Section 11 Feedback report
March 2014
In 2012 Hull Safeguarding Children Board made a commitment that Section 11 audit would be an ongoing process rather than a stand alone event. The practice of inviting agencies in to ‘talk to’ their audits has received positive feedback from both Board members and agencies who presented.

For the 2013/14 Section 11 audit process, agencies have been asked to reflect on and update existing action plans, and invited to come and have a conversation with a panel of Board members and officers to report on progress made over the last year. Where organisations were not part of the 2012 audit, they were asked to complete a full audit and produce an action plan for the coming year.

In the 2012 feedback sessions the commissioner for substance misuse services presented on behalf of all adult drug and alcohol services. In 2013 an agreement was reached that in order for the Board to make a better connection with individual services, each substance misuse service provider would come to speak to their own audit and action plan.

24 agencies presented their progress over 2 ½ days. 5 Board members supported the process as panel members, this included the Independent Chair. There were 3 organisations completing a Section 11 audit for the first time.

**Format for the 2013 Section 11 Audit**

Following the 2012 audit, a partnership action plan was created by the HSCB officer team, in consultation with sub committee chairs. This action plan highlighted key learning and priorities for the coming year and formed the basis for the 2013/14 review.

All agencies were asked to provide the following information:

- Give an update on the progress made from identified areas for development in your agency action plan.
- Describe the challenges which currently exist within your agency in working with; Forced marriage, Female Genital Mutilation and Missing Children and Child Sexual Exploitation.
Describe how you know that the services you provide or commission make a positive difference to the lives of children and share a recent example of good practice which demonstrates this.

Substance misuse services were asked an additional two questions about:

- Progress on access to appropriate safeguarding children training
- Working below the threshold of Children’s Social Care (Early Help)

This was in order to ascertain specific progress on work completed across these services over 2012/13 and linked back to the outcome of the Ofsted thematic inspection.

This report captures some of the lessons learned in relation to safeguarding children good practice since the 2012 Section 11 audit and some of the challenges faced across services. Examples of good practice have been highlighted throughout the report.

**Reflecting on the learning of the last 12 months - An update on progress**

**Voice of the child**

One of the priorities for HSCB, identified in the 2012 /13 partnership action plan was that more robust processes need to be in place to capture the views of vulnerable children and young people, and that all agencies need to improve or develop ways, specific to their respective services to ensure that these views are not only sought but inform service design and delivery.

HSCB reflected that the partnership need to be able to describe confidently and cohesively how the voice of the child is heard, ensuring that the experiences of children and young people are at the heart of informing what services offer.
Challenges

Services which are primarily adult focussed described having a limited capacity to gain the views of children and young people and the constant challenge of keeping ‘children in focus’ in a predominantly adult orientated service.

Services which are primarily child focussed acknowledged that although children and young people are involved at a ‘micro level’ in case management decision making, capturing and evidencing views at service development level is more challenging.

Some agencies described an ongoing concern about securing the views of children and families in developing services, reflecting that children and young people’s views are gathered but are not well recorded or acted upon to improve service delivery.

There have been some good examples provided within the 2013/14 feedback which relate to listening to the views of adult service users to inform and improve service development and delivery. However examples of where the views of children have directly informed service development have been more limited.

**Hull and East Yorkshire hospital Trust** – have developed a Children’s ward ‘Bedside folder’ – they did this in consultation with some local primary school children. The book includes pictures drawn by children.

The aim of the bedside book is to help children understand better what is happening to them when they are staying in hospital. It includes useful information under headings such as ‘What can I bring into hospital with me?’ and ‘can anyone stay with me’

Private fostering

The HSCB partnership action plan 2012/13 determined that more Private Fostering briefings were needed to ensure that professionals across the partnership are aware of their responsibilities. There was a commitment to reinvigorate the Private Fostering workstream in order to support this, and to revisit how the HSCB can further raise awareness.
The 2013/14 audit highlighted that some organisations still had limited understanding about their responsibilities in relation to Private Fostering, identifying a need for continued awareness raising. This is consistent with the findings from the Ofsted thematic *Private fostering: better information, better understanding* (Jan 2014).

**CRI (Crime Reduction Initiatives) - Private Fostering**

CRI is a social care and health charity working with individuals, families and communities across England and Wales that are affected by drugs, alcohol, crime, homelessness, domestic abuse and antisocial behaviour.

Prior to the 2012 Section 11 audit process Private Fostering hadn’t been fully understood by staff across CRI both locally and nationally.

The service identified that the client group that used their service frequently made arrangements amongst themselves/ with neighbours for their children to be cared for by each other.

Having a heightened awareness about the implications of Private Fostering arrangements for substance misusing clients, the service manager put this on the agenda of the organisation at a national level.

Since the 2012 audit, Private Fostering information has been incorporated into policy, training and induction across the whole organisation. CRI are now able to report that this has resulted in a small number of notifications of Private Fostering arrangements to the Children’s Social Care, but in the majority of cases parents upon hearing the information taken their children back home.

**Accessing appropriate Safeguarding Training**

Following the 2012 Section 11 audit, the Training and Development Sub group have produced a Training Strategy on behalf of the HSCB. This is designed to support organisations in assessing the training need within their workforce.

The HSCB also provide a comprehensive multi agency training programme. Where organisations complete their own in house safeguarding training this can be quality assured by the HSCB Training and Development Officers.
In 2012, 2400 professionals from multi agency backgrounds attended the Safeguarding level 1: A shared responsibility training

Challenges

- There is an overall reduced capacity to release staff to attend training.

- For some organisations there needs to be a training needs analysis which will inform decisions about future training and mapping this to competences and personal development plans.

- There is work still to be undertaken on increasing staff confidence in respect of information sharing both below the threshold of concern about significant harm and above.

- HSCB courses are positively evaluated. However evidence of how HSCB training is embedded in practice and what the impact of this training is on practice is still limited and this information needs to be more routinely sought and recorded.

Good practice

- Many organisations describe having a robust staff training programme in place, including additional training for safeguarding leads which supports them with additional responsibility commensurate with the role. This additional responsibility is now more routinely reflected in safeguarding leads’ job descriptions.

- More agencies are now reporting that managers are trained in safer recruitment and that interview panels include as a minimum one person trained in safer recruitment.

- Some organisations describe having a dedicated team or individual who has an oversight of organisational training and development.

**Hull City Council Housing – Introduction to safeguarding training**

Hull City Council housing have ensured that all Kingston Works Ltd (KWL) Construction and maintenance staff have attended the introduction to safeguarding training and there is a commitment to ensure that all contractors have also accessed this same level of training.
Humberside Police – Instance response staff training
As a result of the 2012 Section 11 process, Humberside Police Instant Response staff have accessed HSCB Introduction to Safeguarding training

Substance misuse services - Training audit
During the 2012 Section 11 audit it became apparent that there was lack of knowledge about the safeguarding children training needs for adult substance misuse workers.

In response to this the commissioner for drug and alcohol services worked alongside all drug and alcohol service providers, the Partnership Learning Centre and the HSCB in order to produce a comprehensive training audit. Including how many substance misuse staff had attended.

- HSCB level 1: A shared responsibility (or equivalent)
- Thresholds of need briefing
- Hidden harm, the impact of parental substance misuse on children.

This audit identified there was a training need across the substance misuse workforce and an overview report was produced on the findings which was shared with substance misuse services.

During the 2013 Section 11 audit feedback event, substance misuse services were given the opportunity to reflect on the impact of this audit and some of the changes they had implemented as a result of it:

- All staff, including peer mentors and volunteers now attend as a minimum safeguarding level 1
- There is a focus on the regular review of level 1 after 3 years
- An appraisal process is in place which regularly flags staff training requirements and development.
- The value of multi agency training has been reinforced for those services who would previously have only attended single agency training.
Supervision

In the 2012 audit a number of agencies described supervision as being ‘ad hoc’ or ‘when needed’ basis. Those individuals who are supervising staff working with children and families in the safeguarding arena should have access to high quality supervision training.

From the self reporting in the 2013/14 audit, information would suggest that processes are being put in place more consistently across organisations which recognise the importance of reflective supervision for all staff working in the safeguarding arena.

Safeguarding is increasingly a standing agenda item in supervision, in multi agency meetings and in team meetings.

### Hull and East Yorkshire hospital Trust – Supervision Practice

Supervision training has been undertaken with 70 staff (Midwifery and Community Midwifery) so far this has been developed from HMH training and includes in the package: research; KOLBS reflective cycle; and Toni Morrison’s 4x4x4 model.

A list of supervisors is available for staff who work out of hours. Group supervision is held on a monthly basis and midwives who are case holders each have a planned one hour session every 3 months which can be more frequent on request.

There is also a recommendation that these supervisors undertake some additional training – HSCB Level 2 Safeguarding children and Domestic Abuse Awareness.

The plan is to next role out supervision training to paediatric wards, children’s wards and the Accident and Emergency Department.

There will be an audit of the quality of this supervision.

### Diversity - Responding to the changing needs of the local community

As part of the 2012/13 partnership action plan, HSCB established the ‘Diversity; of faith, culture and community’ workstream, acknowledging a need for an increased understanding of and
appropriate multi agency response to the safeguarding challenges that arise from having an increasingly diverse population.

Feedback from this audit seems to suggest that there is still a lack of understanding around the needs of the local population across the city. The 2011 census results indicate that 11% of the population of Hull are non white British. This is an increase in diversity not necessarily reflected within all organisations service user numbers. The reasons for this have not been fully explored.

A key area identified through the 2012 audit and also reiterated in the 2013/14 audit is that access to and use of interpreters in working with children and young people and their families needs to be more consistent across the partnership.

**Good practice**

A number of services have recognised the importance of using independent interpreters on a regular basis. This has highlighted to those services the importance of understanding subtleties that can be lost in language where interpreters are not used.

Some organisations shared their knowledge about individual pieces of work which were responsive to the emerging needs of their changing service user groups. Describing good inter agency communication and relationship building as being key to securing positive outcomes for children.

**Sports development – Responding to the needs of the local community**

In order to develop the ‘Active Women programme’, we consulted with women areas identified by the ‘insight team’ as having a greater need for service.

Consultation took place through various means, including existing groups in children’s centres, playground discussions, facebook and twitter.

From the consultation we were able to set up sessions based on the needs of the ladies. Some told us that they wanted to have female only sessions with a female instructor as they felt more comfortable exercising this way.

We were then able to approach the coach provider network who identified which coaches could deliver sessions and commission the correct sessions accordingly based on need.
Forced Marriage

Responses to the question about Forced Marriage suggests that this is an area of safeguarding which needs a lot more consideration in order to increase knowledge, awareness and appropriate response locally.

Some agencies have provided feedback that in considering the question about Forced Marriage as part of the Section 11 review, this has highlighted issues for practice and procedure which may not have been explored otherwise.

Challenges

- Seven agencies reported that they were not aware of Forced Marriage having affected anyone in their client group or it ever having come to their attention

- Very few agencies spoke confidently about their understanding of and their organisational response to Forced Marriage

- The response to Forced Marriage is reported as being reactive rather than proactive

- More work needs to be done in this area to raise awareness, particularly linking with Honour Based Violence

- There is a potential that perpetrators may be being used as interpreters

- Some organisations face difficulties in recording information when there is forced marriage or suspected forced marriage. Describing difficulties in being able to protect the identities of individuals at risk
Good practice

• Some organisations have a dedicated ‘lead’ or ‘specialist’ that they can liaise with, if not locally then nationally

• MARACs where there has been suspected Forced Marriage have been ‘closed’ in recognition of the sensitivity needed around information sharing

• Forced Marriage is covered within the domestic violence policy for some organisations

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<th>DAP – Forced Marriage risk assessment</th>
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<td>The risk assessment that DAP use for Forced Marriage and Honour Based Violence is adapted from the ACPO model used by police</td>
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Female Genital Mutilation (FGM)

• Seven organisations said that they had not come across this issue within their client group.

• There was acknowledgement that there is a big gap in knowledge around FGM locally and that more awareness raising work needs to be done.

• Some representatives explained that they thought that awareness around this issue has been raised, but ‘when next?’ That there needs to be some work done on referral pathways.

Good practice

• Some practitioners have attended the awareness sessions delivered by Forward on behalf of HSCB

• Services which have been established to work with directly with newly arrived communities, such as the Gateway Project. These services are able to describe a better understanding of working with FGM

• Some teams have nominated individual practitioners as leads for FGM whose responsibility it is to find out more
A multi agency group of practitioners, managers and strategic leads have started work on local referral pathways

**Missing Children and Child Sexual Exploitation (CSE)**

Most organisations were able to describe some level of understanding about Child Sexual Exploitation. This could be in terms of an adult service identifying a potential perpetrator, or services working directly with children and young people recognising the signs that a young person may be being exploited.

Where good practice was identified it included good multi agency communication, including attendance at multi agency meetings, whether operationally or strategically.

There is recognition by some organisations that within their own service that are more aware and able to respond to this issue than others and that more targeted training might be needed to ensure consistency of recognition and response.

### City Health Care Partnership – Missing and Child Sexual Exploitation

In response to feedback from frontline school nurses about heightened concern for vulnerable children who go missing. The team developed services in response to this, focussing on: Children educated at home, Looked After Children, Missing from school, Pupil Referral Units.

Staff have been employed specifically to engage and work with these groups. There are 1000 children on the ‘managed’ caseload of the specialist vulnerable children’s team but there will be a smaller more ‘active’ caseload.

The CHCP Health Service have an allocated health professional who attends the operational Child Sexual Exploitation and Missing group.

All young people 5-19 years are able to access support for their emotional, physical and sexual health through School Health Services. This support is offered following assessment of individual need. If concerns are raised around sexual exploitation health professionals will liaise and share information with partner agencies to formulate a plan of care.
Making a better connection

One of the key themes identified in the 2012/13 partnership action plan was a priority for the Board to ‘make a better connection’.

Over the last year Board members have been ‘getting out and about’ into frontline services to explore the views and perspectives of staff working directly with children and families.

Making a better connection is an activity which is intended to increase HSCB understanding about how practitioners see their role in safeguarding, explore their confidence in this role, their confidence in the system overall and how things might be different. It is also intended raise awareness of the HSCB activity.

Making a better connection

On 19th December Board member - Safeguarding Children manager and Learning and improvement sub group member from the Youth Justice Service visited a team of Health Visitors, Nursery Staff and School Nurses.

Strengths identified:

- Joint training and shared network events were important
- The strength of relationships with key partners at a local level
- The new ‘Strengthening Families’ model was working well
- The health visitors agreed that they offer universal services to families and are generally well received into family homes and that they were able to recognise when there are issues. They felt that ‘early help’ was key and that safeguarding should be an ethos not a process.

Areas for development:

- Joined up systems
- Improved communication
- Who is doing what? – Clear roles and responsibilities
- Co-location/co-working
How do we know what we do makes a positive difference to the lives of children?

In the 2013/14 audit, representatives were asked to describe how they know that the services they provide or commission make a positive difference to the lives of children. They were also asked to provide a recent example of good practice which demonstrates this.

Case examples were variable in depth and quality. Some organisations demonstrated that they are at the early stages in their understanding of how what they do makes a difference to the lives of children and young people.

Other examples provided described an organisational commitment to understanding how what they do makes a difference to the lives of children and young people, from strategic oversight to operational practice, incorporated into staff induction, training and supervision, with clear mechanisms in place for continuous evaluation and development.

What Organisational good practice looks like.

Consistent themes evident in good practice examples:

- A commitment to embed safeguarding ‘best practice’ throughout the whole organisation, ensuring that every part of the system does what they can to support safeguarding work, ultimately to safeguard children

- A robust process of checking the robustness of safeguarding processes of all services that are commissioned

- A good understanding of the nature and capabilities of their own workforce

- Able to clearly describe how staff are informed about safeguarding children responsibilities, through induction, supervision, personal development and appraisal

- A robust quality assurance and performance management framework with systems in place for continuous development
and learning across the whole organisation, including where the results of audit activity are fed back directly to staff members in reflective supervision sessions

- Having the agility to respond as an organisation to feedback from service users and being creative in developing services to meet the needs of the local community

- Regular review and dissemination of child protection policy and procedures. When internal procedures are updated / reviewed this information is reissued / disseminated through the staff development process

- Regular and consistent dissemination of lessons learned throughout the whole organisation, using various methods, such as intranet, email, blogs, briefings, through supervision and training.

- Some organisations have a specialist safeguarding team who have additional responsibility and training to support the role to act as advisors to other staff within the organisation

Organisational good practice – Case examples

**Humberside Probation Trust**

The IQAM (Integrated Quality Assurance Model) is a quality assurance model developed by Humberside Probation to assess the quality of work across the service.

Trained auditors within the probation service quality assure work using this framework to assess and measure progress against Humberside Probation Trust’s Improvement and development plan and evaluate quality of practice across Humberside Probation Trust.

The IQAM audit tool generates percentage quality scores across the 5 phases of offender engagement. In addition, scores are also generated from bespoke; thematic audits, for instance MAPPA, Child safeguarding. The scores are then used to benchmark quality and evidence future improvement in the quality of work undertaken across Humberside probation trust

25% of cases are audited over the year- Any themes that arise would result in specific actions. Audits are completed by the Central Audit team and feedback from the audits is provided to all Offender Managers via reflective supervision with their manager.
RAPT (Rehabilitation of Addicted Prisoners Trust)

18 months ago RAPt recruited a head of governance and quality who has been putting systems into action throughout the organisation which can look at trends and patterns.

Each service completes a quality audit and reports this on a quarterly basis to cluster / regional managers – this then gets reported to a clinical governance committee and the senior leadership team (these are the Board of trustees) – any collective learning is communicated back throughout the whole organisation. This could be via the intranet.

There are site visits by the senior leadership team and they take a whole system approach to quality assurance.

There is a serious untoward incident process which also informs learning – as an organisation RAPt would like to explore ways in which this learning can be shared with partners also.

What Individual good practice looks like.

Consistent themes evident in good practice examples:

- Being able to clearly describe the impact or potential impact of harm on children.

- Good multi agency communication and negotiated joint working, including joint planning and review in reflective multi agency meetings.

- Robust case specific information sharing arrangements.

- Longevity of pieces of work – ‘staying with’ the individual client and working at their pace.

- Decisions about individual care are informed by what children and young people are saying.

- Feedback to parents in an open and transparent way about the impact of their behaviours on children and young people.
• Safeguarding routinely discussed at team meetings and in reflective supervision – and documented

• Specialist supervision for staff in recognition of the impact of managing high levels of risk

• Observation of direct practice and feedback directly to the worker in reflective supervision

• Examples of proactive rather than just reactive practice.

• A recognition of the importance of accurate record keeping in order to monitor and evaluate change - examples such as the ‘outcomes star’ and regularly reviewed ‘welfare logs’ were described

• Partnership working to access specialist support for an individual child, young person or family

• Safeguarding is a standing item in supervision – with managers trained to deliver safeguarding supervision.

• Working creatively – thinking outside the box

• Having a whole family approach – whilst remaining child focussed

• Promoting the early identification of emerging problems with regard to issues that would impact on parenting capacity and referral routes into appropriate specialist services from a universal level – i.e. alcohol screening
Individual good practice – Case examples

**CRI (Crime Reduction Initiatives) - Early help**

Mary, was 19 and was using heroin when she discovered she was pregnant. She accessed substance misuse support through CRI to help her become drug free prior to her baby being born. CRI worked alongside other agencies to deliver a package of support for Mary and her unborn baby which meant that she although Children’s Social Care were consulted, with regard to risk management, Mary was able to achieve her goals without Children’s Social Care needing to formerly intervene

**Key Themes**
- Early intervention
- Joint working across agencies HMP Hull, CRI, Health, Extended family (Mary’s parents) Children’s centres
- Support for Mary from CRI was ongoing from arrest referral, through custodial sentence,
- When Mary gave birth she was 100% drug free
- Support post pregnancy Mary was fully integrated into community in terms of being not only linked to but engaging with Children’s Centres

**Domestic Abuse Partnership (DAP) – Working with complex needs**

Example provided through audio interview of a mother who sought support from DAP and spoke about the difficulties she experienced leaving a DV relationship, the impact on her and her child and other agencies responses.

**Themes**
- A very clear reflection by this mother about the consistent and sustained support she received
- Sticking with it
- Clear evidence of multi agency working especially between police, DAP, benefit agencies, school, university and housing providers
- In this example the impact of living with DV on her child was clearly recognised by the mother and addressed
- Evidence of how a wrap around support service can effect positive outcomes for children
- Use of a toolkit used women in the BRAVE group we have a copy which includes feedback from women who have attended this group
Hull Training - Working with older young people

The case study of young person A provided an example of the safeguarding pastoral and learning support in place throughout Hull Training. This described:

- A young person centred approach
- Engaging with hard to reach vulnerable young people with complex needs
- Working with a young person at their own pace
- Responding to immediate need / changing circumstances
- Robust internal safeguarding procedures
- Good multi agency communication
- Identifying and addressing barriers to learning which are unique to the individual young person

As a result of the support offered to young person A is on track to complete her first qualification and shows increased confidence and self esteem.

Next steps

Key learning from this report will be fed back to the Hull Safeguarding Children Board in March 2014 for consideration.

Sub group and workstream leads will meet to discuss the detail of this report and support the creation of the 13/14 Section 11 partnership action plan.