLY HELP OFFER

Why was this a priority for the Board in 2017/18?

The Board has recognised that stronger multi-agency front door arrangements are key to ‘getting it right’ first time for children and families who need additional, targeted or specialist help and support. The development of a stronger, more confident and multi-agency targeted early help ‘offer’ will also help to ensure that the needs of more children are met before they become acute and release social work time and expertise to focus on securing change for the children who are most vulnerable and most in need.

What has been achieved during the year?

The Board consistently monitored the development of the EHASH between 2015 and 2017, with focused challenge during 2016/17 designed to accelerate the pace of development and secure more complete ‘buy-in’ by partners. Momentum was increased and the Early Help and Safeguarding Hub (EHASH) went ‘live’ in June 2017.

Once EHASH had gone live, work began on refreshing the Board’s ‘Thresholds of Need’ guidance. As part of this process, important related work was completed on:
- Clearly describing processes for ‘stepping up’ and ‘stepping down’ cases at key thresholds in the system;
- Clarifying the preferred local early help assessment tool and model
- Defining the expected role of lead practitioner

There was wide consultation with key stakeholders across the partnership about the design and content of the guidance, so that it could be as useful as possible for practitioners and decision-makers in their day-to-day work.

The work on developing revised threshold guidance, alongside developing analysis of the volume of contacts and pressures at the ‘front door’ (EHASH) led to a decision at the EHASH strategic board (April 2018) that referrals for local authority ‘early help’ (additional support for children and families) would be made directly to early help rather than via the EHASH. Adjustments were made to contact/referral forms to reflect this change, and the threshold of need guidance was published and launched on 4th May 2018.

There has also been significant further development during the year in the early help arrangements. Ofsted (February 2018) found that: “the co-location of early help within the EHASH supports the timely progression of work to those services” and that “the early help allocation meeting shares information effectively, to ensure the allocation of the right service”.

Over 170 practitioners from a range of agencies and settings were trained in using the ‘Family Star’ early help assessment and the evidence suggests that this is starting to improve the quality of early help assessments and engaging more professionals as lead practitioners.

Early Help Action Meetings (EHAMs) continue to be held weekly in each locality and are well-attended by a range of partners. Regular early help locality events are also well attended and help to embed partnership arrangements.

Prior to the end of the period, the local authority established ‘Children in need’ panels in each locality and this has begun to see success in ‘stepping down’ some children from CSC to targeted early help in an appropriate and managed way. There are also established methods for ‘stepping up’ where risk increases.

**FOCUS DURING 2018/19**

Now that the EHASH has been firmly established with a strategic group overseeing performance, the Board will maintain a focus during the year on the understanding and application of ‘thresholds’ and on supporting and disseminating the audit work designed to:

- Improve the overall quality of contacts/referrals to EHASH
- Clarify the referral pathways for domestic abuse incidents
- Reduce the proportion of CSC assessment work which results in no further action
- Reduce the volume of s47 enquiries and increase the proportion which lead to ICPC.
The Board will monitor the impact via its performance scorecard and work with partners to develop improved processes to track outcomes for those children ‘stepped down’ to early help.

Other Development Work Led by the Board

The following is a summary of some of the other, ongoing, development work led by the Board. This work is taken forward by multi-agency work streams or ‘task and finish’ groups and reflects themes and issues which either require continued focus and attention, or have arisen from learning from local reviews, and/or form part of the Board’s statutory functions.

PRIVATE FOSTERING

The work stream meets twice annually. The main priority of the group is to lead on action to ensure that:

- private fostering arrangements in Hull are identified and reported;
- The suitability of the arrangements are properly assessed
- Where appropriate, support is provided to sustain the arrangements in the best interests of the child.

‘Private fostering’ is not well understood and is often confused, including by professionals, with Independent fostering provision.

Low numbers of children, here and elsewhere, have been identified as living in private fostering arrangements. It has therefore been a constant focus for the group on developing new ways of “getting the message out there.”

Key developments during the year have included:

- Revised leaflets and a poster have been developed and widely distributed. Given the confusion about the term ‘private fostering’ the materials ask “Are you looking after someone else’s child?” The posters and leaflets are displayed in libraries, doctor’s surgeries, children’s centres, customer service centres, schools and other sites and can be downloaded from the HSCB website.
- A ‘one-minute guide’ to PF was produced in June 2017 for professionals and has been widely distributed. PF is referred to on all HSCB safeguarding courses. The guide is available on the HSCB website and has been emailed to all schools.
• PF briefings are still provided as part of the HSCB training offer. However, the briefings were not well attended and some were cancelled as a result. An alternative 20 minute PF e-learning briefing was developed (June 2017) and widely publicised.
• The PF briefing has been cascaded across all CSC sites and teams. Additional bespoke briefings have been provided to children’s centres and customer service centres.

The work stream oversees an annual audit of private fostering cases and will capture and summarise learning from these in order to inform practice development and improvement.

ONLINE SAFETY

This work stream, chaired by a lead practitioner for online safety at a local primary school, ensures that the Board’s advice, guidance and training on keeping children safe on online is regularly reviewed and updated to keep pace with children’s rapidly changing online world.

During the year the group has:

• Produced and widely distributed an A5 colour booklet designed to give key advice to parents/carers on how to keep children safe online
• Revised and refreshed the online safety training. The course has been expanded from a ½ day to nearer a full-day course based on participant feedback
• Provided the training to 166 participants during the year.
• Held workshops in schools to speak directly to young people about their knowledge and current experience of the online world.

FGM WORKSTREAM

This group originally convened in 2015 to develop multi-agency policy, practice guidance and training in relation to FGM. The work of this group was also informed by a local lessons learnt review.

The group is made up of those who have developed an expertise in responding to the emerging issue of FGM in the city. It continues to act as a forum to ensure that training provision, policy and practice are all consistent with current legislation and guidance and that services are sensitive to the needs of affected communities.

The main focus of the group has shifted. The group now has a public health chair and is producing an FGM strategy.

The group will have oversight of the strategy and will continue to monitor the FGM pathway and the action plan produced in support of the strategy.

THE DIVERSITY WORKSTREAM

This group is made up of members from across the partnership and from local communities. Its purpose is to identify safeguarding children issues experienced by different communities and faith groups and the agencies they work with and to develop responses to deal with these various, and often ‘new’, safeguarding challenges.
During the year the group has:

- Continued to deliver safeguarding children sessions to newly arrived communities via the Gateway programme
- Produced good practice guidance in relation to the use of interpretation services and on age assessments and circulated these across the partnership
- Researched and brought into the city best practice from other areas in relation to local safeguarding issues which are emerging – FGM, abuse based on faith or belief etc
- Provided advice and support to other working groups, such as the Humber modern slavery partnership
- Worked on producing safeguarding sessions for travelling communities and ‘insight bitesize’ sessions for practitioners to support engagement with travelling communities
- Reviewed the Board’s ‘becoming culturally competent’ training and commenced work on related practice guidance.

The development of a new training course in relation to responding confidently and appropriately to disclosures of harm, the need for which had been identified by practitioners with a specific role working with children with disabilities. The course was developed and piloted in September 2017 (by members of the work stream). A total of 6 courses have been run (to March 2018). All have been very well attended. Feedback from participants has universally been that their knowledge and confidence has increased.

- Review and minor change to the above course and agreement that the group will produce a ‘one-minute guide’ entitled ‘responding to disclosures from children, young people and vulnerable adults’.

The work of the ‘Neglect’, ‘Engaging men & fathers’ and ‘Children living with domestic abuse’ work streams has already been captured within the priorities section of this chapter.

CHILDREN WITH DISABILITIES AND COMPLEX HEALTH NEEDS

This work stream was formed in response to the government guidance of July 2009, ‘Safeguarding Disabled Children’. The group is chaired by a Team Manager from the Children and Families Disability Team.

The work of the group over the past year has included:
**Background**

All LSCBs have a responsibility for ensuring that there are effective procedures in place for investigating allegations against people who work with children. The Local Authority has a responsibility to have a designated officer or team of officers to be involved in the management and oversight of allegations against people that work with children. In Hull, this is delivered through the Local Authority Designated Officer (LADO) as a single post-holder. The LADO is under the line management of the Manager of the HSCB. The LADO should be informed of all allegations where a person who works with children or young people has:

- Behaved in a way that has harmed, or may have harmed, a child
- Possibly committed a criminal offence against, or related to, a child; or
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children (including children both in and outside of the workplace).

The role of the LADO includes providing advice and guidance to employers; liaising with the police, children’s social care and other agencies; and monitoring the progress of individual cases to ensure they are dealt with thoroughly and fairly and in as timely a manner as possible.

**Summary**

- There have been 414 contacts to the LADO.
- 73 of these contacts met the above allegations management threshold. 341 of these contacts were consultations that did not meet the threshold.
- There has been a year on year increase in the number of consultations and referrals since 2014.
- Social care is the primary source of referral to and consultation with the LADO (178).
- 141 of the consultations and referrals pertained to education.
- 45 of the education-related consultations were not allegations against an identified professional, but may be better characterised as safeguarding issues.
- Physical (130) and sexual abuse (107) remain the primary categories of harm referred to the LADO.
- With regards to the outcomes of those 73 cases deemed to meet the allegations management threshold; 17 were substantiated, 22 were unsubstantiated, 23 had an unfounded outcome, 6 were false allegations and 5 were malicious.
- 10 individuals received convictions following investigations.
- 21 allegations are ongoing or awaiting outcome.
- 24 members of the children’s workforce left their employment following investigations either through dismissal, resignation, deregistration or the cessation of use.
Training and Awareness-raising

- The LADO continues to take lead training responsibility around dealing with allegations against those working with children, training 34 individuals this year.
- The LADO has given presentations on the role to trainee paediatricians, Head Teachers and Humberside Police’s Protecting Vulnerable Unit.
- The delivery of awareness-raising briefings across social care teams in Hull is ongoing.
- The Designated Officers Forum continues to offer networking and information dissemination opportunities.

Themes and Local Operational Issues

Having a centralised LADO role allows for the identification of any city-wide thematic issues arising in relation to the safeness of the workforce undertaking work with children and young people. Regional and national links afford the opportunity for further analysis of such trends.

- There have been a number of cases that have reached the point of charge and in some cases trial or even prosecution before referrals have been made to the LADO. These cases have all been active police investigations, which have been known to the employer and in one instance to social care.
- There has been an increase in allegations against self-employed members of the children’s workforce or those leaders / managers within organisations with no governance above them. Such instances require the LADO to undertake direct liaison with the individual alleged to have caused harm in relation to their role and contact with children. This has seen several instances where the LADO has sought voluntary agreements for individuals to stand aside throughout the course of enquiries.
- There continue to be a number of cases involving the making or sharing of indecent images of children. Effective early notification from the police enables early safeguarding arrangements and suspensions to be implemented in tandem with arrests or the execution of warrants. These cases often result in dismissal, conviction and disqualification or barring from work with children. Hull has also been the focus of action by a small number of vigilante on-line paedophile hunter groups who have taken action in the city. This has led to intervention in one case where the perpetrator was identified as working with children.

Areas for Development and Actions

An action plan has been developed to reflect the areas for development and action in 2018-2019 and beyond, including:

- The commissioning and development of a new allegations workspace / database.
- An update to the relevant HSCB guidance on Allegations of Harm Made Against People who Work with Children.
- Advice and guidance around data protection / retention issues as well as issues arising from unsubstantiated allegations in the context of reference requests.
- The continued development of the Designated Officers Forum.
- Continued awareness-raising across social care, education and Humberside Police.
- Peer audit of LADO work in Hull.
- Consideration of the National LADO Network Principles and whether these should be applied in Hull.
“LSCBs should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result” Working Together, 2015

The Board’s Learning and Improvement framework was published in 2014. Since the framework was published a range of lessons have been identified which have led to tangible improvement across the system. This learning activity has continued during 2017/18 with a heightened focus on:

- Increasing the volume of multi-agency case auditing
- Developing new, innovative ways of disseminating the learning, in particular from serious case reviews.

The Board has not developed mechanisms to ensure that the voice of the child, their views and experiences, are captured and used consistently to inform its work. In November 2017, the Independent Chair nominated a Board member to lead on developing an engagement plan and on devising methods to capture key themes from the engagement work led by partner agencies. It was agreed that this work should be taken forward with the Children, Young People and Families Board to avoid duplication of effort.

The Board is clear that it should not replicate existing structures within which children and young people are already engaged and that systems need to be in place to more effectively gather together information about partner organisations’ existing engagement, the work undertaken and the difference this has made.

Additionally, the Board understands that practitioners work with children on a daily basis and that a key part of that work is to engage directly and understand children’s wishes and feelings. For example, Ofsted found that: “In all casework seen, clear efforts were made to directly engage with the child to gain their wishes and feelings and to understand their experiences.”

By the end of the reporting period, partner agencies had begun to provide examples of engagement activity and its impact, including:

- Care leavers are involved in shaping services and have presented to the local authority Chief Executive and Corporate Strategy Team on things they would like to improve. This has resulted in a number of commitments:
  - All care leavers being exempt from council tax
  - The creation of a ‘local offer’ personal advisor post
  - The use of discretionary housing benefit to bridge the financial gap when care leavers commence an apprenticeship
  - Extended rent-free period to enable all repairs and decorations to be completed before moving into a council property
  - All housing arrears cleared
  - Concessionary travel cards
There has also been a corporate ‘cascade’ to extend the offer of apprenticeships for care leavers which has far yielded 43 offers.

- City Health Care Partnership CIC engaged with a focus group of 24 young people to explore with them if the current service (Adolescent Public Health Nursing Service) could improve access through the use of technology. The findings show that technological solutions can improve access to school nursing services but should not become a substitute for face-to-face contact. The findings from the survey will now form the basis for any future technological development.

- Feedback from complaints, including complaints made by children, forms part of regular service-wide performance meetings in CSC. Reviews of transport arrangements and of contact are underway, informed by the views of children.

- The Independent Sexual Health and Community Paediatrics service (run by CHCP) has held a focus group in sexual health with children and young people aged 13-25. This was to ask for views about the service’s website and how user friendly it was. Following feedback changes and adaptations were made to the website, including the addition of a “teen” section. Changes have also been made to service models based on the outcome of surveys and workshops within secondary schools – as a result more sexual health pop-in sessions have been introduced within schools and colleges.

- The Board’s Online Safety work stream chair and CSE coordinator held two separate workshops with year 10 boys and girls at a local secondary school. The workshops were about staying safe online and other related safeguarding topics. The workshops explored use of modern technology and social media, exploring topics such as sexting, and which platforms and apps young people are using to interact online. The findings are used to inform and update the Board’s online safety training, to ensure that it remains current and relevant. The opportunity was also taken to give young people information about how to keep themselves safe online.

More examples of engagement activity and the impact which this has on service development will be provided to the Board. Opportunities will also be taken to use existing engagement mechanisms (e.g. via children and young people’s parliament, schools’ councils etc) for further direct engagement with children.

**THE VOICE OF PARENTS**

Whenever appropriate, and achievable, the HSCB involves parents and families in serious case reviews and other learning lessons reviews. A consistent offer is also made to meet with parents as part of the child death review process. The purpose of this work is to ensure that the views, experiences and perspectives of parents are heard and inform learning.

- The mother of a baby who died and was the subject of a serious case review (unpublished) gave really helpful feedback. The involvement of agencies with the family focused on neglect. Mum told us that she was never clear about the concerns and what needed to change. Her feedback has helped inform the development of neglect tools and the neglect training.

- A mother whose teenage son had died of an overdose described a service which makes ‘keepsakes’ from finger prints, and how she
had drawn comfort from having a pendant made from her son’s fingerprint. The Paediatrician for Deaths in Childhood undertook to explore whether fingerprints could be included in ‘memory boxes’ prepared for bereaved parents.

The Board also endeavours to ensure that feedback from families is a core part of multi-agency auditing activity. Further work is still needed to ensure that this practice becomes embedded. Where feedback has been obtained this has significantly enhanced learning.

- The multi-agency joint evaluation of cases panel heard some insightful and helpful feedback from a mother whose children had been subject to CPPs for neglect. Mum was able to describe the role of the social worker, her persistence and the way in which she explained neglect and its impact on the children. Mum’s clear description of what made the difference for her has been captured and used in the Board’s neglect awareness training.

THE COMMUNITY VOICE - VCS SECTOR

During 2017/18 the Board continued to support a commissioned VCS safeguarding support contract, provided by East Riding Voluntary Action Service (ERVAS). The service was first commissioned in recognition of the size and importance of the sector in Hull and the need to ensure that VCS providers had help and support to play a full role in keeping children safe.

The contract has secured:

- VCS strategic representation at the Board and various sub-committees and work streams.
- A vibrant VCS safeguarding forum which has provided an important means of two-way communication between the sector, the Board and various safeguarding partners
- Training and regular communication with the sector about safeguarding children issues and developments
- Bespoke help and support to the sector in developing safeguarding policies and practices
- Help and assistance when safeguarding concerns arise (for example, allegations) or where practice needs to improve.
- Support as and when required to help VCS providers engage in serious case reviews and other learning exercises.

REVIEWS OF PRACTICE

Serious case reviews (SCRs) are undertaken to learn lessons and to make improvements to the way in which local agencies and professionals work together to keep children safe. LSCBs must undertake an SCR when the following criteria are met under Regulation 5 of the LSCB Regulations 2006

(a) Abuse or neglect is known or suspected; and
(b) Either (i) the child has died or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child
In some cases, where the criteria for an SCR are not met, the Board Chair nevertheless can decide to undertake a smaller-scale multi-agency learning lessons review (which may or may not be independently led).

For various reasons some SCRs and learning lessons reviews have taken too long to complete and publish. In some cases locally, it has been some considerable time after the death of a child that new information has come to light which has raised suspicion of abuse or neglect. Delays are frequently encountered in identifying suitably qualified, experienced and available lead reviewers. In other cases, the learning has been completed but the report cannot be made public until the conclusion of parallel criminal proceedings. In these cases, any delay in publication does not prevent implementation of learning and improvement actions.

- The Board’s SCR sub-committee met on six occasions during 2017/18
- One new SCR was commissioned
- Two SCRs (Baby J & Child D) were published
- One (independently led) learning lessons review was published
- The Chair made a final decision not to publish one SCR which was finalised in 2016/17. This was on the grounds that publication would harm the surviving siblings of the child, who would be readily identifiable given some of the unique features of the case. Advice was sought from the National SCR Panel which felt that the Board should publish the report.
- In one case which met the criteria for a Domestic Homicide Review the Board agreed to work closely with this review to share learning

- The sub-committee considered all serious incident notifications and made decisions about whether cases met the criteria for SCR or needed to be reviewed in any other way.

**Serious Case Review – BABY A (unpublished)**

A summary of the learning from this review was included in the 2016/17 annual report. The learning informed the development work on ‘neglect’ which has been described elsewhere in this report (pp). This case also revealed unresolved professional difference of opinion.

**Serious Case Review – BABY J**

Baby J lived at home with both parents. When he was four weeks old he was taken to hospital unresponsive. He was found to have significant bleeding inside his brain as a result of head trauma associated with being violently shaken. He died in hospital two days later. Baby J’s father was convicted of manslaughter and sentenced to 8.5 years in custody.

**Key Learning from the Review**

- Assessments of risk would be enhanced by the use of evidence-based tools
- Written agreements do not keep children safe when there are no mechanisms for monitoring, review and sharing
- The importance of considering history in assessments
- A need to better understand coercive control in relationships
- A need to better understand the impact of perpetrator change programmes on risk
- The need to engage all agencies (including those working with the adults) so that relevant information can be shared and considered.
- The need to engage directly with men and fathers

**Impact**

- Training for social workers, health visitors and others on DASH assessments
- Use of DASH written into social work practice standards
- Review of HSCB domestic abuse training – clear focus on coercive control
- ‘Simple’ guide to perpetrator programmes produced by CRC and widely circulated
- Routine enquiry introduced to a range of new services, including adult substance misuse services
- Establishment of DA strategic group.

**Serious Case Review – CHILD B**

Child B lived at home with both parents. There was considerable input from universal and early help services in helping and supporting the couple to care for Child B. Child B died aged six weeks. The post-mortem recommended ‘sudden unexpected death in infancy’ as the cause of death. Sometime later medical opinion was provided which suggested that injuries to the child identified during post-mortem (but not linked to the death) were most likely non-accidental.

Child B was being well cared for by his parents, albeit with intensive support from a number of services. The review concluded that the child’s circumstances never met the threshold for referral to CSC.

**Key Learning from the Review**

- Parental learning difficulties and vulnerabilities – the possible impact of these on parenting ability – the need for adults’ services to work more closely with children’s services
- ‘Think family’
- The need for ‘early help’ services to coordinate involvement with families by means of an early help assessment, ‘team around the family’ approach and clear SMART child’s plan.

**DISSEMINATING AND EMBEDDING LEARNING FROM SCRS**

The Board has historically used a range of approaches to communicate learning from SCRs:

- Ensuring that local learning is built into HSCB safeguarding training
- Sharing learning at the trainer’s forum so that learning can be built into single agency training
- Spending time at Board meetings discussing learning and seeking commitment to action and for learning to be shared
- Providing SCR briefings routinely as part of the Board’s training programme
Some agencies (for example, CSC) have also delivered their own lunch-time briefings on learning from SCRs.

During the year we designed and introduced an additional new approach. Brief learning packs were prepared for the Baby A and Baby J SCRs. The packs contain a brief summary of each case and the key learning. They are designed for use in team meetings or staff supervision. Professionals are expected to consider the learning and what this means for their own practice, producing brief individual and team action plans.

Briefings on the packs were provided to agency leads from across the partnership, each of whom made a commitment to use the resource packs to explore learning and implications for practice within their own agency. A similar learning pack was subsequently developed for Child D and sent to agency leads.

The Board is now seeking feedback about how extensively the resources have been used and whether they are helpful. By the end of the period, the following feedback had been received:

- 8 children’s centres (65 practitioners and managers) have used the resources in team meetings and completed action plans. Feedback was very positive:
  - “kept the staff focused and provoked pro-active discussion”
  - “the action planning tool was helpful to identify changes needed”
  - “the Baby A SCR was really useful to use alongside the Neglect briefing and helped practitioners to make the links between learning from SCRs and changes to practice”

- Children’s centres identified a number of specific actions arising from the learning:
  - Ensure safe sleeping is discussed on visits
  - Increase completion of family star assessments
  - Being more alert to coercive control
  - Look at including dads more in assessments

- One CSC (assessment pod) used the resources for a reflective discussion. Feedback was also positive:
  - “Link practice/poor practice to own practice and reflect on own caseloads”
  - “Action plan helped to establish better practice”
  - “Would welcome more resources like this for group supervision”

**MULTI-AGENCY CASE AUDITING**

A full programme of multi-agency case auditing has run during the year – known locally as joint evaluation of cases. The Board has taken a thematic approach in order to derive maximum learning. Themes have been chosen to reflect both the Board’s key priorities and JTAI (joint targeted area inspection) themes. During the year 15 neglect cases and 9 domestic abuse cases were evaluated by the panel.

Cases for audit are selected from a ‘long list’ prepared by CSC using the criteria in JTAI guidance. Key agencies which will be
involved in any future JTAI (CSC, police, probation, CRC, youth justice and health providers) are standing members of the panel. Each agency evaluates its own involvement in a case and also provides a chronology of recent involvement. Chronologies are integrated and packs sent to panel members prior to each meeting. Individual schools and any other agency with significant involvement with the child are invited to contribute.

The audit schedule works on a four-month cycle: 3 cases are audited each month for three months and the fourth month is devoted to consolidating the learning and tracking progress on the actions agreed from audits.

The panel has identified examples of good single and multi-agency practice. Equally it has evaluated some cases which have given cause for concern about progress. In these cases, the panel has agreed further action which is needed and re-visited cases at future meetings to track progress.

At the end of each period of auditing, the panel produces an agreed one-page summary of the key learning. These are widely distributed. (see pages 42 & 43). The summaries have been received as helpful by strategic leaders, managers and practitioners.

Learning from auditing also generates specific improvement actions, for example:

- Auditing showed that GPs are not routinely invited to CPCs nor approached to share information. In too many cases this meant that GP records did not capture any concerns for a child’s safety or welfare. Equally learning from this process, and other cases, showed that practitioners have a limited understanding of the ‘health family’ (range of different health providers) so that some key providers are not included in multi-agency planning for children. The Board and key health safeguarding leads produced and widely distributed the ‘Health Umbrella’ and ‘Think Health. Think GP’ guide for practitioners. Feedback has been that this is helpful. (pages 44 & 45).

- Unresolved professional disagreement was a feature in a small number of cases audited. This has also been a recurring theme in local SCRs. Panel members were tasked with ensuring that their managers and practitioners know how to escalate concerns and that it is their responsibility to do so. All panel members reported back that this task had been completed.

The panel identified good and effective practice in one ‘neglect’ case in particular and has used this as a case study in its neglect awareness training.
Why did we carry out practice audits on cases where children are living with neglect?

Neglect is a risk factor in 60% of all Serious Case Reviews and is the most common reason nationally for taking child protection action. Neglect featured prominently in a recent local serious case review. ‘Children living with neglect’ is also the ‘deep dive’ theme for the Joint Targeted Area Inspection between May-Dec 2017 and is an HSCB priority. We wanted to learn from a wider sample of cases in order to identify strengths and areas for development. We initially jointly evaluated 6 neglect cases and a further 21 were subject of a CSC single agency audit. Between Oct – Dec 2017 we jointly evaluated a further nine cases which were identified as featuring neglect.

Strengths

- Evidence from assessments and case notes that social workers, and pods, know children and families well
- Evidence of good communication between agencies in most cases – regular, well-attended core groups and conferences.
- Examples of assessments which carefully considered the individual needs of each child and recorded good information-gathering from partner agencies.
- Records from across agencies generally reflected a consistent history of multi-agency working.
- Evidence of progress in most cases which had led to improvements in the lives of children.

One assessment in particular demonstrated a good understanding of the cumulative impact of neglect for both children.

- An example of a SMART CP plan which described a strong multi-agency plan of action.
- Decision-making in relation to the most recent concerns appeared sound and appropriate.
- Examples of good quality referrals from Police & NPS – including a high quality Police DA ‘913’ which recorded the views of the child.
- Examples of really positive and effective joint working between schools and locality social workers
- Feedback from one school that the new EHASH arrangements helped improve communication with CSC.

Areas for Development

- There was no evidence of the use of evidence-based neglect tools to inform assessments & work with families
- Children’s plans were seldom SMART – often lists of actions, with lack of clarity about what needs to change and timescales.
- In many cases there was some evidence of ‘drift and delay’ – e.g. repeated episodes of CSC involvement, short-term improvement & re-referral and delay in bringing cases to ICPC and/or PLO
- The recording available to auditors did not always reflect the work actually undertaken
- Cases evidenced regular core groups but it was not always clear how purposeful these were and records of meetings were not always available.
- There was no evidence of health involvement in strategy discussions in the majority of cases.
- Maternal mental health issues were referenced in many cases but with little evidence that these issues were explored further as part of ongoing work.
- In some cases the role of men and fathers could have been more fully assessed and considered.
- Chronologies were not readily available to help identify historical factors/patterns
- Cases showed inconsistent engagement and communication with GP’s

Issues for practitioners to consider:

- Beware of ‘over-optimism’ and placing too much emphasis on short-term change – carefully assess parental capacity to make and sustain change in the long-term
- Clearly identify what neglect is for each child and its impact on them. This is essential so that families and professionals are clear about what needs to change and how change will be measured.
- Ensure that historical information is available and fully considered.

What is being done to strengthen our work on ‘neglect’ across the partnership?

- Evidence-based tools to help practitioners recognise neglect and assess its impact have been locally developed and tested and are now being used across the partnership
- Revised HSCB neglect training has been developed. This is designed to help practitioners use the new tools and develop a deeper understanding of neglect and its impact on children. Training on the use of the new tools is ‘live’ – impact training is being piloted in January 2018
- Work is planned on producing some guidance on ‘good’ children’s plans.
- The Board has developed a neglect strategy which will be launched in Feb/March 2018.
- Work is being undertaken to better understand the extent and nature of neglect in Hull and how to measure improvement.
- Work is continuing to strengthen engagement with men and fathers across services and in all contexts.
- Materials have been developed and circulated to help agencies disseminate the learning from the recent local serious case review.
- A simple ‘Think GP’ guide is being produced to help strengthen engagement with GP’s.
- Work has been undertaken with CPC chairs to ensure that, where neglect is the main concern for a child’s safety, that this is ‘named’ and reflected in CP categorisation.
Why did we carry out practice audits on cases where children are living with domestic abuse?

It is estimated that domestic abuse is a factor in over 50% of cases referred to children’s social care in Hull. Over the last few years there has been a significant increase in the volume of domestic abuse incidents reported to the police. Domestic abuse has been a significant feature in a number of recent local serious case reviews. For all of these reasons, reducing the impact on children of domestic abuse is a priority for the Board. The impact of domestic abuse on children is also a theme for the Joint Targeted Area Inspection programme. We agreed that we should see what could be learned about contemporary multi-agency practice and jointly evaluated six cases in this round.

Strengths

- The ‘Routine Enquiry’ question being asked in midwifery and leading to appropriate contact with EHASH
- The individual needs of children being reflected in social work assessments
- Good quality police reports (913’s/DASH) which recorded the impact of the domestic abuse on children in the household
- Good communication and inter-agency information sharing which was helping to keep children safe
- Appropriate and timely referrals (e.g. from NPS (Probation) to EHASH) where there was an identified linked risk from a known offender.
- Strategy discussions which included health partners alongside the police and children’s social care.
- Regular core groups which were well attended
- The work of schools in providing emotional wellbeing support to children who are, or who have been, living with domestic abuse
- The individual needs of children with a disability, and the impact of their disability on their own and their parents’ wellbeing, being well understood.
- Schools also reported that they were well informed by social workers and through Operation Encompass about DA incidents, family history and the impact on children where this was known.

Areas for Development

- There needs to be a stronger/more consistent link between the work taking place (with men) on perpetrator programmes and child protection/safety planning, including a better shared understanding across the partnership about the purpose and impact of programmes, including on levels of risk.
- The impact of separation (including imprisonment) on levels of risk needs to be fully understood and assessed (especially where coercive control is present)
- More work is needed to ensure that all police DA incident reports assess the impact on children. 
- GP’s should always be invited to attend/contribute information to child protection conferences
- Where there is a clear assessment of risk and a safety plan in place (for example, for perpetrators to stay away from the family home) there needs to be a clearly articulated contingency plan and action taken when this is not complied with to support victims and children
- Multi-agency children’s plans need to be SMARter
- The impact of DA on children needs to be better understood and their individual needs for support identified and met
- Relevant health providers are not always invited to contribute to planning – e.g. midwifery in relation to unborn and adult mental health services

What is being done to strengthen our work on ‘domestic abuse’ across the partnership?

- A cross-partnership Domestic Abuse Strategic Group has been established to coordinate work across the city to tackle domestic abuse
- A Domestic Abuse strategy and action plan have been published, overseen by the strategic group
- DASH briefings have been provided for different groups of professionals (including social workers and health visitors)
- There has been a focus on updating and providing domestic abuse training, with a particular focus on coercive control:
  - HSCB provides a variety of DA training, Humberside Police have trained front-line officers and call handlers, funding is available via H/Police for further training in 2018/19 for social workers and other professionals on assessing risk and EHASH staff have been updated on coercive control.
- Significant further work is ongoing with schools on the ‘Expect Respect’ toolkit
- Operation Encompass has been launched so that schools receive early notification about DA incidents
- A ‘Think GP/Think Health’ simple guide is being produced to help practitioners better understand how to engage health partners

Issues for practitioners to consider:

- The purpose of involvement is to reduce risk.
- It is important to understand history and established patterns of behaviour: integrated multi-agency chronologies and evidence-based tools (e.g. DASH) should be used to help assess and manage risk.
- The focus must be on the child’s lived experience and should always consider their individual support needs.
- Mobilising family capacity to reduce risk must be monitored and subject to review.
- Men and fathers should be directly engaged in risk reduction work.
The Health Umbrella
"Think Health"

Each health professional/organisation may hold, or need, a vital "piece of the jigsaw". Therefore always think about requesting & sharing relevant information in order to aid decision-making in safeguarding children.

Routinely consider which health professionals from which services need to be invited to attend meetings and/or to provide information by a written report or answers to specific questions.

If GP registration details are not known, email pcse.informationservices@nhs.net (Each request for information must clearly state who the requester is e.g. the organisation or body which they work for), the relationship between themselves and the person whose information is being requested and the reason for why the information is being requested).

Think GP!

- Always invite the child’s GP to child protection conferences.
- Always send meeting minutes and decision outcomes directly to the GP practice so that they are made aware of the multi-agency decisions and recommendations.
- Liaise in person with the GP or practice manager if further information is required or needs to be shared following a meeting.
- Nominate a specific individual at the meeting to action this, particularly if there are actions relating to the child / family that need to be brought to the attention of the GP.

What this will achieve?

- Better communication & two-way sharing of information -> improved decision making
- Building of relationships between different professionals
- Increased understanding of roles & responsibilities
- Clearer, enhanced knowledge of family/child/issues
- Greater awareness of risks/concerns
- More shared understanding about potential vulnerabilities
- Appropriate action/follow-up being taken
- Better partnership working to improve outcomes.

Useful contacts...

<table>
<thead>
<tr>
<th>Named GP - Safeguarding Children</th>
<th>Adult Mental Health Response Service</th>
<th>Adult Drug and Alcohol Services</th>
<th>Let's Talk - Adult Emotional Well-being Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>07702 867 506</td>
<td>(01482) 301 701</td>
<td>ReNew (01482) 820 013</td>
<td><a href="http://www.letstalkhull.co.uk/">http://www.letstalkhull.co.uk/</a></td>
</tr>
<tr>
<td>ReFresh - Substance Misuse</td>
<td>Humber Foundation Trust Safeguarding Team</td>
<td>CHCP Safeguarding Children Team</td>
<td>Call 01482 247 111 or Text TALK to 61825</td>
</tr>
<tr>
<td>Service under 16's</td>
<td>(01482) 331 059</td>
<td>(01482) 617 675</td>
<td>NHS Hull Clinical Commissioning Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Designated Nurse</td>
</tr>
<tr>
<td>Child Protection Team (Acute)</td>
<td>Child and Adolescent Mental Health Service (CAMHS)</td>
<td>Community Children’s Nursing Team</td>
<td>Safeguarding Children / LAC</td>
</tr>
<tr>
<td>Ariaby Suite</td>
<td>(01482) 674 061/674 589</td>
<td>(01482) 344 296</td>
<td>(01482) 344 781</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Corner House</td>
</tr>
<tr>
<td>Sexual Health, Family Planning</td>
<td>Hull and East Yorkshire Hospital</td>
<td>The Administration Team 0-10</td>
<td>Young People’s Sexual Health in Hull &amp; East Yorkshire</td>
</tr>
<tr>
<td>&amp; Contraception Services</td>
<td>Trust</td>
<td>Health Visiting &amp; School Nursing Teams</td>
<td>(01482) 327 044</td>
</tr>
<tr>
<td>Wilberforce Health Centre</td>
<td>Named Nurse Safeguarding</td>
<td></td>
<td>Community Midwives</td>
</tr>
<tr>
<td>(01482) 247 111</td>
<td>(01482) 674 589</td>
<td></td>
<td>(01482) 602 658</td>
</tr>
<tr>
<td>Headstart</td>
<td>Named Midwife Safeguarding</td>
<td></td>
<td>Community Learning Disability Team (Adults)</td>
</tr>
<tr>
<td>(01482) 815 707</td>
<td>(01482) 674 589</td>
<td></td>
<td>(01482) 336 740</td>
</tr>
</tbody>
</table>
SINGLE AGENCY CASE AUDITS AND OTHER LEARNING

HSCB partner agencies also undertake their own case auditing and other safeguarding learning and improvement work. The Board needs to further develop the way in which it captures this learning and summarises as part of regular partnership performance monitoring reports.

- CSC has introduced a strengthened and revised programme of case auditing with approximately 50 cases audited by managers each month. Learning from audits is captured and reported on a monthly basis. The learning from audits has informed the development of new practice standards for social workers and the provision of learning events linked to audit outcomes (case recording and chronology, SMART planning, role of managers in improving practice etc).
- Humberside Police has an ongoing rolling programme of internal audits to continually assess the quality of investigations and has also jointly audited s47 enquiries to review decision-making, response and timeliness. Arising from this learning the College of Policing Specialist Child Abuse Investigator Development Programme will be delivered to all investigators starting in 2018/19. Police officers will be trained jointly with social workers.
- The Community Rehabilitation Company operates an Integrated Quality Assurance Model and undertakes audits on a quarterly basis. A need to improve some aspects of safeguarding practice was identified through this process. Areas for development included: that a ‘known persons’ safeguarding check needs to be completed in all cases; prompt referrals must be made in all cases once safeguarding concerns are identified; the need to strengthen management oversight on safeguarding cases. A range of actions have been taken including a series of safeguarding practice development events covering neglect, CSE, CCE, Trafficked and missing children and the new EHSh referral process.
- All Youth Justice Service assessments and reports are quality assured by a senior youth justice officer to ensure that safety and wellbeing needs are identified and addressed in the intervention plan. The service has strengthened internal safeguarding practices during the year: monthly safety and wellbeing meetings are held by the senior leadership team to look in-depth at cases where high safety concerns have been identified during assessment; new cases are discussed at weekly reflective discussion meetings with a clear focus on safeguarding; cases with safeguarding concerns are prioritised in supervision.

PERFORMANCE DATA

Historically the Board has had weaknesses in relation to the availability of regular, reliable and accurate data about performance across the partnership. During the year the Business Group revisited and agreed a ‘core’ partnership safeguarding dataset. The first revised performance report was presented and considered at the Board meeting in November 2017. Members gave positive feedback about the usefulness of the data presented.

More work is needed to ensure that the agreed data sets are routinely provided in a timely fashion so that they can be combined into one report. Further development is then needed to build in available
intelligence about quality and outcomes for children and young people.

- Data in the November 2017 report led members to request a more detailed update about developments within the CAMHS service and waiting times for assessment. The CAMHS leads (commissioner and provider) attended the next Board meeting to provide this more detailed update.

- The data about the front door (contacts, referrals, etc) has informed the development of thresholds and changes to the contact/referral systems.
THE CHILD DEATH OVERVIEW PANEL
The Child Death Overview Panel (CDOP) is a multi-agency panel, chaired by the City Manager for public health and enables the Hull Safeguarding Children Board to carry out its statutory functions relating to child deaths. The full CDOP Annual Report can be found [here](#).

### CDOP facts and figures during 2017/18:

- 19 child deaths were **notified** to the LSCB – a decrease from 27 notified in the previous year (244 child deaths have been notified in the 10 years since CDOP records began)
- 12 deaths were male (63%) and 7 (37%) were female
- The CDOP met five times and **reviewed** 25 children’s deaths - 229 deaths (94%) have been reviewed since 2008
- Half of the deaths reviewed this year were unexpected
- 8 deaths remained unexplained at the time of the review (3 were registered as Unascertained/Undetermined and 5 were recorded as Sudden Infant Death Syndrome (SIDS).
- 13 deaths were due to a perinatal/neonatal event or from chromosomal, genetic or congenital abnormalities
- None of the deaths reviewed were as the result of accidental injury or as a result of suicide or deliberate self-inflicted injury
- 14 male: 11 female (the overall proportion in Hull since 2008 is similar to proportions for the whole of England (60%:40%)
- 22 of the child deaths reviewed were aged less than 1 year; 13 were under 28 days

As part of its functions, the CDOP is required to categorise the preventability of a death by considering whether any factors may have contributed to the death of the child and if so, whether these factors could be modified by means of locally or nationally achievable interventions to reduce the risk of future child deaths. During 2017/18, the CDOP identified modifiable factors in 16 of the 25 deaths reviewed.

Following a development day, the CDOP is confident that all cases are reviewed comprehensively and that professional challenge remains a central part of the review process.

### CDOP Impact 2017/18

- The rate of infant mortality (deaths of children under the age of 1) in Hull has decreased to 3.8 (Mortality rate per 1,000 live births, 2014-2016) – not significantly different from the England average

The majority of ‘modifiable factors’ related to parental lifestyle which may have contributed to a child’s vulnerability, ill-health or death e.g. parental smoking, maternal smoking in pregnancy and unsafe sleeping environments. Through its partners, Hull CDOP continues to raise awareness and educate professionals and families about the impact and risks of parental lifestyle and behaviours.

- Safer sleep training for professionals explains prevention measures parents can take to reduce risks of sudden infant death. Key
messages, guidance and fact sheets are provided to professionals who have contact with parents in hospital and in their homes. Workers from the Domestic Abuse Project, Teenage Pregnancy Support Service, substance misuse support services and other early help services are being trained to deliver infant safer sleep advice in order that all local professionals are delivering consistent messages and are encouraged to enquire and view an infant’s sleeping place. Pregnant clients of the local substance misuse support service will be managed more closely within main service provision, in terms of implementing safer sleep advice.

- CDOP is represented on a local multi-agency Infant Safer Sleeping Steering Group which co-ordinated the sharing of safer sleeping advice from local and national reviews to support the 3rd national Safer Sleep Week campaign - CDOP partners promoted updated key messages and resources around infant safer sleeping and the risks associated with an adult sharing a bed or sofa with a young infant, particularly after taking drugs and certain prescribed medication and after drinking alcohol.

- 76 professionals attended a local Safer Sleep seminar and received a Lullaby Trust resource pack - feedback from the event was positive; with many noting increased confidence in raising the issues and supporting families. CDOP were pleased to learn that the number of families with young babies that seminar delegates worked with in a year was typically in hundreds, which helps give an indication of the potential scale of impact of an event of this kind.

- A CDOP development day presented local data on neonatal deaths during 2008 – 2017 to commissioners to strengthen the need for targeted smoking cessation interventions and discussions at the local maternity services forum. CDOP received assurance from commissioners and providers that a local partnership approach (between CCG, Public Health & Children Services, Doula service, GPs, Smoking Cessation Service, Maternity Service) to reducing maternal smoking had identified the challenges and developed some training, development and communications plan to deliver some effective outputs and outcomes.

  - CDOP members received reassurance that adequate information and precautions around the sedative effects of prescribed Tramadol are given by midwifery in hospital to new and vulnerable parents.

  - Hull & East Yorkshire Hospitals Trust reviewed their policy to provide an interpreter for appointments that relate to bereavement and delivering medical information to people whose first language is not English.

  - Panel members welcomed a bereavement midwife post, to roll out the pilot of the National Bereavement Care Pathway designed to improve the quality of bereavement care experienced by parents and families. The midwife is invited to local case discussion meetings and relevant rapid response meetings to pick up any bereavement related issues and requests for support.
595 professionals, predominantly from health, police and children’s social care, have now attended training in responding to the unexpected death of a child which helps contribute to ensuring that each unexpected child death is investigated in a thorough and systematic way that is sensitive to and supportive of parents, and that as professionals and communities we learn lessons to help prevent future deaths. Typical comments were that delegates left the training more confident about implementing the process due to an increased knowledge and appreciation of other agencies’ roles and responsibilities. A further 3 training dates are scheduled for 2018/19.
TRAINING & DEVELOPMENT
The HSCB continued its longstanding commitment to multi-agency safeguarding training during 2017/18. This commitment stems from a shared understanding of the value of multi-agency training, reinforced in the major reviews of the ‘child protection system’ led by Lord Laming (2010) and Professor Eileen Munro (2011). The Board employs two full-time Training & Development Officer posts (3 people) and training capacity is supplemented by subject experts across the partnership, including the Board’s professional practice officers.

The learning opportunities provided by the Board are designed to meet the diverse needs of staff at different levels across the wide range of organisations that work with children, young people and adult family members.

**HSCB MULT-AGENCY TRAINING SUMMARY 2017/18**

- In support of Hull’s year as City of Culture in 2017, the Board provided safeguarding training (Basic & Level 1) to 338 volunteers who had a key role to play in ensuring that events in the city took place safely.
- A further 163 contractors and sub-contractors undertaking repair and maintenance work to the council’s housing stock undertook safeguarding training as potential extra ‘eyes and ears’ in keeping vulnerable people safe.
- Previous measures to improve training accessibility saw an increase to 866 in the number of local authority children, young people and family services staff accessing training.
## AGENCY ATTENDANCE AT HSCB MULTI-AGENCY TRAINING & LEARNING EVENTS

### LOCAL AUTHORITY EMPLOYEES 1346
- City Safe & Early Intervention 405
- Childrens Safeguarding 263
- Learning & Skills 198
- Neighbourhoods & Housing 175
- Customer Services 66
- Hull Culture & Leisure 57
- Adults Social Care 26
- Property & Assets 84
- Other 70

### HEALTH PROVIDERS 143
- City Healthcare Partnership 68
- Hull and East Yorkshire Hospital Trust 53
- Humber NHS Foundation Trust 10
- Other (medical centres, dentists) 12

<table>
<thead>
<tr>
<th>Category</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SCHOOLS &amp; COLLEGES</strong></td>
<td>2678</td>
</tr>
<tr>
<td>Others</td>
<td>1020</td>
</tr>
<tr>
<td><strong>EARLY YEARS SETTINGS</strong></td>
<td>606</td>
</tr>
<tr>
<td>Foster Carers</td>
<td>264</td>
</tr>
<tr>
<td>Change, Grow, Live</td>
<td>106</td>
</tr>
<tr>
<td><strong>STUDENTS</strong></td>
<td>370</td>
</tr>
<tr>
<td><strong>OTHER VCS</strong></td>
<td>137</td>
</tr>
<tr>
<td><strong>LOCAL AUTHORITY FOSTER CARERS</strong></td>
<td>73</td>
</tr>
<tr>
<td><strong>CONTRACTORS</strong></td>
<td>163</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td>40</td>
</tr>
<tr>
<td><strong>HOTEL STAFF</strong></td>
<td>35</td>
</tr>
<tr>
<td><strong>HUMBERSIDE FIRE &amp; RESCUE SERVICE</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>NATIONAL PROBATION SERVICE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HUMBERSIDE POLICE</strong></td>
<td></td>
</tr>
</tbody>
</table>
HSCB Training Programme and Course Content

The Board continues to adopt a flexible and dynamic approach to multi-agency safeguarding training. Individual courses are always subject to ‘same-day’ evaluations. Lead trainers actively use participant feedback to review and revise course content, and apply current research, national and local learning to ensure that content is relevant and contemporary.

The programme evolves and develops to try to meet demand and in response to emerging issues and local learning from serious case and other reviews. Key local and national safeguarding themes are ‘threaded through’ all HSCB safeguarding training, for example: that safeguarding is everyone’s responsibility; thresholds; the importance of professional curiosity and challenge.

New training courses have been developed recently in response to specific learning from serious case reviews and new and emerging safeguarding challenges. Other existing courses have been adapted to reflect this learning:

- **HSCB ‘Becoming Culturally Competent’** training was developed in recognition of Hull’s increasingly diverse population, together with learning from the Board’s ‘Diversity Conference’ in 2015 and from major reviews elsewhere which identified practitioner ‘ignorance’ or fear of causing offence acting as barriers to effective intervention.

  “I have learnt to not worry about offending people if you get something wrong. Not to be frightened to report something for fear of being labelled racist”

  “Be more aware of my own values and how this can impact on my work”

- A new course on **‘Responding Effectively to Disclosures’** was developed following specific issues which arose from the HSCB ‘Children with a disability’ work stream. The ‘confidence rating’ for all participants increased after the course:

  “I will feel more confident should a child at my school make a disclosure”

  “The course was delivered very precisely, easy to understand and in a way which will make me always think about how to react to disclosures”

- The Board’s existing **‘Domestic Abuse Awareness: The impact on Adults, Children & Communities’** course was reviewed and updated to include more content specifically in relation to coercive control. Coercive control was a feature in two recently published local serious case reviews:

  “Excellent, informative and interactive. Great information about coercive control”.

  I will “be aware more acutely of the impact of domestic abuse on the families and children I work with.”
The Board staff team have continued to think about ways of achieving a greater ‘reach’ with its training programme, recognising that, in an increasingly busy working life with higher demand across all services and sectors and where training needs and priorities differ markedly across roles and services, it can be difficult to release staff for safeguarding training.

- The ‘Safeguarding Children Online (E-safety) course was adapted from a full-day course to a half-day course. However, the consistent feedback from participants was that the course needed to be longer to ensure enough time and space to properly consider the range of issues covered. As a result, the course has reverted to nearly full-day.

- An increasing use of key briefings designed for safeguarding leads and managers to deliver and cascade within their own workplace:
  - Briefings on the new ‘Neglect Observation Tool’ and ‘Neglect Assessment Framework’ for cascade. During the first six months over 600 practitioners had received the ‘Neglect Observation Tool’ briefing.
  - A new approach to disseminating learning from local serious case reviews. In addition to HSCB briefings, separate briefings were provided for safeguarding leads who were provided with ‘learning packs’ for each recent SCR, designed for use in team meetings & supervision.

**Same-day Evaluations**

It is standard practice that HSCB course participants complete a same-day course evaluation. This evaluation has been recently adapted. Participants are asked to rate their experience of the training on a scale of 1-6 (‘no/poor’ to ‘yes/excellent’) including: the content of the training; the knowledge and ability of the trainer; the usefulness of the training to practice; and whether or not children and young people will directly benefit from the training.

The Board has analysed a total of 908 evaluations (a representative sample from across the programme):

- Overall, 95.6% of participants experienced the Board’s training as either “excellent” (79.5%) or “very good” (16.1%)
- Fewer than 1% of participants provided either a “neutral” rating or “not good”.
- There were strong approval ratings (ratings of ‘6’ & ‘5’) for course content: 94.2%; trainer knowledge and ability: 97.8%; the usefulness of training to practice: 94.3%; and the extent to which training would have a direct benefit to children and young people: 96.4%

Participants are also asked for their views about how the training could be improved, about three key things they have learnt and about what they will do differently as a result of the training.

There were very few suggestions for improvement. Comments from participants included the following:
“I will be confident to challenge and not afraid to ask awkward questions”, school child protection coordinator, ‘Preparation for attendance at a child protection conference’

“I will be using TED (xxxx) when home visiting and 1:1 with families”, ‘Responding effectively to disclosures from children, young people and adults’

I have a “better understanding of sexual abuse of children and the ways grooming takes place”, “Exploring the impact of child sexual abuse”

I will “ensure a DASH is completed with all service users who have or are experiencing potential domestic abuse” (adult substance misuse service practitioner) and I will have “increased awareness when working with families and more confidence in my knowledge of how to support families”, ‘Domestic abuse awareness: The impact on adults, children and the community’.

I will: “ensure I escalate concerns around multi-agency working”; “continue to place the child at the centre of my work and be confident in challenging other professionals”; and “be more aware of my own responsibilities”, ‘Safeguarding children – a shared responsibility (level 2).

I will: “refocus practice so it is not dominated by the adults in the family”; “put myself in the child’s shoes” and “take more time to look at what life is like for the child and consider this even when the service user is the parent”, ‘Hidden harm: Parental substance misuse and the impact on children.’

Many participants (and in particular school child protection coordinators and other designated safeguarding leads) described how they intended to cascade key learning to colleagues in their own workplace.

Course Content and Structure

HSCB trainers carefully consider participant feedback and use this to adapt course content and structure. Courses are regularly reviewed to ensure that the content is relevant, up-to-date, and takes account of current research. Specific learning from local practice audits and serious case reviews is built into training. For example, ‘online safety’ training is reviewed and updated before each course to keep pace with online behaviours and developments. The ‘impact of domestic abuse’ training content was revised recently to ensure a stronger focus on ‘coercive control’.

The Board’s training is devised to maximise the benefits of multi-agency learning, giving participants the opportunity to work in ‘mixed discipline groups’, using case studies and exercises to embed learning, explore dilemmas and develop a better understanding of respective roles and responsibilities. Some common themes are reflected throughout the Board’s training: safeguarding children is everyone’s business; the application of thresholds; and, the need to challenge each other and escalate concerns where there is disagreement, for example.
The Joint HSCB and Safeguarding Adults Board Conference, October 2017 – ‘The Impact of Domestic Abuse’

The Board held a joint conference with the Hull Safeguarding Adults Board to raise understanding about the impact of domestic abuse. The choice of theme reflects the cross-partnership focus on tackling domestic abuse as a key priority. The event attracted the attendance of 138 professionals from a range of organisations and roles.

The conference combined presentations, a powerful play ‘Lady in Red’ by Certain Curtain Theatre Company and workshops. Feedback gathered from delegate evaluations was almost universally positive. Delegates were asked:

What was the most useful part of the day for you?

“Talking to others and learning about local provision to tackle domestic abuse.”

“The drama, learning key messages, networking opportunities.”

“The impact on children and young people workshop. Thought provoking.”

Can you tell us something that you have taken from the day that will inform your practice?

“Greater insight into how the victim might feel. The importance of professional curiosity.”

“To be more mindful of coercive control.”

“A better understanding of the impact on the whole family will drive forward how we provide support and help for the children.”

If we were to run an event like this again what would be your suggestions to improve it?

“Can’t fault what was in place, excellent speakers and venue, I would have loved to attend all the workshops, one of the best courses I have attended.”

“Teachers are aware of the issues – the safeguarding training [provided] is excellent. We need more practical guidance on what to do when suspicions arise but there is no disclosure.”

“More discussion and thinking about how we can work differently with domestic abuse. Services are working well, however domestic abuse remains high in Hull. Services appear to just want women to leave men, this just moves the problem. We need tools to work with people to change values and behaviours……”

Training Priorities Going Forward

• Strengthen the training evaluation processes to better measure the longer-term impact on practice and outcomes
• Review the training currently provided on child sexual exploitation to increase reach
• Better utilise existing HSCB communication channels to strengthen engagement from some key partners
• Strengthen the Board’s pool of trainers available to deliver training on behalf of the Board
• Continue to explore ways of making training more accessible without compromising quality
• Deliver ‘Neglect Awareness’ training to support the Board’s wider development work on ‘neglect’.
## HIGHER LEVEL STRATEGIC VISION

“Our vision is to make Hull an inspiring and enterprising City – safe and healthy to learn, play, work and live in. We want all children and young people and their families to make healthy lifestyle choices, be safe from harm and have the confidence to be ambitious and to achieve their aspirations.”

## HSCB MISSION

“To work together, as organisations and across communities, to ensure that local services and arrangements are effective in keeping children and young people in Hull safe from harm.”

### What? | Key Actions | Success Measures
---|---|---
Reduce the harm to children from Domestic Abuse | Review local DA training offer | Training is effective and accessible  
Promote further use of DASH tool to inform assessments | Relevant DA action plan priorities are achieved  
Ensure effective systems to identify risk | Audits show improved assessment of risk.  
Review and expand the range of services engaging male perpetrators and working with families | ’Change’ programmes show tangible outcomes

Reduce the harm to children from Exploitation (CSE/CCE/Missing/ Trafficking) | Produce problem profile which captures risks and prevalence  
Improve completion rate of return interviews  
Jointly evaluate practice – including MACE arrangements  
Complete strategy – and supporting action plan and performance framework  
Training for taxi drivers as a condition of licence. | Problem profile helps to inform strategic and tactical responses  
Multi-agency audits show good practice and identify areas for development  
100% of Hull’s taxi drivers trained.  
Performance framework captures impact of multi-agency work  
Consistent ’joined up’ systems are in place to identify and meet the needs of children who are being exploited and those who go missing

Continue to strengthen & develop the Board’s quality assurance & performance improvement activity | Regular, routine reporting on Board’s key dataset  
Regular joint evaluation of cases – learning is captured and disseminated  
Develop shared analysis & capture agency QA activity  
Re-visit s11 – progress update on action plans  
Collect and analyse ‘voice and influence’ information from partners | Complete performance reports produced quarterly – enabling the Board to monitor effectiveness and agree improvement priorities  
Multi-agency auditing leads to improved practice  
S11 process shows strengthened safeguarding practices  
Children’s priorities and experiences are captured and used to inform service development

Sustain the Board’s existing statutory functions & support the safe transition to new arrangements in 2019 | Initiate and complete SCRs and LLRs as required – effectively disseminate learning and track actions  
Review all child deaths – identify themes and disseminate learning  
Maintain up-to-date, relevant and accessible guidelines and procedures  
Continue to provide high quality and accessible safeguarding training  
Produce weekly safeguarding bulletins  
Develop and agree plans for new arrangements | Agencies actively use SCR learning materials and feedback on their usefulness  
SCR (and LLR) action plans are tracked and can show improvements  
Reviews of child deaths lead to improved practices  
Training is widely accessed and well-evaluated  
Plans are developed and published for new arrangements
Appendix A

THE BOARD

“An LSCB must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.” Working Together 2015

The HSCB is the key statutory partnership body overseeing child safeguarding arrangements in Hull. The work of the Board is governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006.

The Board is made up of senior representatives from a range of different agencies and organisations each with statutory duties to safeguard children. In addition the Board has direct access to expert advice from designated professionals (doctor and nurse) and the input of Lay Members.

LSCBs have two main objectives as defined in the Children Act 2004: to coordinate the way in which local agencies work together to keep children safe and to ensure that this work is done effectively. The guidance and regulations set out a range of statutory functions in relation to these objectives.

The HSCB does not either directly provide, or commission services, and cannot direct organisations. It does though have a key role in providing advice and challenge and in highlighting where improvement is needed.

KEY ROLES AND RELATIONSHIPS

The Independent Chair

“Every LSCB should have an independent chair who can hold all agencies to account.”

Rick Proctor has been the Independent Chair of the HSCB since May 2015. The role of chair is to lead the Board and ensure that it fulfils its statutory objectives and functions. The chair has a key role in working with all partners to establish a culture of transparency, challenge and improvement which is essential to effective safeguarding work.

The chair is accountable to the local authority Chief Executive for the effective working of the Board. Regular meetings took place between the two during the year. The chair also worked closely with the Director of Children, Young People and Families Services on various safeguarding challenges and improvement priorities.

The HSCB Staff team

The work of the Board is supported by a dedicated staff team which includes a Board manager, professional practice officers, training and development officers, child death and serious case review coordinator and business support.
Between them this group of staff take the lead in ensuring that the Board carries out its core statutory functions, including

- Maintaining and developing up-to-date and relevant multi-agency guidelines, procedures and practice guidance (including thresholds guidance)
- Undertaking child death reviews, serious case reviews and other learning lessons reviews
- Planning, coordinating and leading on the delivery of multi-agency safeguarding training
- Leading on the development of new ways of working in addressing learning from local reviews and/or responding to emerging safeguarding issues
- Disseminating learning from local practice audits and reviews
- Leading on regular multi-agency case auditing.

Kingston upon Hull City Council

The local authority is responsible for establishing the LSCB. The local authority chief executive, drawing on other HSCB partners and, where appropriate the Lead Member for children’s services, holds the chair to account for the effective working of the Board. The Lead Member contributes to the Board as a “participating observer”.

BOARD BUSINESS DURING THE PERIOD

The full Board met on three occasions during the year, based on a model of three full-day meetings each year established in 2016/17. This model had been established to create more ‘space’ for the Board to scrutinise practice and performance on specific priority themes in more detail. The structure of the agenda was adjusted during the year to achieve a better balance between a single ‘thematic’ focus and a wider, but still in-depth, consideration of Board business and priorities.

**Hull Safeguarding Children Board agendas for 2017/18**

**Wednesday 26th July 2017 – 09.30 – 16.00, Hull History Centre**

1. Introductory Session
   1.1. Introductions/Apologies
   1.2. New Director – Introductions
   1.3. Business Group Updates
   1.4. EHASH Update
2. ‘Children Living With Neglect’ – Context
   2.1. What is ‘Neglect’?
   2.2. What do we know about neglect in Hull?
   2.3. Why focus on neglect? – Board priority/JTAI theme
3. Board-led Improvement Work
   3.1. Brief description of the work
   3.2. ‘Draft’ Neglect Strategy
   3.3. Workforce Development Plan
   3.4. ‘Neglect Toolkit’
4. Learning from Practice
4.1. What is our learning from: Baby A SCR & ‘Audit’ Activity?
5. Group Discussions & Plenary
6. Board Member ‘Audit’ Activity
7. Joint Targeted Area Inspection – Developing our Improvement Plan
8. Feedback & Close

Wednesday 29th November 2017 – 09.30 – 16.00, Hull History Centre

1. Introductory Session
   1.1. Introductions/Apologies
   1.2. Minutes of the previous meeting
2. Annual Reports
   2.1. Hull Safeguarding Children Board Annual Report
   2.2. Hull Safeguarding Adults Partnership Board Annual Report
3. Performance Report
4. Continuum of Need (Threshold)
5. Working Together 2018 Consultation
6. Working Together 2018 Feedback
7. Sub-Committee Updates and Priorities
8. Board Structure
9. Any Other Business

Wednesday 7th March 2018 – 11:00 – 14.00, Brunswick House

1. Introductory Session
   1.1. Introductions/Apologies
   1.2. Minutes of the previous meeting
   1.3. Matters arising
2. Ofsted ‘Focused Visit’
3. Children’s Voice and Influence
4. CAMHS Presentation & Performance
5. HSCB Performance Report
6. Quality Assurance & Performance Improvement Sub-Committee
7. Thresholds & Early Help
8. Update from the Board Business Group & Sub-Committees
9. Any Other Business
   9.1. Neglect Strategy
   9.2. Multi-agency safeguarding arrangements

BOARD MEMBERSHIP AND ATTENDANCE

Attendance and broad representation at the Board has continued to be good throughout the year. Where designated Board members have been unable to attend, they have normally ensured that their agency or service is represented by a suitably senior and well-briefed deputy. A list of current Board members is set out at the back of this report.
The attendance rates by agency (and role) for 2017/18 are set out below. The (person symbol here) shows the number of seats per organisation.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
<th>Attendance</th>
<th>No. seats per organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon Bush</td>
<td>Head Teacher, Greenmoor Academy</td>
<td>Representing Primary School Heads</td>
<td>67%</td>
<td>1</td>
</tr>
<tr>
<td>Councillor Peter Clark</td>
<td>Elected Member</td>
<td>Children's Services Hull City Council</td>
<td>67%</td>
<td>1</td>
</tr>
<tr>
<td>Stephen Clay</td>
<td>Board Manager</td>
<td>Hull Safeguarding Adult Partnership Board</td>
<td>33%</td>
<td>2</td>
</tr>
<tr>
<td>Neil Collinghup</td>
<td>Board Manager</td>
<td>Hull Safeguarding Children Board</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Tim Fielding</td>
<td>City Health and Wellbeing Manager</td>
<td>Public Health</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Fiona Fitzpatrick</td>
<td>City Children Safeguarding Manager</td>
<td>Children's Services Hull City Council</td>
<td>87%</td>
<td>3</td>
</tr>
<tr>
<td>Hillary Geldhill</td>
<td>Director of Nursing</td>
<td>Humberside NHS Foundation Trust</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Chloe Halgh</td>
<td>Deputy Director of Nursing</td>
<td>NHS England</td>
<td>33%</td>
<td>1</td>
</tr>
<tr>
<td>Reena Heff</td>
<td>Service Manager</td>
<td>CAP2CASS</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Tracy Hanley</td>
<td>City Safe and Early Intervention Manager</td>
<td>Children's Services Hull City Council</td>
<td>87%</td>
<td>3</td>
</tr>
<tr>
<td>Elaine Hamlett</td>
<td>Interchange Manager</td>
<td>H, L &amp; NV Community Rehabilitation Company</td>
<td>67%</td>
<td>1</td>
</tr>
<tr>
<td>Matthew Hutchinson</td>
<td>Detective Superintendent</td>
<td>Humberside Police</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Brigitte Lastie</td>
<td>Lay Member</td>
<td>Representing the Community</td>
<td>33%</td>
<td>2</td>
</tr>
</tbody>
</table>
The Board has two Lay Members. Lay members make a crucial contribution to the work of the Board: they offer a different, non-professional perspective and help make links between the Board, community groups and the wider community.

For different and unanticipated private and professional reasons our Lay Members have not been able to make the full contribution that they would have wanted to the work of the Board this year.

We will ensure that we work with them during 2018/19 to maximise the contribution that they are able to make.

FINANCIAL ARRANGEMENTS

“All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective.”

Partner agencies continued to contribute to the HSCB’s budget for 2017/18, although the burden of supporting the Board still rests disproportionately with the local authority and CCG.

For the financial year 2017/18 the Board had an income of £376,070 from the following sources:

- Children, YP and Families Services: £220,789
- NHS Hull CCG: £85,000
- Hull Schools (DSG): £35,000
Various partners also make contributions ‘in kind’, for example by providing trainers to help deliver multi-agency training, staff time and free venues. In addition to its direct financial contribution the local authority also meets most of the premises costs and provides the main training venue and administration of the Board’s training programme ‘free of charge’.

The HSCB had historically accrued a surplus (due mainly to a period of time during which income was provided for posts which remained vacant). Key HSCB funding partners agreed that this surplus could be carried over from year to year to sustain HSCB capacity and offset the annual deficit of income compared to spend.

The Board brought forward £92,758 into 2017/18 and will carry forward £47,662 into 2018/19.

Expenditure 2017/18

Staffing (excl Training) - £261,424
Training & Conferences (incl staffing) - £79,227
Printing, supplies and equipment - £7620
Serious case (and other) reviews - £15,213
Independent Chair - £24,780
VCS Safeguarding Support - £34,611