CABINET AGENDA

HARTLEPOOL
BOROUGH COUNCIL

20 August 2012

at 9.30 am

**in Committee Room B,
Civic Centre, Hartlepool**

MEMBERS: CABINET:

The Mayor, Stuart Drummond

Councillors Hill, Lauderdale and Thompson.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   To receive the Record of Decision in respect of the meeting held on 6 August 2012 (previously circulated)

4. **BUDGET AND POLICY FRAMEWORK**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   No items.

7. **ITEMS FOR DISCUSSION/INFORMATION**

   7.1 Annual Report and Business Plan of the Hartlepool Safeguarding Children Board 2011-2012 - *Director of Child and Adult Services*

8. **REPORTS FROM OVERVIEW OF SCRUTINY FORUMS**

   No items.

CABINET REPORT

20th August 2012

Report of: Director of Child and Adult Services

Subject: ANNUAL REPORT AND BUSINESS PLAN OF THE HARTLEPOOL SAFEGUARDING CHILDREN BOARD 2011-2012

1. TYPE OF DECISION/APPLICABLE CATEGORY

Non key

2. PURPOSE OF REPORT

2.1 To inform Cabinet of the publication of the Annual Report and Business Plan of the Hartlepool Safeguarding Children Board

3. BACKGROUND

3.1 The core objectives of Hartlepool Safeguarding Children Board are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and
- To ensure the effectiveness of what is done by each such person or body for that purpose.

3.2 The Apprenticeships, Skills, Children and Learning Act 2009 introduced the requirement for Safeguarding Children Boards to produce and publish an Annual Report on the effectiveness of safeguarding in the local area. The report should provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children, set against a comprehensive analysis of the local safeguarding context. It should recognise achievements and the progress that has been made in the local authority area as well as providing a realistic assessment of the challenges that still remain.

3.3 Hartlepool Safeguarding Children Board have produced and published such a report each year since 2008. Each has reported positive progress in meeting the outcomes set the previous year.

4. SUMMARY

4.1 The report consists of three parts:

- The Annual Report for 2011 – 12;
- A Performance Book in which there is a comprehensive set of data and reports that support the conclusions contained in the Annual Report; and
- The Business Plan for 2012 – 13.

4.2 The Annual report published in 2011 confirmed the following priorities for the work of the Board during 2011-2012:

- Children and young people live in households where they are properly cared for, all of their needs are met and they are free from the impact of neglect.
- Children and young people live free from the impact of Domestic Violence
- Adolescents in Hartlepool are supported to make safer choices and are safeguarded from significant harm
- Children and young people safely access and use existing and
- emerging technologies to aid their enjoyment and achievement.
- Staff working with children and young people are suitably trained to meet their needs

4.3 In her Forward, the Independent Chair of the Board thanked staff of all of the agencies who have worked hard during the year to help the board achieve its overall objective that **Children Live Safely In Hartlepool**. She recognised the challenges facing the Board in a time when agencies are facing financial cutbacks and change but felt that the Board remained committed to keeping a clear focus on safeguarding and retaining the excellent progress that has already been made.

4.4 The Board is supported by an Executive Group and a number of sub groups that progress the action plans agreed by the Board to tackle the issues identified as the Board's priorities. The membership of the various groups is multi-agency. Staff also contribute to the work of the Tees wide groups that ensure consistency and reduce duplication.

4.5 The funding of the Board is from a pooled budget with contributions from the main agencies. Expenditure has been curtailed but the income levels have not fully kept pace and the report concludes that financial commitment from all agencies is critical to ensure the full effectiveness of the work of the Board.

4.6 During the year two success conferences were held, one on risk taking behaviour by adolescents and one on parental substance misuse. The multi disciplinary audience gave excellent feedback on the usefulness of both conferences.

4.7 In relation to children within the child protection system, in common with the national trend, there has been an increase in the number who have become subject of a protection plan. Those aged up to 9 continue to constitute the majority on a plan – although there has been an increase in the number of teenagers this year. Neglect is still by far the most common category at 81%. There has been a slight rise in children becoming subject to a plan for a second or subsequent time during this year but as part of a downward trend. There is evidence of several agencies working with families before the child becomes subject of a plan and there is also evidence of social work support to families being continued after ceasing to be on a plan – often for a prolonged period to ensure an effective transition to support from universal services and preventing a return to the child protection system.

4.8 Individual agencies have reported positively on safeguarding with the Fire Service noting no child deaths in house fires during the year. A similar picture of low child road casualties was also recorded from the Road Safety Unit.

4.9 There has been a reduction in the overall n umber of children and young people who were reported as Running/Missing from Home/Care from the previous year and this allied with the finding that the greatest reduction was in relation to those children and young people who had done so more than once, strongly suggests that the introduction of independent interviews with those identified as potentially more vulnerable has been a successful innovation.

4.10 The result of a self audit survey of the agencies providing a direct service to children and young people concluded that there were no areas of concern or risk.

4.11 The training priorities for the year were met and included further development of training in conjunction with all of the schools.

4.12 There were no Serious Case Reviews initiated during the year but one case involving long term neglect was overlaid with sexual abuse was dealt with under the auspices of a Learning Review. Feedback to staff of all agencies on the main lessons has been done.

4.13 The analysis of local safeguarding activity concludes on page 17 of the Performance Book that:

> "*Overall, the information contained in this report supports the assertion that agencies are safeguarding the children of Hartlepool and the Board is fulfilling its responsibility for this aspect of the role."*

4.14 In setting priorities for the forthcoming year the Board, at its development day decided to retain the existing priorities for next year, 2012 - 2013, given the large agenda associated w ith those issues.

4.15 The Business plan for the Board is based on the priorities noted in section 4.2 above. The action plans seek to identify specific actions that will lead to improvements in the lives of children in each of the priority areas. One particular aspect of the Business plan is the need to provide evidence of the impact of the work of the Board on children.

4.16 At the Hartlepool Safeguarding Children Board meeting on 10th July 2012, the Annual Report and Business Plan were agreed subject to two short reports that were presented late being agreed via the electronic process subsequently. Unanimous agreement was confirmed on 3rd August 2012.

4.17 The Report will be published on the Board web site www.lscbhartlepool.org.uk. A copy must be passed to the Chief Executive of the Local Authority and Police and Crime Commissioner [when appointed].

5. FINANCIAL CONSIDERATIONS

5.1 Hartlepool Safeguarding Children Board is funded on a pooled basis with contributions from the main agencies with the local authority as the major contributor. While there are financial pressures generally, this report has no financial repercussions for the authority.

6. RECOMMENDATION

6.1 That the Annual report and Business Plan be received by Cabinet.

7. APPENDICES AVAILABLE ON REQUEST, IN THE MEMBERS LIBRARY AND ON-LINE

- Appendix 1 - Hartlepool Safeguarding Children Board Annual Report 2011 – 2012
- Appendix 2 - Hartlepool Safeguarding Children Board Annual Report Performance Book
- Appendix 3 - Hartlepool Safeguarding Children Board Business Plan 2012 – 2013

8. BACKGROUND PAPERS

8.1 The Apprenticeships, Skills, Children and Learning Act 2009

9. CONTACT OFFICER

Sally Robinson, Assistant Director (Prevention, Safeguarding and Specialist Services), Child and Adult Services, Level 4, Civic Centre. Tel (01429) 523732. Email sally.robinson@hartlepool.gov.uk

Hartlepool safeguarding children board

Annual Report

April 2011 – March 2012

Hartlepool Safeguarding Children Board

Annual Report 2011-12

&

Business Plan 2012 – 13

CHILDREN LIVE SAFELY IN HARTLEPOOL

To support that overarching outcome, the following outcomes remain priorities of the Board

1. Children and young people live in households where they are properly cared for, all of their needs are met and they are free from the impact of neglect.
2. Children and young people live free from the impact of Domestic Violence.
3. Adolescents in Hartlepool are supported to make safer choices and are safeguarded from significant harm.
4. Children and young people safely access and use existing and emerging technologies to aid their enjoyment and achievement.
5. Staff working with children and young people are suitably trained to meet their needs.

The Board acknowledges the hard work that has been done by staff of all agencies throughout the last year that has contributed to the successful progress made on the priorities set out in the Annual Report and Business Plan 2011. Chairs of Subgroups and Task and Finish Groups are also thanked for their written contributions that are contained within this report.

Agreed by Hartlepool Safeguarding Children Board on _____and published on _____

Contents

Forward

I am delighted to introduce this report of the Hartlepool Safeguarding Children Board (HSCB). Since I took up the role as the Board's first Independent Chair, I have been impressed by the commitment of all Board partners to work together to improve safeguarding arrangements in Hartlepool, to operate in a spirit of mutual support and challenge, and to endeavour to make the Board's work open and transparent to the wider public. The Board's focus has rightly remained on what is in children's best interests, and to making a difference to the children and young people of Hartlepool.

I'd like to take this opportunity to record my thanks to Nicola Bailey who provided quality leadership to the Board during the time prior to the appointment of the Independent Chair, and who continues in her commitment to safeguarding in Hartlepool.

The Board and its subgroups have worked hard to deliver the objectives set and to respond to emerging challenges and changing agendas. This is testament to the hard work put in by staff at all levels and across all organisations. And yet there is more still to achieve.

Having a skilled and effective workforce in every partner agency is key to safeguarding children. The Board has commissioned and coordinated a robust multi agency training programme in safeguarding and in addition through developing further the audit programme has begun the process of incorporating challenge and reflection. This will over time result in further improvements in practice to keep our children safe.

I am particularly pleased that the Board has begun to work more directly to listen to the views of young people in relation to the work of the Board. I have no doubt that the young people will ask us some tough questions and I know that all partner agencies will rise to the challenge of answering those questions.

The future for safeguarding and the capacity of the Board to maintain its momentum looks very challenging in the climate of financial cutbacks and rapid change. Every partner agency is facing significant losses of funding and staff, which will inevitably impact on work of the Board and its sub groups. In the months ahead, the Board is committed to keeping a clear focus on safeguarding, particularly for those who are most vulnerable, and in ensuring the impressive progress of recent years is not lost in the change process. I look forward to leading the Board through the challenges ahead.

I would like to thank the staff from all agencies who have worked hard during the year to help the Board in its attempt to meet its overarching objective of:

Children Live Safely In Hartlepool

Eileen Hinds

Introduction

Reporting of the work of Hartlepool Safeguarding Children Board has been published in three parts; this Annual Report that highlights the priorities agreed for this year, how far the Board and the agencies met those priorities and confirmation of the key objectives for the forthcoming year; The Business Plan for 2012 – 13; and the Performance Booklet that gives the detailed information of all aspects of the performance of the sub groups and the overall Safeguarding Activity from referral to the child no longer being subject to a Protection Plan. The three documents constitute a suite that will give a comprehensive account of the activity of the Board and make it easy to access the information.

Governance Arrangements

Hartlepool Safeguarding Children Board is accountable to the Local Authority Chief Executive and has a specific interface with the Children's Trust, although that relationship will be shared with the Health and Wellbeing Board when it becomes fully operational. The Board continues to meet bi-monthly under their Independent Chair and are supported by the Executive Group and a number of sub groups. The Board plays a key role in co-ordinating the efforts of agencies in safeguarding children in Hartlepool.

Hartlepool Safeguarding Children Board

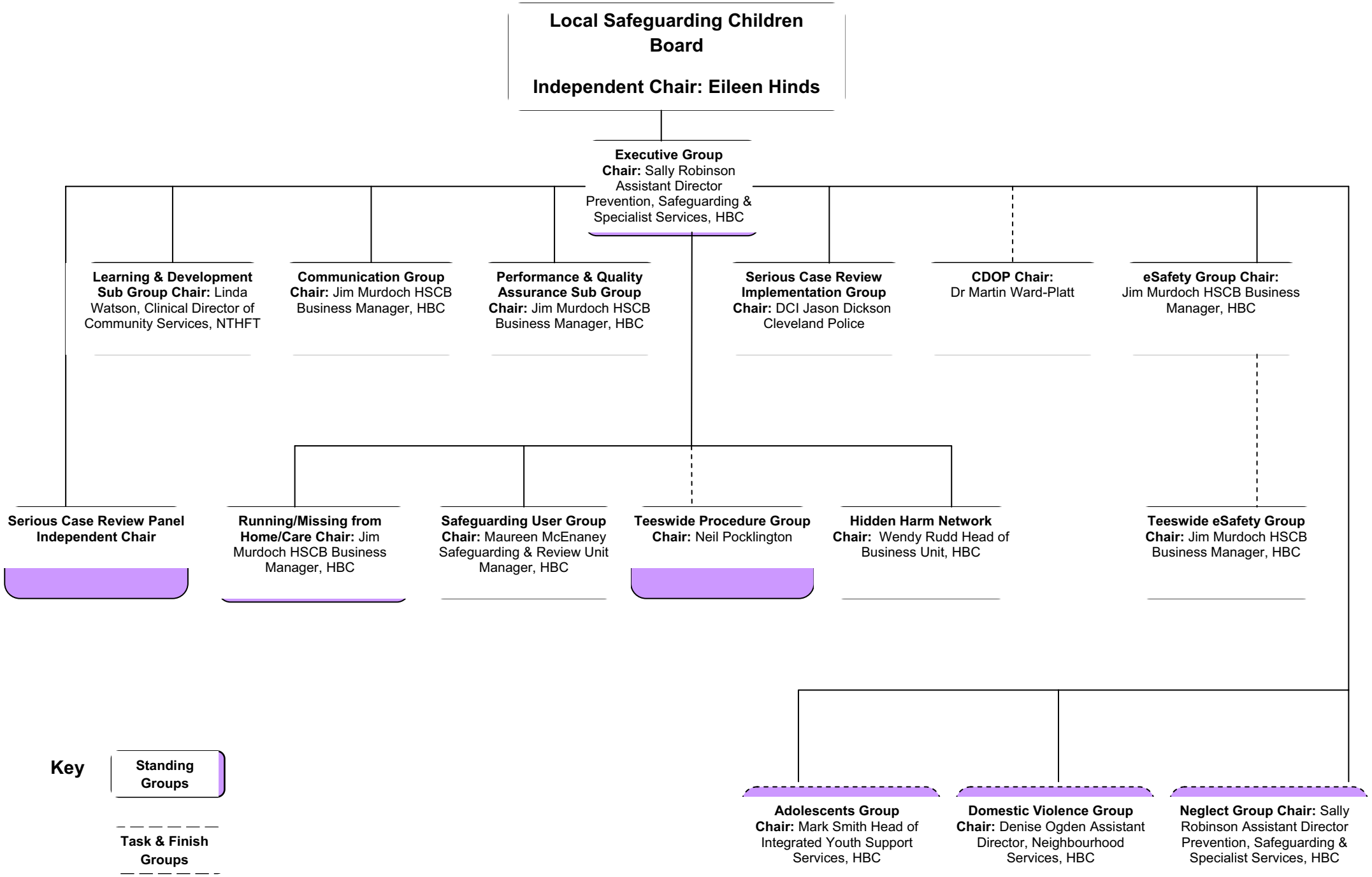
The membership of the Board continues to give full support to its work and there is a high level of participation by most members, including the most recently appointed Lay members.

The requirement to operate a Child Death Overview Panel continues to be met by the joint arrangement with the neighbouring Boards on Teesside assisted by the regional contract that ensures that all of the statistical information is made available to the Panel. Their annual report is published and a copy can be located on the Board website www.lscbhartlepool.org.uk

The Executive Group acts to co-ordinate the work of the Board and manages much of the work of the Board with all of the standing sub groups reporting to it. Details of the groups are given below.

During the year the Policy, Procedure and Practice sub group was disbanded as all of its functions could be met by other groups, especially following the production of the web based Teeswide Child Protection Procedures. The remaining subgroups have all largely achieved their action plans with any outstanding issues likely to be completed before the end of July 2012.

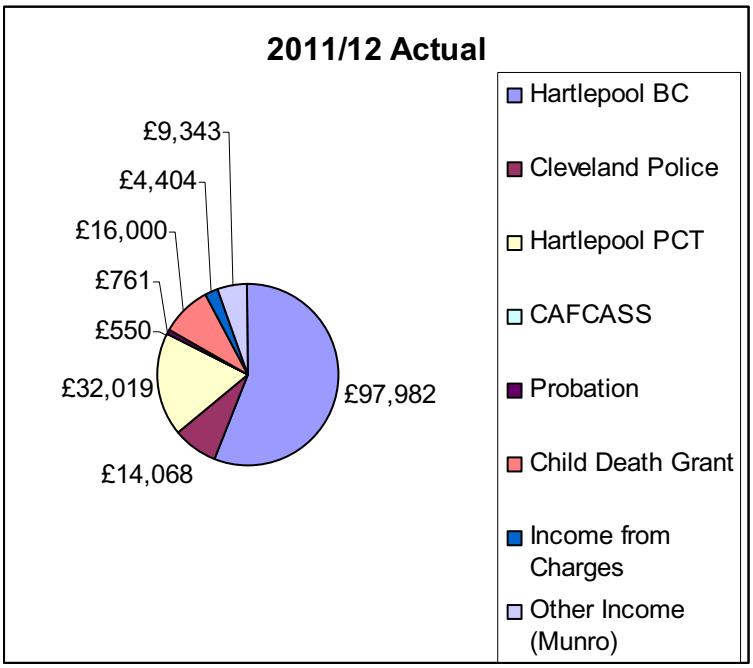
Two of the sub groups – Learning and Development Group and the Running/Missing from Home/Care Group produce Annual Reports and these are included in the Performance Booklet. The other groups have action plans that are derived from the key outcomes of the Board and the action plans for the forthcoming year are detailed in the Business Plan document as are the action plans for the three Task & Finish Groups that have been established to carry forward the recommendations of the major reports received by the Board in the last 18 months – Neglect, Domestic Violence and Safeguarding Adolescents.


Local Safeguarding Children Board
Independent Chair: Eileen Hinds
Executive Group
Chair: Sally Robinson Assistant Director Prevention, Safeguarding & Specialist Services, HBC
Learning & Development Sub Group Chair: Linda Watson, Clinical Director of Community Services, NTHFT
Communication Group Chair: Jim Murdoch HSCB Business Manager, HBC
Performance & Quality Assurance Sub Group Chair: Jim Murdoch HSCB Business Manager, HBC
Serious Case Review Implementation Group Chair: DCI Jason Dickson Cleveland Police
CDOP Chair: Dr Martin Ward-Platt
eSafety Group Chair: Jim Murdoch HSCB Business Manager, HBC
Serious Case Review Panel Independent Chair
Running/Missing from Home/Care Chair: Jim Murdoch HSCB Business Manager, HBC
Safeguarding User Group Chair: Maureen McEnaney Safeguarding & Review Unit Manager, HBC
Teeswide Procedure Group Chair: Neil Pocklington
Hidden Harm Network Chair: Wendy Rudd Head of Business Unit, HBC
Teeswide eSafety Group Chair: Jim Murdoch HSCB Business Manager, HBC
Adolescents Group Chair: Mark Smith Head of Integrated Youth Support Services, HBC
Domestic Violence Group Chair: Denise Ogden Assistant Director, Neighbourhood Services, HBC
Neglect Group Chair: Sally Robinson Assistant Director Prevention, Safeguarding & Specialist Services, HBC
Key
Standing Groups
Task & Finish Groups

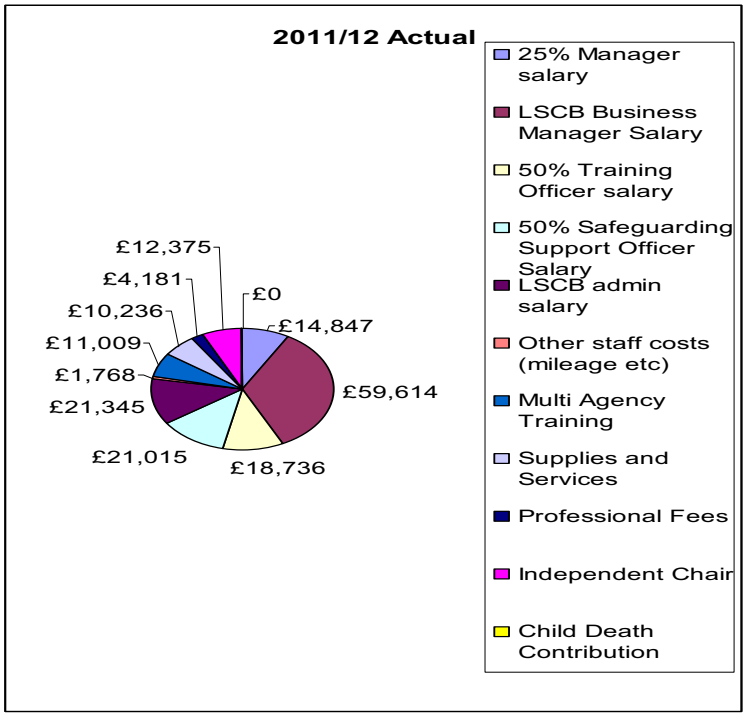
Funding

There have been significant financial challenges during this year with only one of the main contributors to the budget giving inflation uplift in their contribution – the local authority. There have been strenuous efforts made to reduce expenditure across the whole budget and producing the Board web site with the support of the local authority rather than commissioning that area of work has led to a significant saving. It was recognised that the appointment of an Independent Chair would have a financial impact as well as the advantages of the independent input. Part way through the year it was recognised that to obtain the maximum advantage, the chair needed to attend additional regional meetings and this required adjustments within the budget. The new level of up to 24 days of work is seen as the most cost effective and the 2012-13 budget reflects this.

Income 2011-12.



Expenditure 2011-12



Since the current funding arrangement came into place in 2007/8, there have been corresponding increases in both income and expenditure. A reserve was built up in the first two financial years to ensure that the extra-ordinary expenditure arising from Serious Case Reviews or similar could be met, at least in part, without placing a major demand on agencies in that particular year. That reserve has been reducing each year to ensure that the budget is balanced at the end of each financial year. One factor in this has been due to agencies not always increasing their contributions to keep pace with inflation.

It is recognised that for some organisations there is a national agreement about the level of support to Safeguarding Boards – Probation and CAFCASS but others are permitted to determine the level of financial support individually. The local authority has consistently made the largest contribution and increased it by significantly more than inflation until last year. In her report, Professor Munro referred to the potential for a nationally agreed funding formula for Boards since she recognised the disproportionate financial burden met by local authorities across the country. The impact of the application of such a formula would inevitably require the Board to examine its expenditure and determine its priorities for spending. Indeed, the Budget for 2012-13 has recognised that there will be a risk of needing to use further provision from the reserves if there is any unplanned expenditure e.g. a Serious Case Review.

Expenditure 2008 - 2012

Breakdown	2007/8	2008/9	2009/10	2010/11	2011/12
Salaries *	71664	93874	113323	129602	149700
Training	3986	12000	16770	18125	11009
Supplies & Services	11260	12000	9053	14702	10236
Professional fees		10000	13380	14455	4181
Commissioned work	9705	5000	3000	0	0
Child Death Overview Panel	0	0	17000	18000	0
Totals	96615	132874	172526	194884	175126

* including Independent Chair from May 2011

A summary of expenditure since 2007-8 shows a pattern of increases, year on year, for most expenditure headings until this last year when financial controls were applied rigorously. The training costs have been reduced by using in-house trainers and using local authority premises where there is very little hire cost. A decision was made to send electronic copies of handouts rather than print and distribute them at the sessions and both have helped to reduce overall costs.

Printing costs for other material has been addressed and significant reductions made. Placing Tees protocols on the web site for staff to access rather than producing copies has contributed to this saving.

By transferring the responsibility for the web site maintenance from an independent company to in-house staff has had a significant effect on the Professional fees expenditure. Similarly, there has

been no Commissioned work initiated in the last two years although one piece of work on the Guides for staff has been put in place for payment in this current year.

The Child Death Overview Panel expenditure in the two years noted was added to by grants from other agencies and a surplus was created and as the surplus can be carried forward no payments were needed in the last year. There may be a cost in the current year but the amount is not yet known.

There remains only limited scope for further reductions in these areas by significant amounts without seriously restricting the progress of the work of the Board. However, it is plain to see that the largest proportion of the budget relates to staff – including the Independent chair from May 2011. Without a commitment to increase contributions from all agencies, it will be difficult to sustain the same level of direct staffing support to the work of the Board.

Key Outcomes 2011-2012

Overarching Outcome:

Children Live Safely In Hartlepool

Priority Outcomes:

- Children and young people live in households where they are properly cared for, all of their needs are met and they are free from the impact of neglect.
- Children and young people live free from the impact of domestic abuse.
- Adolescents in Hartlepool are supported to make safer choices and are safeguarded from significant harm
- Children and young people live in environments where they are safe and supported appropriately
- Staff working with children and young people are suitably trained to meet their needs.

Performance on outcomes

Conferences

There was a very successful and thought provoking conference on Risk Taking by Adolescents in March 2012, with a significant contribution from young people throughout the day. Similarly, a Hidden Harm Conference was delivered in July 2011 [arranged by the Child and Adult Services Workforce Development Team] and this made a significant contribution to the wider work of the Board.

Neglect

While the recommendations of the major report to the Board on neglect have been addressed, there is not yet evidence of significant impact in terms of reducing the proportion of neglect cases in the overall total or even in absolute numbers. It must be recognised that cases involving neglect require the most change in the life style of a family and the need to retain a plan while they maintain the progress does contribute to such cases being those that remain on a plan, on average, more than any other category and thus any change in new registrations will take at least 1 to 2 years to work through the system.

Domestic Violence

Many of the recommendations of the investigation and report related to the more efficient co-ordination of the various initiatives that impact on this area of concern. A number of the structural changes are tackled within the Domestic Violence Strategy produced by the Safer Hartlepool Partnership who will take overall responsibility for implementing the strategy that incorporates all of the recommendations of the report presented to the Board. The chair of the Partnership is also a member of the Board.

Safeguarding Adolescents

As the report was received in last quarter of the year, there has been little time to see any impact of proposed changes that have already been made. The action plan of the group is included in the Board's Business Plan.

The Child's Journey

In common with the national trend, there has been an increase in the number of children who have become subject of a protection plan. Those aged up to 9 continue to constitute the majority on a plan – although there has been an increase in the number of teenagers this year. Neglect is still by far the most common category at 81%. There has been a slight rise in children becoming subject to a plan for a second or subsequent time during this year but as part of a downward trend. There is evidence of several agencies working with families before the child becomes subject of a plan and there is also evidence of social work support to families being continued after ceasing to be on a plan – often for a prolonged period to ensure an effective transition to support from universal services and preventing a return to the child protection system.

The child protection case conference process has been monitored for the last year and the main findings are that there is still room for improvement in attendance by agencies at child protection case conferences. Failure to share of reports with parents prior to the conferences still remain an issue but the pilot scheme for joint reports may assist this in the future. This will also have an impact on increasing the number of conferences that start on time. The timescale standards for Core Groups were also noted as having been met in 90% of the time with only short delays noted for those that didn't meet the standards.

Fire Safety

Cleveland Fire Brigade work with partners within the four local authority areas to protect children from harm. They have a small dedicated team that work with young people across the area to ensure a coordinated and consistent approach is taken to safeguarding. Raising awareness of the dangers of fire is a key element in this work with regular visits to schools and other settings where young people are accessible to the service.

Local Authority Designated Officer [LADO]

A total of 14 adults were notified to the LADO as potentially presenting a risk to children – a slight increase from previous years. In 2 cases staff were dismissed and one resigned. The circumstances of all three were reported to the Independent Safeguarding Authority. In all other cases staff returned to their work place with appropriate advice [3] or support [allegations unfounded].

Licensing Authority

The Licensing Act 2003 was introduced in November 2005 and brought about a fundamental review of licensing laws. Local authorities became 'licensing authorities' and, as such, the administration and enforcement of the Act is now undertaken by the Council's Licensing Team and Cleveland Police.

The Licensing Act identifies a number of 'Responsible Authorities' that must be consulted whenever an application for a licence is made. One such responsible authority is identified as Hartlepool Safeguarding Children Board and is consulted whenever a licence application is submitted to ensure that the licensing objective of "Protection of children from harm" is considered.

In 2011/12 a total of 41 applications were received by Hartlepool Borough Council and were considered by the officers representing the Safeguarding Children Board.

Private Fostering

During the year, adverts in the local free magazine highlighted the need to notify the local authority of any private fostering arrangements. Leaflets were revised and distributed to all public access points and Board led training courses had private fostering included in them in an attempt to raise the awareness of the issue. Schools were issued with guidance and leaflets during National Private Fostering Week to make them more accessible to those involved. At the end of March 2012, there was one private fostering arrangement known to the local authority. The local authority are having discussions with their neighbouring authorities to explore joint initiatives to raise public awareness

Road Safety

The annual report on road safety concludes:

'In general, casualties amongst children of school age are at low levels and have been kept relatively low through the initiatives and interventions detailed in this report. However, in order to sustain these levels and reduce casualties further, existing partnerships must be reinforced and new partnerships formed with other agencies including the civil sector.'

Running/Missing from Home/Care

The annual Report of this multi-agency group runs from July to June each year due to the implementation date of the national guidance. It is available in the Performance Book. Of particular interest is the reduction in the overall n umber of children and young people who were reported as Running/Missing from Home/Care from the previous year and this allied with the finding that the greatest reduction was in relation to those children and young people who had done so more than once, strongly suggests that the introduction of independent interviews with those identified as potentially more vulnerable has been a successful innovation.

Section 11 Questionnaire

S.11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. In meeting the Board's responsibility to ensure that agencies are compliant with section 11, agencies are asked to complete a detailed questionnaire covering all aspects of safeguarding and return it to the Board with an action plan to address any shortfalls identified. This year, either a questionnaire was requested or an update of the action plan form last year arising from a questionnaire. Generally, there were no serious gaps or areas of risk.

Training

The Learning and Development Subgroup priorities for 2011/12 were to plan, co-ordinate and deliver a comprehensive, effective inter-agency learning and development programme and also, to evaluate and undertake quality assurance of all single and multi agency learning and development activities provided. These were achieved during the year. This included the development of an appropriate safeguarding and child protection learning and development programme for schools and childcare settings. The annual report is presented in full in the performance book.

Water Safety

The annual report produced by the Beach Safety Team confirmed the continuing concentration on delivering the water safety message to all users as well as providing an effective Beach Lifeguard Service during the summer period.

Individual agencies represented on the Board

The summary by each of agencies that completed the template are contained in the Performance Book but generally they all confirm that the agency has met its requirements to keep children safe. Of particular interest are the significant changes made by the North Tees & Hartlepool NHS Foundation Trust in respect of eSafety, having been alerted to certain issues arising form the completion of the Section 11 questionnaire earlier in the year.

Serious Case Reviews

There were no cases that met the criteria for a Serious Case Review. However, the Board initiated a Learning Review in the case of a family where longstanding neglect issues contributed to sexual abuse not being recognised until a disclosure was made after the children were in foster care. The methodology of the Learning Review was to create a multi-agency chronology for consideration by a group of staff from the agencies involved and for them to use it to understand and analyse what had happened so that the underpinning reasons for the progress of the case seeking particularly to determine the lessons to learned and passed to staff to assist their future practice. The review team fed back to the practitioners centrally involved before sharing the main lessons with staff generally.

The key points of learning were:

- Identify families where neglect issues require multi agency involvement using a theoretical model to inform the assessments
- Intervention to focus on meeting the needs of the children and not be diverted to dealing with the parent's agenda or behaviour.
- Much greater use of defensible decision making approach by agencies and accurate recording of the reasons for actions/decisions.
- Reporting of indications of sexual abuse must lead to a strategy meeting being convened – even when the child is already subject of a protection plan under a different category.
- Use of reflective supervision to be used to guard against 'start again syndrome'
- Promote the effective use of Core Groups by staff.
- Increase capacity for Professional Challenge by all staff.

An action plan was agreed by the Board and the Learning and Development Group have responsibility for the dissemination of the leaning and the Serious Case Review Implementation Group are actively controlling the overall implementation of the action plan

Priorities for 2012 – 13

At the Board Development Day in January 2012, the priorities determined by the Board two years ago were agreed as still remaining as the priorities of the Board. It was recognised that they represent issues where change will potentially be relatively slow as there is a need to affect the behaviour of parents across a wide range of families as well as the responses of professionals.

In relation to Domestic Violence the Board were made aware of the new Domestic Violence Strategy developed by the Hartlepool Safer Partnership as part of their response to the Board's major investigation and subsequent report of 2011. Within the overall strategy, the Board's Task & Finish Group will tackle the action plan arising from the Board's report and maintain links with the town-wide strategy.

Further outcomes could be determined during the year as fresh challenges are placed in front of the Board.

One particular challenge will arise from the Munro report whose recommendations will be taken forward by the Board as developments unfold from Central Government. The revision of Guidance will have an impact on the work of the Board and will need to be addressed. The change from a perceived over dependence on procedures to an increase in professional judgement will present a challenge to the agencies involved and they will look to the Board for support and training.

Hartlepool Safeguarding Children Board
Child & Adult Services Department
Hartlepool Borough Council
Level 4
Civic Centre
Victoria Road
Hartlepool
TS24 8AY

Contact: 01429 523825

Email: HSCB@hartlepool.gov.uk OR HSCB@hartlepool.gcsx.gov.uk

Website: www.lscbhartlepool.org

Teeswide Child Protection Procedures Website:

www.teescpp.org.uk

If you have concerns about a child please contact:

The Duty Team - 01429 523 872 (During working hours)

The Emergency Duty Team - 08702 402 994 (Out of hours)

In an emergency contact the Police – 01642 326326

Safeguarding Children is everyone's responsibility

Hartlepool safeguarding children board

Annual Report
April 2011 – March 2012

Performance Book

CHILDREN LIVE SAFELY IN HARTLEPOOL

To support that overarching outcome, the following outcomes remain priorities of the Board

1. Children and young people live in households where they are properly cared for, all of their needs are met and they are free from the impact of neglect.

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5. Staff working with children and young people are suitably trained to meet their needs.

Contents

Annual Performance Report for Safeguarding and Child Protection in relation to safeguarding of children in Hartlepool for the period April 2011 – March 2012.

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1. Introduction

Hartlepool Safeguarding Children Board has the responsibility to evaluate how well the represented agencies on the Board are performing to keep children safe and to put in place effective safeguarding arrangements to promote the welfare of children in Hartlepool. .

Within the review of child protection carried out by Professor Eileen Munro a recommendation was made to revise the performance data used by Safeguarding Boards to evaluate their effectiveness. It recommended a reduced number of national performance indicators and an increase in the use of more locally focussed information.

In preparing this report, data produced by the Local Authority Child and Adult Services Department has been utilised. Part of the justification for this choice is that the Local Authority has the lead responsibility for the safety and welfare of children in partnership with other public organisations, the voluntary sector, service users and carers. Their key objective is to ensure that children are protected from harm and provided with a wide range of care and support services. The Local Authority has specific duties under the Children Acts1989 and 2004 to safeguard and promote the welfare of children in need in their area and in so far as it is consistent with the child's safety and welfare to promote the child's upbringing with their families, providing services appropriate to the needs of the child.

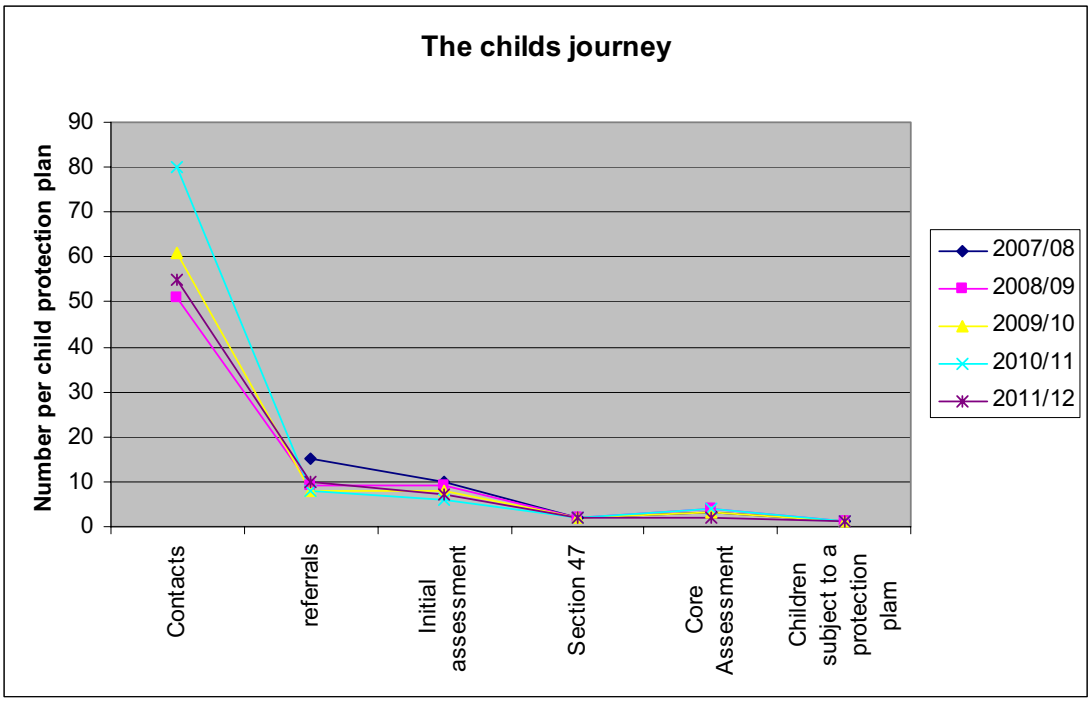
Within the Local Authority, the Child and Adult Services Department is the principal point of contact for children about whom there are concerns. Under Section 47 of the Children Act 1989, children's social care has a duty to make enquiries if they have reason to suspect that a child is suffering, or is at risk of suffering, significant harm to enable them to decide whether they should take any action to safeguard the child and promote his/her welfare. Where a child is assessed as at risk of suffering significant harm, children's social care is responsible for co-ordinating an assessment of the child's needs, the parents' capacity to keep the child safe and the wider family circumstances.

In her report, Professor Munro (2011) drew attention to the need for early intervention services to play their part in safeguarding the welfare of children. If there is effective early intervention, she argues that escalation to levels of risk that would place children in significant danger may be avoided. Bearing this in mind, additional information for this report has been sought about the interface between the early intervention/universal services and the child protection system. Examination of records of children made subject of a protection plan to determine to what level there had been any early intervention support/services provided has been carried out. In addition consideration has been given to the duration of support provided by a social worker on a child in need basis once the protection plan has ceased.

Figure One-The Childs Journey

The first figure – The Child's Journey – attempts to show graphically the 'funnelling' effect of the process whereby reported concerns are dealt with through the process and result in a child becoming the subject of a child protection plan. The very large

numbers involved in terms of initial concerns expressed are such that the diagram has been devised so that it is based on the relative figures that result in **one** child becoming subject of a protection plan.



From this diagram it is clear that a significant number of reported concerns do not result in a referral whereby a Social Worker visits the family and initiates an assessment of the circumstances (the conversion rate is approximately 12%). The threshold audit completed last year made a number of recommendations and it was hoped that there would be an improvement in the "focus" of reported concerns with an increase in the conversion rate of contacts to referral. This has happened – from 10% to 12%- and whilst this is a small change it is in the preferred direction and suggests that the focussing efforts have been effective to some extent.

In stark contrast, the percentages of referrals that do not have an initial assessment are exceedingly small [5%]. This suggests that the 'sifting' process when considering reported concerns is very effective and a high proportion of referrals progress to assessment.

Another reason for an Initial Assessment not being completed is when there is professional disagreement between the Team Manager of the Duty Team and the Team Manager of the Initial Response Team. This may have been as a result of further additional information being available to the Initial Response Team Manager subsequent to the receipt of the referral. Any such disparity of view is then discussed thoroughly between the two Team Managers and is part of the continuing mechanism of quality assurance that the appropriate threshold is being maintained in terms of who receives a service.

After completion of the Initial Assessment process, a decision is made as to whether a Section 47 enquiry will be conducted and this happens in approximately one quarter of all cases where an Initial Assessment has been completed. After conclusion of the Section 47 enquiry, which should involve contributions from other involved agencies, approximately half of the children about whom concerns have been expressed continue the journey and become subject to a child protection plan.

A Core Assessment is a more detailed examination and analysis of a child's circumstances and entails the gathering of information from all involved agencies. Scrutiny of the diagram confirms that there are more Core Assessments than Section 47 enquiries and this is a result of additional Core Assessments being completed in

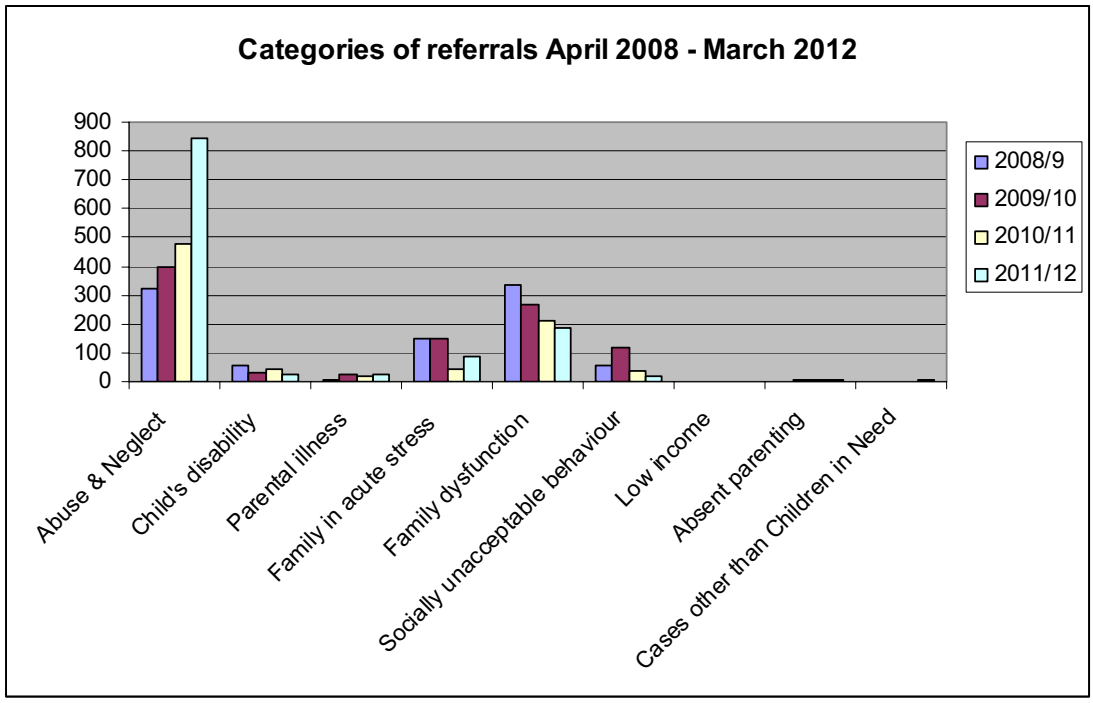
relation to children subject to a protection plan for example following a change in circumstance.

The overall pattern of the child's journey over the last 4 years has remained relatively similar – (apart from the slightly improving conversion rate between contacts and referrals). This picture has been noted at independent inspections conducted by OFSTED and no adverse comment offered on the relative proportions at each stage.

Bearing in mind the comments above in relation to Professor Munro's recommendations about including the early intervention services into the child's journey within child protection, preliminary investigation has been made into the previous circumstances of those children who have become subject of a protection plan during the last year. A dip sample of these cases confirmed that there were relatively few children who had not had at least two agencies involved alongside universal services prior to the identification of the concerns that led to them becoming subject of a protection plan. This confirms Munro's view that most children who become subject of a protection plan have already had input from a number of universal or targeted services prior to their journey taking them into the child protection system.

Whilst not carried out in great detail this work did identify a number of themes which would merit deeper scrutiny by the Performance and Quality Assurance Group. Better recorded evidence of the use of the Common Assessment Framework and the use of the Lead Practitioner role is required to provide evidence of how effective the early intervention services are being in meeting needs at a lower level and preventing families from requiring more specialist services. The production of a chronology of agency involvement and the outcomes achieved needs to be more bedded into practice in all the agencies. With the move to more integrated services delivered within a locality a more detailed audit of these cases would provide useful evidence for how best these new services can be delivered.

Figure 2



The above table provides a comparison over the last 4 years of the categories of referrals made to the duty team in children's social care. It is immediately obvious that in the category of abuse and neglect there has been a significant increase that is not reflected in any of the other areas, indeed most of the others have reduced in number. The level of referrals for abuse and neglect have been reflected in an increase in the number of children subject of a protection plan suggesting that the

referrals are relevant and appropriate. It is more difficult, however, to offer suggestions as to why there have been nearly twice as many such referrals during the last year, bearing in mind there has been no national case at the forefront of the media. It is more likely that there has been an increase in awareness by agencies and the public about the impact of abuse and neglect and an increasing willingness to report. The conference on neglect commissioned by the Board in April last year may have contributed to the increase in awareness of the impact of continued neglect on children and perhaps in raising that awareness this has prompted professional staff to make a referral. In addition the current climate of austerity and recession may well be having an impact on those more vulnerable families living on a low income in areas of high deprivation and contributing to more families being classed as living in poverty.
Whatever the underlying causes for this increase in referrals it is placing an increased pressure on the social work teams who receive and deal with them.

Figure 3

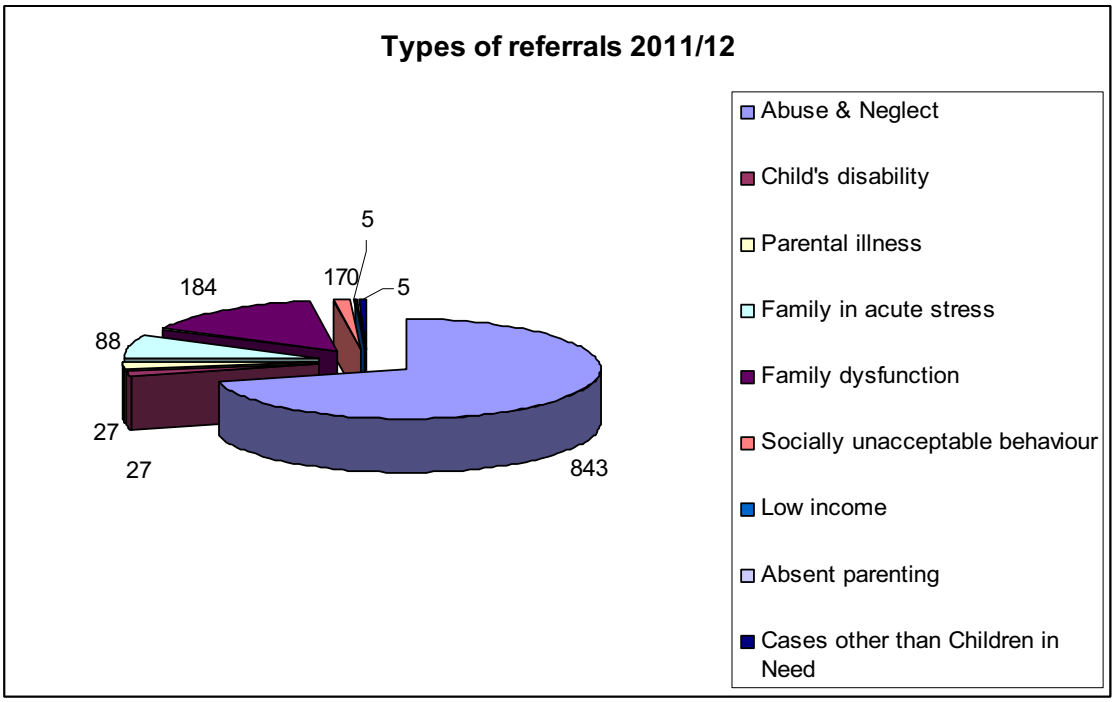


Figure 3 provides the relative proportions of the types of referral for the last year and highlights the significant proportion of cases relating to abuse and neglect. The overall increase in this category has clearly contributed to the increase in the number of children subject to a protection plan during the year.

This is also represented in figure 4 below although, as can be seen, the numbers do not reach the highest level of 2009/10 that was probably influenced by the baby P case. The trend line confirms that Hartlepool is following the national trend of significant increases over the last few years albeit with some variation. If this trend continues then there will be additional pressure on staff of all agencies during a period of retrenchment and reframing of resources. The Board will need to monitor the impact of the increased demand on staff and guard against a reduction in effectiveness of any part of the service to children.

Figure 4

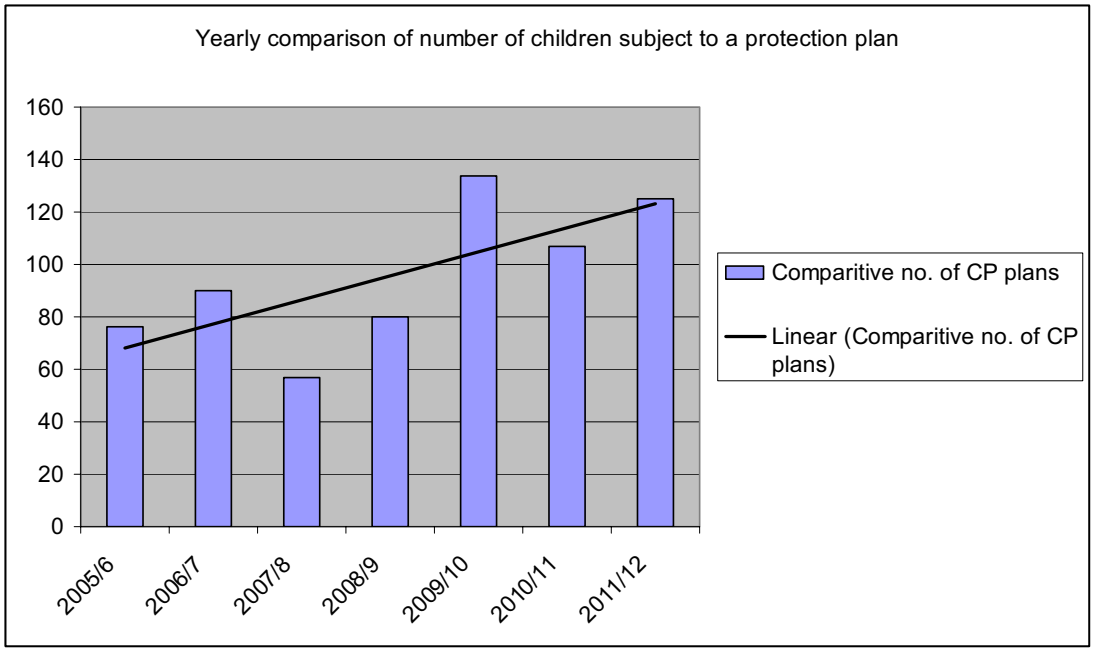
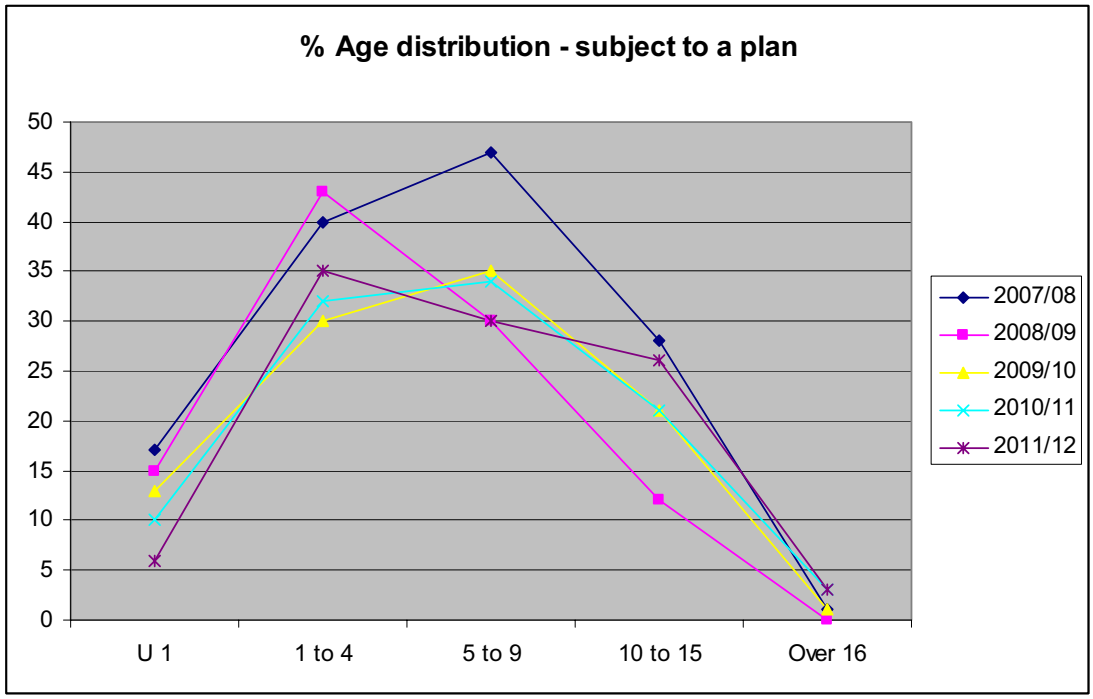


Figure 5



When the age distribution of the children subject of a protection plan is examined in figure 5, it is apparent that the previous pattern has continued broadly during the last year. It is interesting to note that there is not nearly so wide a difference between the two age groups of 5 to 9 and the group aged 10 to 15.

Figure 6

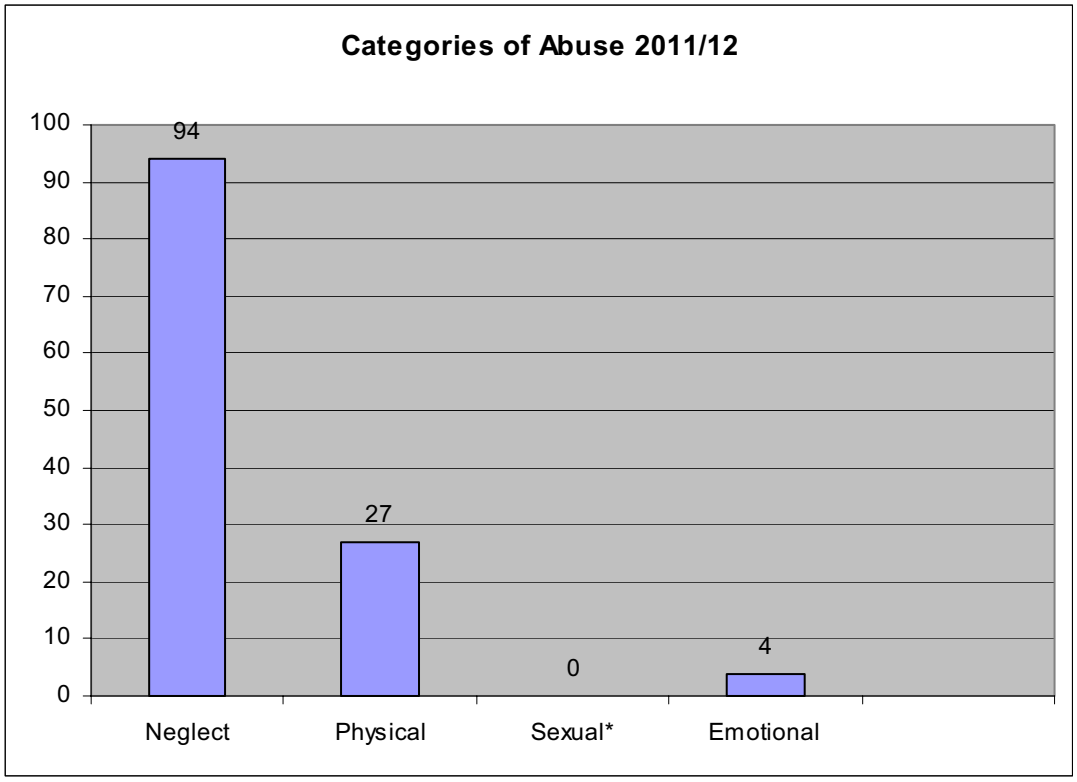
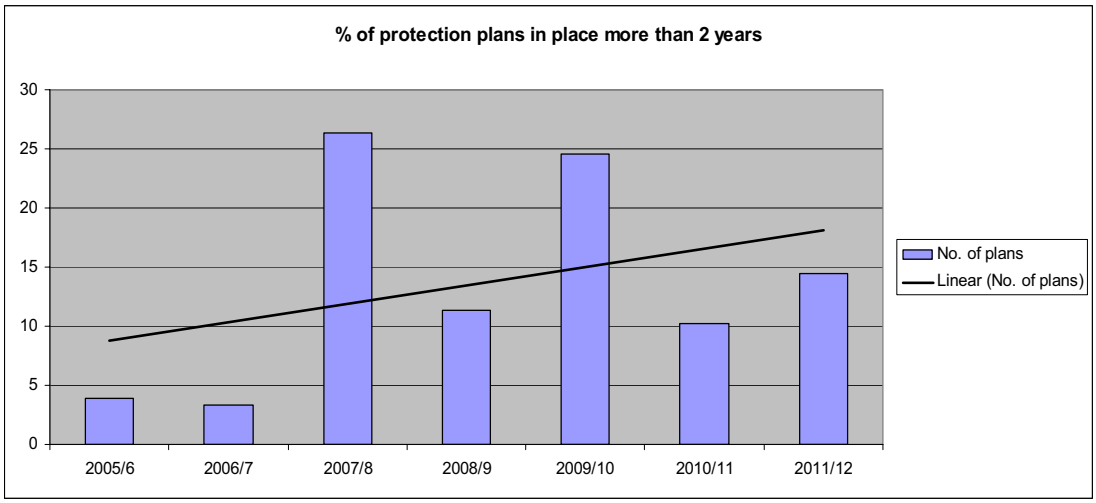


Figure 6 confirms that the highest proportion of children falling into the category of neglect continues to be the case. While the recommendations of the major report to the Board on neglect have been addressed, there is not yet evidence of significant impact in terms of reducing the proportion of neglect cases in the overall total or even in absolute numbers. It must be recognised that cases involving neglect require the most change in the life style of a family and the need to retain a plan while they maintain the progress does contribute to such cases being those that remain on a plan, on average, more than any other category and thus any change in new registrations will take at least 1 to 2 years to work through the system.
This category will include those children who have been assessed as being at risk as a result of a high level of domestic violence within the home and as members are aware this remains a priority area for the Board to oversee improvement in outcomes for children for whom this is the case. As a result a database has been established to drill down into the neglect category and accurately record the incidence of domestic violence to provide more useful performance data to the Board in future reports.

It is expected that the Board will be seeking to assure themselves that all of the Neglect report recommendations have been fully implemented and the impact measured – leading to a reduction in future years.

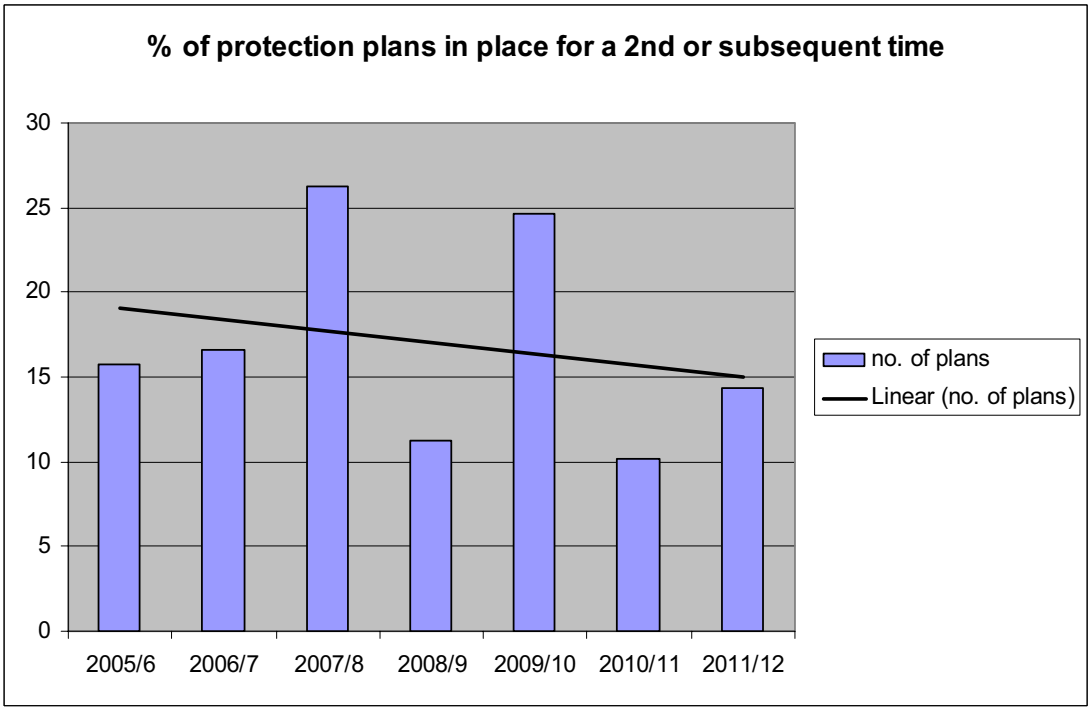
*While there were no children subject to a protection plan in the category sexual abuse on the 31st March 2012, there were 5 who did during the year but the plans were discontinued as a result of the risk reducing significantly within a short period. This usually involved the alleged perpetrator leaving the household on a permanent basis.

Figure 7



Effective work with families and children should be achieved within a reasonable timescale and the national indicator uses 2 years as the watershed. While figure 7 indicates that the trend in Hartlepool is going up this should be treated with caution as the 5 children concerned in this last year are all siblings from one family. Unsurprisingly, the case involves neglect issues and the parents have been unable to consistently maintain improvements that they have made. There is an active monitoring arrangement in place to alert staff to cases where there is a likelihood of cases exceeding 2 years on a plan and consideration is given to a complex case meeting being convened to consider the issues to provide independent scrutiny.

Figure 8



In spite of a small upturn last year there is an overall downward trend shown in Figure 8. In the previous 2 years, there has been a practice of auditing each of these cases by a multi agency group within the Performance and Quality Assurance sub

group with the findings revealing that while in a number of cases the circumstances were very similar at the second period of being subject to a plan, there was no evidence that poor decisions had been made when a conference had decided to cease a plan in the first instance. In the last year, the scrutiny of each such instance has been done by an Independent Reviewing Officer not previously involved in the case. Their findings have mirrored those previously reported. A point to note is that again the small numbers are inflated disproportionately by examples including sets of siblings from only 6 families in this last year.

While the aim of a protection plan is to reduce or remove the risk to the child, it is recognised that an abrupt reduction or removal of levels of support to the family could be counterproductive and there should be a period of transition following the plan ceasing. The direct input from social workers is expected to be continued for a period of at least 3 months within the Board's procedures and guidance. This period of transition should be used to re-establish the family's links with universal and community services that continue to be used by the family after they cease to be assisted within a Child in Need status by the social workers.
Following the concept of the Child's Journey, as portrayed within the Munro report, all of the cases where the protection plan had ceased during the year were analysed particularly in respect of the interventions provided when the protection plan came to an end.

Figure 9

Outcomes following cessation of Protection Plans April 2011 – March 2012

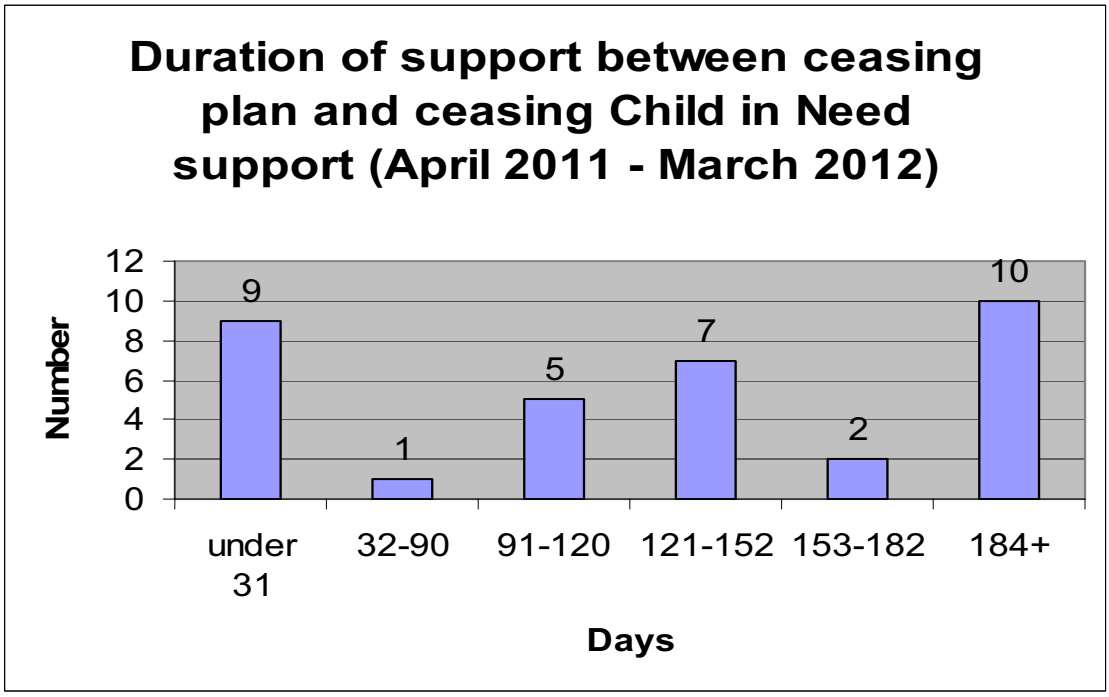
Outcome	Number
Ceased Plan – subsequently ceased support as Child in Need during the year	34
Ceased Plan – become Looked After Child	13
Ceased Plan – still supported as Child in Need at 31st March 2012	59
Total	**106**

It should be noted that the 13 children who became looked after had done so as a result of increased risk to their wellbeing and the need to be protected outside of the family setting.

Since the analysis has to be limited to a specific year, there will be children in the third group in figure 9 where their plan ceased shortly before 31st March and thus this figure is not a complete description of the support being given to those families but is useful for comparison purposes.

Detailed analysis of the length of time support was given under a Child in Need status is given in figure 10 below.

Figure 10

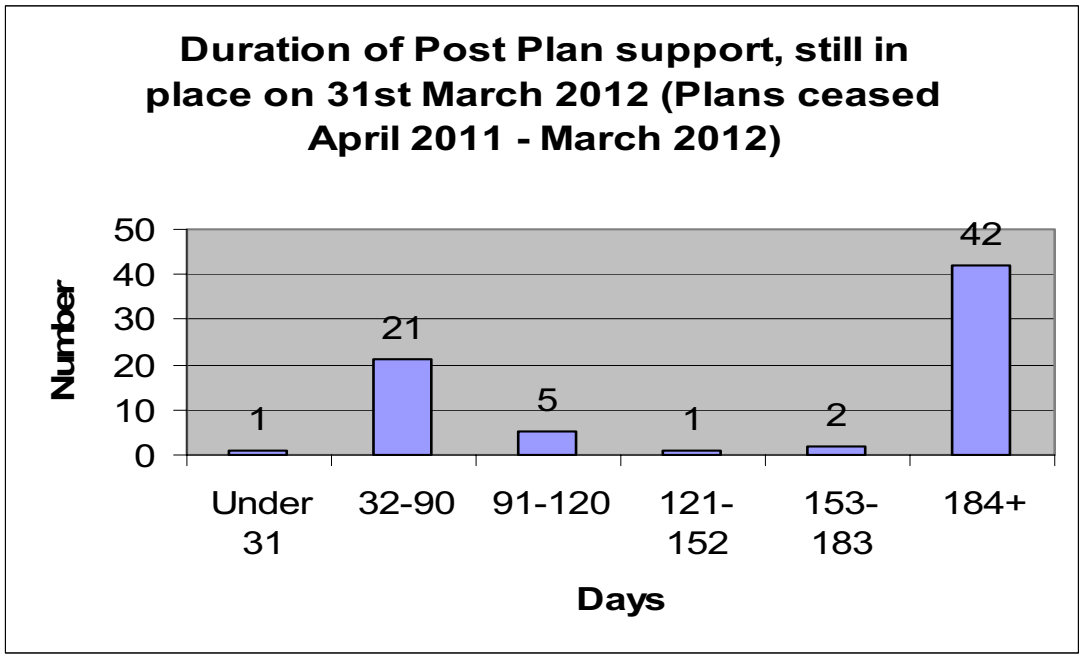


Given the Board's guidance, it is initially surprising to note in figure 10 that 9 children had their support stopped within one month of the protection plan ending. However, detailed examination showed that 6 children moved to another area and the plan continued in the new area. One entered the care of a neighbouring authority with his sister who was resident there. In one other case, the conference specifically recognised the exceptional progress made by the family and recommended that no period of Child in Need status – with the consequent level of support – was necessary. This was ratified by the relevant Head of Business Unit and the Safeguarding & Review Manager. This leaves only 1 case where a decision was made to shorten the period by the Child and Adult Services Department. Their records show that there was discussion with other agencies prior to the decision being made.

The number of cases where the Child in Need status continued for more that 6 months suggests that a piece of work should be done to explore whether there is a difficulty in the interface between the universal or community services and the statutory ones. It may be that the complexity of the difficulties of the families remains high even after the risk of abuse or neglect is deemed to have reduced sufficiently to permit the plan to cease.

Figure 11 gives a breakdown of cases where support under Child in Need status is still in place at the 31st March 2012. It must be recognised that a number of cases will only have ceased to have a protection plan after the 1st January 2012 and it would be expected that their support would be continuing. However, it is easily seen that for 42 cases, that level of post protection plan support has continued for more than 6 months. When this is added to those in figure 10, a grand total of 52 out of the 106 children whose plan ceased during the year had Child in Need status support for at least 6 months. This adds weight to the suggestion that this merits further research.

Figure 11



Case Conference Activity

In the last year, it has been possible to collect detailed information around the case conference system. A preliminary report on the first quarter of the year was presented to the Board and from that, there was the opportunity to address the issues raised on an interim basis. The following tables give the results for the whole year.

Table One

Attendance at Child Protection Case Conferences April 2011 – March 2012

Those Invited	% Attended - Initial	% Attended - Review
Mother	87	81
Father/Stepfather/Partner	75	67
Lead Social Worker	90	90
Team Manager	81	17
Senior Nurse – CP	47	2
Police Vulnerability Unit	59	4
Schools	91	87
GP	7	0
Probation	67	71
Health Visitors	100	93
School Nurses	90	81

There is an expectation that the first six groups of those listed in Table One will be invited to, and attend, every Initial Child Protection Conference and consequently it is disappointing to note that in respect of the professionals, the percentage attendance is much lower than the 100% target. An interim report, based on the first quarter of the year, highlighted this issue. Both Health and Police indicated that the increased volume of conferences both in Hartlepool and Stockton was making attendance an

issue for them. Both confirmed that they would, at least as an interim measure, prioritise attendance at Initial conferences. Both have done so but, in spite of their very low attendance at Review Conferences, they have been unable to achieve high levels of attendance at Initial Conferences.

The lower percentage of father/stepfathers/partners reflects the experience of the difficulties in engaging this particular group and it remains a challenge for practice. Considering Review Conferences, the low level of attendance by Team Managers reflects the approach of the Child and Adult Services Department that has given priority to Team Managers chairing the first Core Group after the Initial Conference to enhance the process of expanding the protection plan. In all cases, the Team Manager countersigns the Social Worker's report, thus confirming support for the findings and recommendations contained in it.

Looking at the 5 other agencies in the rest of table above, where invitations to attend are frequent, it is pleasing to note that Health Visitors attended every Initial conference to which they were invited. This contrasts markedly with GPs.

Table Two

Reports seen by Parents prior to the Conference

Author	Initial Conference	Review Conference	Conferences Initial / Review
Lead Social Worker	21%	6%	67 / 139
School	34%	8%	50 / 131
Health Visitor	32%	12%	37 / 94
School Nurse	0%	0%	38 / 88
Probation	0%	5%	13 / 19

It should be noted that the expectation is that the reports will be shared with the parents at least one day before the conference. Even more surprising is the lower performance for Review Conferences where there is much more time to make arrangements to plan the writing and sharing of the reports. There is anecdotal evidence to support the assertion that many are shared with the parents very shortly before the conference so that the conference is not delayed to allow the parent to read the report. However, this can hardly be described as best practice since the parent has little opportunity to consider the content especially if they are just about to attend a conference. The level of delay in the start of conferences is given in the following table.

Table Three

Conferences starting on time

	Started on time	Didn't start on time	Total conferences
Initial	30 (41%)	44 (59%)	74
Review	78 (52%)	73 (48%)	151
Total/Average %	108 (48%)	117 (52%)	225

There is an expectation that if all agencies have shared their reports with the parents before the Conference and the parents have been assisted to attend, then the conference will start on time. Regrettably, as shown in Table Three above, this target is far from being met. The information in Table Two – clearly demonstrates why the majority of conferences are delayed to permit the reading of reports by parents. While the tight timescales inherent in Initial Conferences makes sharing reports more difficult, the same justification cannot apply for Review Conferences where the date is known months beforehand.

The Board have agreed to a pilot scheme on joint reports to conferences and part of the brief of the pilot scheme is to address the issue of reports being shared with parents before the conference.

Table Four

% of Review Conferences – visiting standards by Social Workers

	Standards met	Standards not met	Total
Review Conferences	118 (77%)	35 (23%)	153

The standard expected is that either the Lead Social Worker or Co-worker will see the child(ren) at least every 15 days. The electronic case recording system informs the conference of the performance of the standard. The vast majority of cases of non-compliance are no more than 4 days out of date and none over 10 days late. Higher priority demands having to be met is the reason most often given for lateness of visits.

Table Five

% of Review Conferences – Core Group standards met

	Standards met	Standards not met	Total
Review Conferences	135 (90%)	15 (10%)	150

The standard expected for Core Groups is that the first will be held within 10 days of the initial conference and thereafter at monthly intervals. Specific information is recorded on the Child and Adult Services electronic case recording system and detailed examination of cases that didn't meet the standard shows that in all cases only one Core Group in the sequence of either 3 (between initial conference and first review conference) or 6 (between review conferences) was held late and usually by only a few days [often to accommodate a number of professionals involved or as a result of sick leave by the Lead Social Worker.

Table Six

% of Children/Young People who attended any conference

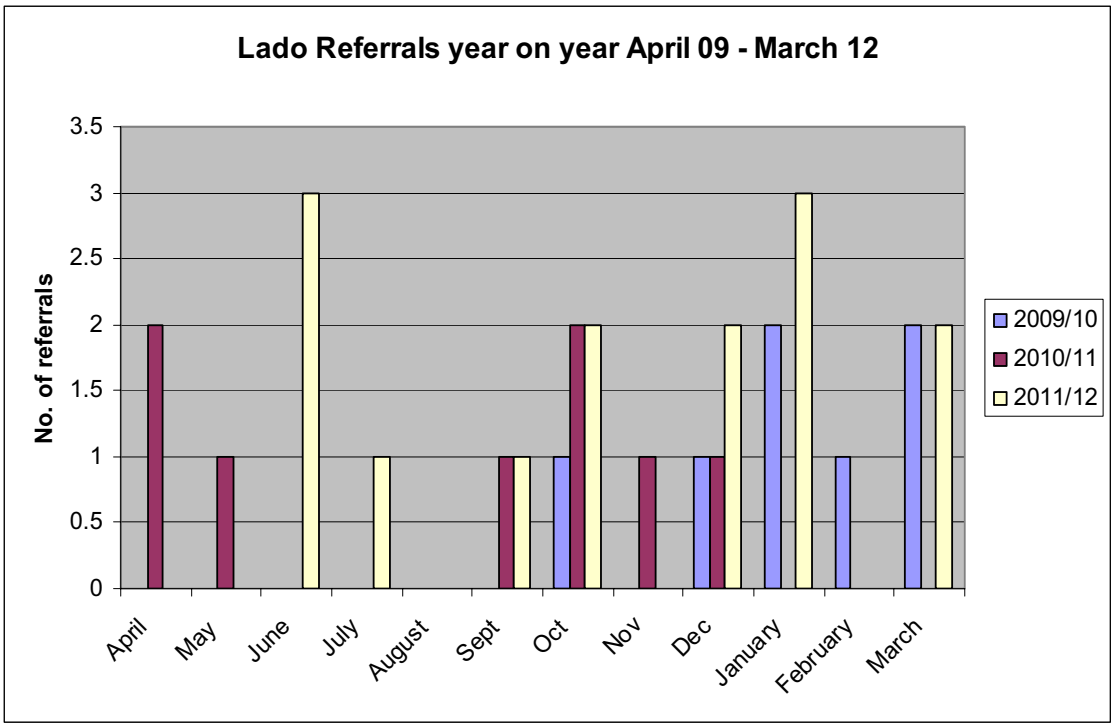
	Attended	Didn't attend	Total
Initial Conference	0 (0%)	72 (100%)	72
Review Conference	10 (6%)	143 (94%)	153

Working Together, in listing those who may have a significant contribution to make at a child protection conference, start that list with the child. Yet, by far they are the least present of any on the list. The extremely low number of children/young people who attended conferences is reflected elsewhere in the country. All who attended were teenagers who particularly asked to attend. There was only one young person who received an invitation but did not actually attend. The case recording of the Social Workers confirms that the young people appreciated their attendance although a couple had been slightly anxious prior to the actual meeting.

This contrasts markedly with Looked After Reviews where the child's attendance and involvement is frequent. Bearing in mind the importance of both types of meetings, there may be merit in a more detailed piece of work to

examine how children and young people can take part in conferences – albeit that they are currently held during school hours.

Figure 12



Note: The process started in October 2009, hence there are no incidents recorded before that date

Managing Allegations Against Staff

Any concern or allegation with regard to a member of staff is considered under the Managing Allegations against Staff Procedures and there is now an agreed set of procedures for all the Tees Safeguarding Boards. Any enquiries into staff conduct are considered using the following criteria:

- Behaved in a way that has harmed, or may harm, a child.
- Possibly committed a criminal offence against, or related to, a child; or,
- Behaved in a way that indicates s/he is unsuitable to work with children

All local authorities must appoint a Local Authority Designated Officer (LADO) to deal with these matters and for Hartlepool this is covered by the Board's Business Manager and the Safeguarding and Review Manager.

There continues to be a wide variety of concerns and allegations considered under these procedures. In the announced Ofsted inspection of safeguarding in children's social care, positive feedback was received with regard to how these situations were being managed.
The Local Authority Designated Officer Annual Report is included in the Performance Booklet attached. The main conclusions are that from the 14 incidents reported, 11 of the staff returned to their posts – 3 with the benefit of additional guidance while two were dismissed and one resigned. In the last 3 cases, the circumstances were reported to the Independent Safeguarding Authority [ISA]. The ISA are not permitted to confirm their decision on Barring from work with children & vulnerable adults to the notifying LADO. All of the cases were resolved within 17 weeks, with the majority within four weeks.

Conclusions

One of the functions of the Board is to keep agencies accountable for their safeguarding performance. Examination of performance data is one way in which this can be done. Information for the last year – with interpretation of the implications – has been presented in this report.

There is a national trend for an increase in the number of children subject of protection plans and Hartlepool has mirrored that trend. Preliminary examination of the history of intervention with those children – prior to the protection plan – suggests that universal and community services have been involved.

However, in attempting to implement the recommendations of the Munro Report, the Board could consider a piece of work to determine that work done before a child protection referral is as effective as possible in tackling the issues within the family and hopefully prevent the escalation of risk that leads to the child's journey progressing into the child protection system.

Similarly, an area for investigation is the interface between services offering support after the protection plans have ceased with a view to determining that the optimum timing of transfer from the Child in Need status is the most effective.

Overall, the information contained in this report supports the assertion that agencies are safeguarding the children of Hartlepool and the Board are fulfilling their responsibility for this aspect of their role.

LEARNING & DEVELOPMENT GROUP

Hartlepool Safeguarding Children Board has a responsibility under Working Together to Safeguard Children 2010 to ensure appropriate safeguarding children and child protection learning and development is provided to the children's workforce in Hartlepool.

The Learning and Development Subgroup undertakes the planning, development, delivery, monitoring and evaluation of a comprehensive inter-agency learning and development programme required by the children's workforce in Hartlepool to effectively safeguard and promote the welfare of children and young people.

The Learning and Development Subgroup priorities for 2011/12 were to plan, co-ordinate and deliver a comprehensive, effective inter-agency learning and development programme and also, to evaluate and undertake quality assurance of all single and multi agency learning and development activities provided.

The group has considered a range of learning and development issues during the year including the learning and development needs identified by individual agency workforce development representatives or as a result of the work of the other subgroups. Achievements of the group include:

- **Development and delivery of an inter-agency learning and development programme:** the group has successfully developed, coordinated, promoted and delivered a comprehensive inter-agency safeguarding and child protection learning and development programme, which incorporates the wider safeguarding agenda. Each course has been reviewed and redesigned to ensure up to date information, the promotion of the Common Assessment Framework and information sharing is incorporated. They have also included recommendations from local Serious Case Reviews, Learning Reviews and Management Reviews within all safeguarding and child protection learning and development.
- **Maintaining a multi agency team of front line practitioners to support the delivery of safeguarding and child protection learning and development:** Several front line practitioners from different disciplines are supporting the

delivery of safeguarding and child protection learning and development thus ensuring that delivery is provided on a multi agency basis whenever possible.

- **Procurement of learning and development providers:** The group progressed with a comprehensive quotation questionnaire ensuring that all external learning and development providers are evaluated against both quality (65%) and cost (35%) prior to them being commissioned to provide safeguarding and child protection learning and development.
- **Supporting the development of an appropriate safeguarding and child protection learning and development programme for schools and childcare settings:** The group has developed a programme of learning and development by working in partnership with the local authority and Headteachers to provide childcare settings and all Hartlepool Schools with a proposed plan of accessible safeguarding and child protection training. This programme assists them in meeting their Ofsted inspection criteria and the requirements of Working Together to Safeguard Children 2010.
- **Impact evaluation of safeguarding and child protection learning and development on working practices:** the group have analysed the impact evaluation feedback from practitioners on all multi agency learning and development activities in order to review how they have incorporated their learning from this programme into their working practices.
- **Delivery of a 'Risk Taking Behaviours of Adolescents' Conference:** the group commissioned and coordinated an interagency conference in relation to Risk Taking Behaviours of Adolescents which included a specialist keynote speaker, i.e. Children's Society, Drama Group: Bishop Auckland Theatre Hooligans, Hartlepool Psychology Team, Hyped, Integrated Youth Support Team, Police, Youth Offending Service Team Manger, Young People, and other key personnel to enable practitioners to receive a clear understanding of the Risk Taking Behaviours of young people and the impact this can have on their safety.
- **Progressive activity of the HSCB Learning and Development Working Group.**
  Workforce Development Representatives from various agencies continue to undertake the work of the HSCB Learning and Development Subgroup by:
  - developing toolkits to undertake the work of the learning and development subgroup action plan;
  - evaluating quotation questionnaires received from learning and development providers in relation to the commissioning of training;
  - reviewing, updating and developing safeguarding and child protection learning and development courses.

In 2012/13 the priorities will be to:

- Continue to build on our success by reviewing existing multi-agency safeguarding and child protection learning and development activities, as identified by local, regional and national imperatives and feedback from practitioners and their managers.
- Review agency learning and development activity and ensure all of the children's workforce in Hartlepool are accessing appropriate safeguarding and child protection learning and development activities in line with Working Together to Safeguard Children 2010's suggested target groups.
- Continue to co-ordinate, support and develop front line practitioners to enable them to deliver effective safeguarding and child protection learning and development activities.
- Incorporate learning and development requirements into the HSCB Inter-agency Learning and Development Programme in response to the other HSCB subgroups, local and regional Serious Case Reviews, Learning Reviews, Management Reviews and commissioned work within agencies of the children's workforce.
- Review and quality assure all single agency learning and development activities accessed by any member of the children's workforce in Hartlepool to ensure it is accurate; up to date and the content is appropriate to the target audience. Also,

to prevent duplication and where possible undertake delivering on an inter-agency basis in partnership with other agencies.

- Promote the new web-based Teeswide Safeguarding and Child Protection Procedures to the children's workforce in the four local authority areas across Teesside and ensure that all practitioners have access to learning in relation to these procedures.
- Monitor and review the impact of learning on working practices in response to all learning and development activities.
- Update the HSCB Learning and Development Strategy and all learning and development activities in line with the Munro Review recommendations.
- Review the Learning and Development Strategy and all learning and development activities in line with the updated Working Together to Safeguarding Children (due for release in July 2012).
- Continue to explore the options for safeguarding and child protection training sessions being commissioned on a Teeswide basis.

LOCAL AUTHORITY DESIGNATED OFFICER

Children can be subjected to abuse by those who work with them in any setting and all Local Safeguarding Children Boards have a responsibility, as outlined in Chapter 6 of Working Together 2010, for ensuring there are effective inter-agency procedures in place for dealing with allegations against people who work with children and monitoring and evaluating the effectiveness of those procedures. Appendix 5 of Working Together provides more detail on how these allegations should be managed.

It is essential that any allegations of abuse made against a person working with children, in whatever setting, are dealt with fairly, quickly and consistently in a way that provides effective protection for the child and at the same time supports the person who is the subject of the allegation.

The relevant procedure "Arrangements for managing allegations against people who work with children or those who are in a position of trust" has been adopted by all Tees Safeguarding Boards and is well established.

Any enquiries into staff conduct are considered using the following criteria:

- Behaved in a way that has harmed, or may harm, a child.
- Possibly committed a criminal offence against, or related to, a child; or,
- Behaved in a way that indicates s/he is unsuitable to work with children

Practice guidance with regard to managing allegations requires that the Local Authority Designated Officer (LADO) should provide data to the Board in order that monitoring and evaluation can be undertaken and any need for improvement identified and action taken. This data should include the number of allegations received during the monitoring period, the organisation from which the allegation arose and the nature of the allegation. The data should also record the time taken for the process to be completed and details of the conclusion. The attached table provides this information for the period April 2011 to March 2012

As can be seen from the attached table there is wide scope and variety in the allegations that have been considered under managing allegations against staff procedures as well as a range of severity in the nature of the allegations made.

From the table it can be seen that in 8 cases, staff returned to their duties at the conclusion of the investigations. In 3 of the cases, some action was taken to actively address the issue that had generated the referral. Two members of staff were dismissed at the conclusion of the internal disciplinary process and one resigned prior to the disciplinary hearing. In all of those 3 cases the Independent Safeguarding Authority [ISA] were notified of the circumstances.

Given the criteria in 1.4 above, the majority of the cases 9 in total related to alleged harm directly to a child, while the remaining 5 centred on behaviour that might indicate unsuitability to work with children.

Due to positive interagency co-operation, seven of the cases were resolved within one month, five taking less than three months and only the two complex cases that involved a considerable number of Police interviews took longer – taking 16 and 17 weeks respectively.

Recommendations
That members of the Board note the contents of this report and feel satisfied that the management of allegations against staff are being effectively managed in Hartlepool.

That members of the Board continue to be vigilant in ensuring the practitioners in the organisations are aware of the managing allegations against staff procedures and effectively implement them.

RUNNING/MISSING FROM HOME/CARE

In June 2008, the Secretary of State for Children, Schools and Families published the "Young Runaways Action Plan". The plan was developed after evidence from The Children's Society report "Stepping Up", and findings from a series of parliamentary hearings led by Helen Southworth MP and other members of the All Party Parliamentary Group for "Children Who Run Away or go Missing". They concluded that more needed to be done to support young people who run away from home.

Key Findings of "Still Running" (Children's Society)

- **52 percent** of young runaways returned to their home or care placement after one night away
- **1 in 6** young runaways sleeps rough: and
- **1 in 12** young runaways is hurt or harmed while away
- **Up to two thirds** of episodes of running or missing from home or care are not reported to the Police

In July 2009 The Department of Education issue statutory guidance to local authorities in respect of children and young people under 18 years of age who are reported "Running or Missing from Home or Care" (RMHC). At the centre of the guidance was the need for local authorities and police services to exchange data and work together to prevent, identify and support children who have become RMHC.

The report has two purposes related to the statutory guidance. The first is to inform Hartlepool Safeguarding Children's Board (HSCB) about the size and characteristics of the population of children who are reported RMHC for example their ages, gender and frequency of episodes. The second is to update HSCB about the development of processes and responses for those children who become RMHC.

The information gathered for this report came from two sources. Basic quantitative data provided by Cleveland Police in Hartlepool for each episode when a child was reported as RMHC between 2009 and 2011. This data was cross referenced against the Safeguarding & Specialist Services Integrated Children's Services Protocol records. In 20010/11 quantitative data was collected on the number of return interviews requested and qualitative data was gathered from a sample of 16 of the initial return interviews. The statutory guidance states that return interviews should take place when single or several criteria are met. A list of the criteria for return interviews are contained in appendix 1.

The data presented in this report covers the period **1st of July 2010 to the 30th of June 2011.** The data is also provided for 2009/10 to compare the 2010/11 data against. The data for 2008/9 has not been presented. This is because in 2009 Cleveland Police altered their processes for classifying missing episodes as RMHC. This resulted in a rise of 41% in the number of children being recorded as RMHC between 2008/9 and 2009/10. Therefore, it is not possible to accurately compare the data for 2008/9 against the data for subsequent years.

In 2010/11 the total number of children less than 18 years of age reported as RMHC to the Police was **222.** The total number of reported episodes of RMHC in 2010/11 was **371**.

In 2010/11 the total number of episodes of RMHC split by gender was **44.5%** female and **55.5%** male. See appendix 2 table 1.

In 2010/11 the peak age(s) of being reported RMHC by gender was **15** for females and **14** for males.

The data presented for the total number of episodes by frequency and category are based upon the statuses children had each time they became RMHC. Therefore, if they were reported missing more than once they could have been coded in more than one category within the figures. An example is one episode could have been coded as GP and another as CIN.

In 2010/11 the split of RMHC by category of instances of RMHC was general population (GP) **59 %**, children in need (CIN) **18%** and looked after children (LAC) **23%**. Although the term "General Population" (GP) has been used as a category this does mean that these children are not receiving interventions from services other than Prevention Safeguarding & Specialist Services. See appendix 2 table 2.

In 2010/11 the split of episodes of RMHC by home or care was **77%** from home and **23%** from care.

In 2010/11 the number of children who were reported RMHC when they were the subject of a child protection plan was **6. Five** were reported on **1** occasion and **1** had **2** episodes. The statutory guidance does not include as one of the criteria being subject to a child protection plan when a first episode of RMHC is reported. However, in Hartlepool return interviews are requested when these circumstances arise.

In 2010/11 a small number of children reported the most frequently as RMHC accounted for a significant amount of the total number of episodes. The **9** children reported RMHC the most frequently accounted for **87**, **23.5%**, of the total number of episodes.

Of the **4** children categorised as GP, who were reported missing the most frequently, on five or more occasions, **2** were now in receipt of services from the Prevention Safeguarding & Specialist Services and **1** is in receipt of prevention services from the Youth Offending Service. **One** was offered prevention support from the Youth Offending Service but declined support. Although, a worker from Youth Offending Service prevention services does have contact with the young person who is now aged 17 because a sibling is also supported by the service.

In 2010/1 **all** of the children reported RMHC were found by the Police and taken home or returned home of their own accord.

In October 2010 return interviews were introduced within Hartlepool. A total of **137** return interviews were requested and **123** were completed. On **3** occasions young people declined to take part in return interviews. All **3** young people were in receipt of support from Safeguarding & Specialist Services. In **3** episodes it was judged not

appropriate to request return interviews. For example for **1** young person the episode of RMHC coincided with them being sectioned under the Mental Health Act 1983.

In 2009/10 **232** children were reported RMHC. In 2010/11 the figure was **222**. This represents a reduction of **4.3%** of the total number of children being reported RMHC between the two years. In 2009/10 there were **425** episodes of RMHC. In 2010/11 the figure was **371**. This represents a reduction of **12.7%** of the total number of reported episodes of RMHC between the two years. These reductions coincided with the introduction of return interviews in October 2010 and the establishment of the RMHC Co-ordinated Response Group which started in December 2010. The RMHC Co-ordinated Response Group is comprised of staff from Child & Adult Services and the Police and meets ever two months. The terms of reference for the group were agreed via the Executive group of the HSCB.

Although it is to early yet in terms of data collection to consider trends, it is interesting to note that the reduction in the total numbers of episodes starts from those children reported RMHC twice or more. This is one of the key criteria for return interviews to be undertaken. Therefore, the reduction of total episodes for 20010/11 did not occur solely because there was only a significant reduction in the number of children reported RMHC the most frequently. However, it needs to be acknowledged that there was a slight reduction in the small group of children reported RMHC 5 or more times, from **18** to **15**. See appendix 3 table 3.

In 2010/11 the total number of episodes of RMHC split by gender was **44.5%** female and **55.5%** male. In 2009/10 the number of episodes split by gender was **46.1%** female and **53.9%** male. These were similar for the two years. The episodes of RMHC for 2010/11 split by gender and frequency are contained in appendix 3 table 3.

In 2010/11 the peak age(s) of being reported RMHC by gender was **15** for females and **14** for males. This was the same as in 2009/10. This is in line with national research published by the Children's Society. A full breakdown of the ages of children who became RMHC by numbers of episodes for 2009/10 & 2010/11 are contained appendix 3 tables 4 & 5.

In 2010/11 the split of RMHC by category was general population (GP) **59 %**, children in need (CIN) **18%** and looked after children (LAC) **23%.** In 2009/10 the split of RMHC by category of instances of RMHC was GP **55 %**, CIN **21%** and LAC **24%**. An increase in GP for 20010/11 was off set by a reduction in CIN with LAC remaining similar. The comparison data between 2009/10 and 2010/11 for episodes of RMHC split by category and frequency are contained in appendix 3 table 6.

In 2010/11 the split of episodes of RMHC by home or care was **77%** from home and **23%** from care. In 2009/10 the split was similar **76%** from home and **24%** from care.

In 2010/11 the number of children who were reported RMHC and were the subject of a child protection plan was **6**. The figure for 2009/10 was **3**.

In 2010/11 the **9** children reported RMHC the most frequently accounted for **87**, **23.5%**, of the total number of episodes. In 2009/10 the **13** most reported children accounted for **109**, **25%**, of the total number of episodes.

In 2010/11 and in 2009/10 **all** of the children reported RMHC were found by the Police and taken home or returned home of their own accord.

There is no data to compare return interviews between 2009/10 and 2010/11 as they were implemented in 2010/11. In 2010/11 return interviews were undertaken by a range of services within Child & Adult Services e.g. social workers and prevention workers from the Youth Offending Service. If children were working with an allocated practitioner from one of a range of Children's Services then the relevant worker undertook the return interview. When children's cases were not open to services

workers from the Team around the Primary School or the Prevention Service within the Youth Offending Service undertook the return interviews.

In all of the 16 return interviews analysed the reasons for children becoming RMHC were identified and in 5 cases more than one cause was identified.

Push factors are when children felt they were forced through the actions of adults to runaway as a response.

In three of the 16 interviews only push factors were identified. An example of these factors included when children had gone missing or runaway as the result of an argument with parents or carers.

Pull factors are when children were drawn to people and or activities that resulted in them being reported missing.

In six of the interviews only pull factors were identified. An example of a pull factor was children going to see or be with friends.

In seven of the interviews push and pull factors were present.

There were two main causes of RMHC identified from interviews. Eleven episodes involved going to see or be with friends/peers and in 7 cases it was a dispute with parents/carers.

The summary of the positive findings from analysis of the return interviews found engagement rate of practitioners in completing interviews with children and their parents or carers was good. The recording of the initial return interviews were consistent and clearly identified the causes of children becoming RMHC and the support that was offered to children and their parents and carers.

The summary of the areas indentified for improvement from the analysis of the return interviews found the timescales within which interviews were completed needed to be improved. There was also a need to improve the identification of whether or not there is a risk or not of future episodes of RMHC occurring and the recording of any risk.

Data for the small number of children who are looked after and placed outside of Hartlepool and become RMHC has begun to be gathered and will be included in the annual data report for 2011/12.

There is now two years quantitative data available to compare between 2009/10 and 2010/11. With the former years data gathered prior to the introduction of statutory return interviews and improvements in communications between the Police and Child & Adult Services via the RMHC Co-ordinated Response Group. Therefore this 2009/10 can be used as a comparison year to judge data from future years against.

The RMHC Action Plan for 20010/11 had an emphasis on improving inter agency working between Child & Adult Services and the Police at practice level. During 2010/11 return interviews have been implemented and the RMHC Co-ordinated Response Group established. It is the view of staff from Child & Adult Services and the Police that these developments have contributed to improved communications and working between staff from the two agencies.

Training on RMHC has been offered to staff in November and December 2011. Return interviews will be a core element of the training and will address the areas for improvement that were identified in the analysis of the return interviews.

The previous action plans have ensured that the responses required by the statutory guidance to RMHC are now in place and being evaluated. Therefore for 2011/12 there does not appear to be the need for an action plan. Although, the data for RMHC will still need to be gathered, monitored, evaluated and provided to HSCB.

The Local Authority and the Police have made steady progress in addressing the statutory guidance for RMHC. Data has been produced that supports a better understanding and analysis of the issues associated with and responses to episodes of RMHC. In addition there were reductions in the number of individual children and the total number of reported episodes of RMHC for 2010/11 compared to 2009/10.

It is recommended that:

- The six monthly update should focus on producing quantitative data and information from return interviews

- The annual report should focus on providing quantitative data and information about numbers of individual children and total number of reported episodes of RMHC

Appendix 1

This appendix is the criterion from the statutory guidance for a return interview for children who become RMHC

- RMHC on two or more occasions
- RMHC for more than 24 Hours
- Believed to have been a victim or perpetrator of crime whilst RMHC
- Been involved as a victim or perpetrator of criminal behaviour whilst RMHC
- Known mental health issues
- Known risk of sexual exploitation
- Known risk of contact with persons posing risk to children

Incidents that have generated assessment of needs via Common Assessment Framework (CAF), s.17 or s.47 of the Children Act (1989)

In Hartlepool incidents where children are subject of child protection plan when a first episode or RMHC occurs have also been included in the criterion.

Appendix 2

The breakdown of the 2010/11 population by **gender and frequency** of episodes were:

Gender	1 Episode	2 Episodes	3 Episodes	4 Episodes	5+ Episodes	Total	%
Female	78	7	7	1	5	98	44.5
Male	96	12	4	2	10	123	55.5
Totals	**174**	**19**	**11**	**3**	**15**	**222**	**100**

Table 1

The breakdown of the 2010/11population by **category and frequency** of episodes were:

Category	1 Episode	2 Episodes	3 Episodes	4 Episodes	5+ Episodes	Total
GP	154	22	15	8	21	220
CIN	26	8	15	0	16	65
LAC	12	8	12	0	54	86
Total	**192**	**38**	**42**	**8**	**91**	**371**

Table 2

APPENDIX 3

The breakdown of the 2009/10 and the 2010/11figures for comparison by **gender and frequency** of RMHC were:

Year	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11	2009/10	2010/11
Episodes	**1**	**1**	**2**	**2**	**3**	**3**	**4**	**4**	**5+**	**5+**
Female	77	78	19	7	5	7	2	1	4	5
Male	89	96	15	12	4	4	3	2	14	10
Totals	**166**	**174**	**34**	**19**	**9**	**11**	**5**	**3**	**18**	**15**

Table 3

2009/10

The breakdown of the population by **age**, **gender and numbers** was:

Age	Female	Male	Number	Percentage
1	1	0	1	**0.23%**
2	2	1	3	**0.70%**
3	0	0	0	**0 %**
4	2	4	6	**1.4%**
5	2	3	5	**1.16%**
6	1	8	9	**2.1%**
7	1	6	7	**1.6%**
8	2	4	6	**1.4 %**
9	2	6	8	**1.86 %**
10	3	3	6	**1.4%**
11	7	11	18	**4.2%**
12	10	28	28	**6.54 %**
13	18	42	60	**14.0%**
14	35	75	112	**26.1%**
15	59	25	84	**19.62%**
16	20	48	68	**15.88 %**
17	7	9	23	**5.37 %**
Totals	**172**	**253**	**425**	**100 %**

Table 4

2010/11

The breakdown of the population by **age**, **gender and numbers** was:

Age	Female	Male	Number	Percentage
1	1	0	1	**0.26%**
2	1	1	2	**0.53%**
3	2	3	5	**1.34 %**
4	1	1	2	**0.53%**
5	1	1	2	**0.53 %**
6	0	2	2	**0.53 %**
7	2	12	14	**3.77 %**
8	2	11	13	**3.50%**
9	1	5	6	**1.61%**
10	2	9	11	**2.96%**
11	3	10	13	**3.50%**
12	9	24	33	**8.89%**
13	9	12	21	**5.66%**
14	43	42	85	**22.9%**
15	44	27	71	**19.13%**
16	33	34	67	**18.05%**
17	11	12	23	**6.19%**
Totals	165	306	371	**100 %**

Table 5

The breakdown of the 2009/10 and the 2010/11figures for comparison by **category and frequency** of episodes were:

Year	**2009 /10**	**2010 /11**	**2009 /10**	**2010 /11**	**2009 /10**	**2010 /11**	**2009 /10**	**20010 /11**	**2009 /10**	**2010 /11**
Episodes	**1**	**1**	**2**	2	**3**	**3**	**4**	**4**	**5+**	**5+**
GP	154	154	17	11	5	5	5	2	2	4
CIN	29	26	6	4	3	5	1	0	6	2
LAC	9	12	5	7	4	4	2	0	6	6
Total	**192**	**192**	**56**	**38**	**36**	**42**	**32**	**8**	**109**	**91**

Table 6

SECTION 11

Working Together 2010 states that the core objectives of all Local Safeguarding Children Boards are to:

- co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority.
- ensure the effectiveness of what is done by each such person or body for that purpose.

One of the key functions of Hartlepool Safeguarding Children Board (HSCB), is to "monitor and evaluate the effectiveness of what is done by the Local Authority and Board partners both individually and collectively to safeguard and promote the welfare of children and to advise them on ways to improve"; and, that the Board should "have a particular focus on ensuring that those key people and organisations that have a duty under Section 11 of the Children Act 2004 or section 175 or 157 of the Education Act 2002 are fulfilling their statutory obligations about safeguarding and promoting the welfare of children".

Each Agency or Trust that makes up the HSCB provides different contributions towards the Safeguarding and promoting the welfare of children, depending on the

functions for which they have responsibility**.** It is recognised that each agency has its own arrangements to safeguard and promote children's welfare, in addition to those factors that are common, or likely to be, across all agencies.

Nationally, the section 11 audit is undertaken by the Local Safeguarding Children Board as a way to benchmark current standards, and to identify good practice, areas of concern and areas for further development.

Rather than repeat a full report from agencies for a third year it was decided to audit the action plans produced from the 2010 audit that had been completed by those agencies and Trusts. NHS Tees, new partners to the Board, all Hartlepool schools and those who failed to complete the audit in 2010 were given the opportunity to complete the full audit.

Action plan Audit Participation

The completion rate of the 2010 audit had increased to fourteen agencies, and all agencies identified some actions to ensure compliance, therefore all were provided with a copy of their 2010/11 action plan and asked to confirm, with sources of evidence, how far they had achieved the indentified actions and outcomes. They were also invited to add any new actions that related to safeguarding that they had addressed in the interim period

Agencies responded positively to the request but there was no return from Cafcass

It should also be noted that Health also work towards the National Service Framework (NSF) of which standard 5 is Safeguarding and Promoting the Welfare of Children and Young People.

Section 11 Action Plan Audit 2011 Findings

Standard1. Senior management commitment to the importance of safeguarding and promoting children's welfare

- Hartlepool College of Further Education has updated the job description for both the lead and deputy designated person to show their responsibility for safeguarding children and introduced formal supervision for staff dealing with safeguarding issues when required.
  Both the YOS and Housing leads for safeguarding have job descriptions clearly defining their role and responsibilities in relation to safeguarding and promoting the welfare of children and young people, and is evidenced through supervision and appraisal records.
- Lead officers in respect of eSafety have been identified by Hartlepool College of Further Education, North Tees & Hartlepool Foundation Trust and Tees, Esk and Wear Valley NHS Trust.
- The designated Senior Nurse Safeguarding Children for NHS Tees has ensured there is a culture of listening to and engaging in dialogue with children and young people both when developing services and when making individual case decisions but no source of evidence has been provided for this.

Standard2. A clear statement of the agency's responsibilities towards children is available for all staff

- Hartlepool Child and Adult Services Department, as well as other agencies represented on the Board, has been working with other Tees authorities and agencies to produce updated web based child protection procedures. It is expected these procedures will be launched on 1st May 2012. HBC Housing now have regularly reviewed policies and procedures in place that are in line with LSCB guidance.

- The newly implemented Induction process gives NHS Tees the opportunity to advise staff how policies, procedures and updates are available to them.
- Given that no member of staff is allowed access to the internet unless a business case has been submitted and that all leisure sites are blocked, Cleveland Police will not be writing an eSafety policy and procedure. The Information Security Officer is responsible for the current eSafety procedures and a routine audit of access is undertaken and will ensure the procedures are reviewed every three years.
  Barnardos highlighted the agency was launching nationally reviewed procedures including eSafety and social networking in March 2012.
  North Tees & Hartlepool Foundation Trust has introduced an acceptable use policy in line with the HSCB eSafety strategy, to protect children using digital equipment whilst in their care.
  Hartlepool Child and Adult Services Department has completed work on an eSafety Strategy and Standards for Hartlepool. These became available in July 2011, and will be reviewed every 3 years.
- Tees, Esk and Wear Valley NHS Trust have now reviewed their policies and have confirmed that complaints systems are made clear to service users and their families. Complaints information and information about how to raise concerns and allegations is available to all service users Additionally, the organisation has both a Whistle Blowing Policy and a policy dealing with complaints, concerns and compliments.
- Senior Police staff are to ensure that any commissioning process undertaken by Cleveland Police Authority, has clear specification and guidelines to ensure compliance with section 11

Standard5. Staff training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children and families.

- North Tees & Hartlepool Foundation Trust has revised their induction and patient safety programme and this will now include eSafety.
- Tees, Esk and Wear Valley NHS Trust now keep a register of staff who have completed induction and basic child protection training this is done through staff training records and linked to the electronic Staff record.
- All Youth Offending Service staff are encouraged to undertake HSCB eSafety training, this is evidenced through supervision and appraisal records.
- Training and reading material is made available to staff in the YOS and HBC Housing and they are encouraged to attend through supervision, case managers meetings and staff meetings.

Standard6. Safer recruitment / allegations management

- Barnardos' are to implement a nationally reviewed acceptable use policy in March 2012.
  Tees, Esk and Wear Valley NHS Trust have reviewed the use of technology with in the trust and have implemented information governance policies and procedures for staff that cover the required range of digital technology in use in the Trust. They have identified that as extended technology becomes available appropriate guidelines will require development. For children and young people there are local operational guidelines in in-patient units both for service users own equipment and Trust supplied technology.
- Hartlepool College of Further Education has introduced a procedure to formally record eSafety incidents.
  North Tees & Hartlepool Foundation Trust will use the Datix system to record eSafety incidents and a flowchart will be developed to aid staff awareness as will Tees, Esk and Wear Valley NHS Trust.
- The Director of HR (Probation) is to review the policy and procedures around handling allegations against staff and volunteers to ensure they are suitable for

purpose. This will complement the current Tees procedure for dealing with this issue.
- Temporary and agency staff working for NHS Tees will receive the local induction which will make clear to them the responsibilities in relation to safeguarding

Standard7. Effective inter-agency working to safeguard and promote the welfare of children

- In order to demonstrate strong strategic leadership Barnardos will have nominated by 31/1/12 a deputy for attendance at the HSCB meetings
- A pilot for the use of the pre CAF by Cleveland Police has been launched in Stockton. If successful it is likely to be extended to other Boroughs across Tees.
  Hartlepool College of Further Education are awaiting training through Hartlepool Borough Council with regards the implementation and use of the CAF.
  Hartlepool Child and Adult Services Department has reshaped the support given to agencies in respect of implementing the use of the CAF and this has led to an increase in the number of CAF documents completed and an improvement in their quality.
  North Tees & Hartlepool Foundation Trust has in place CAF champions and a working group to increase the use of CAF documentation across the Trust with specific focus to be in community services.
- The Youth Offending Service now have processes in place to ensure the agency can complete actions from SCRs, gather the evidence required and embed the learning into practice. This is achieved through briefings, training and reading available information
- Probation have requested further clarity with regards their role in relation to Private Fostering. This has been passed to the HBC Private Fostering Lead for further discussion and training.
  Barnardos staff have now received some single agency training in relation to Private Fostering, and all staff are to be encouraged to attend additional HSCB training in relation to Private Fostering.
  Similarly some YOS staff have now undertaken Private Fostering training in order to cascade the information to others.
  HBC Housing are continuously reminded of their responsibilities with regards Private Fostering through staff briefing and reminders

Hartlepool Child and Adult Services Department, HBC Housing and the YOS have not yet had agreed a system to formally record eSafety incidents

The YOS service has not yet shared their accountability framework in relation to safeguarding with staff.

<u>Further actions identified by agencies</u>

In addition to the actions identified through the section 11 audit, agencies were also asked to confirm whether they had identified any other areas for action since the audit was completed, and if so what had been put in place with regard to the issue.

Whilst the majority of agencies have not identified any further areas, some agencies have identified actions as follows:
- The Integrated Youth Support Service identified and implemented a procedure with regard to safeguarding concerns whilst on educational, residential or overnight visits
- Barnardos has undertaken staff briefings with regard to family thinking and looking at safeguarding vulnerable adults procedures and processes.
- A Self assessment undertaken by North Tees & Hartlepool Foundation Trust identified the need to revise the Safeguarding Children Policy. This work was completed in December 2011. Similarly, a training needs analysis is to be completed to identify targeted training needs with regards safeguarding over the three months ending July 2012. It has also been identified that publications and

promotional material should be made available to parents, carers and children who are in receipt of services from the Trust.

- Tees, Esk and Wear Valley NHS Trust have identified that further policies with regard to keeping children and young people safe when using digital technologies are required and that raising awareness about eSafety incident recording is also essential.

Section 11 full audit 2011

The Audit Tool 2011

Following the Section 11 audit of 2010 it was recognised by the HSCB eSafety Group that whilst some eSafety issues were recognised in the audit tool, it was felt that these issues should be highlighted as risks to children and young people that may require addressing by some agencies.

The audit tool has been developed to recognise this and the audit now gives nine clear standards that are expected from all agencies and Trusts represented on the Board. Each of these nine standards is further broken down to enable them to be evidenced.

Audit Participation

The previous audit in 2010 looked at the safeguarding practices of fourteen agencies affiliated to the HSCB. However there was little participation from the education sector, the Safer Hartlepool Partnership, Cleveland Fire Brigade, and Adult Substance Misuse Service.

A full audit for 2011 was therefore requested from all 37 Hartlepool schools who had not previously completed one, and those agencies who did not participate in the 2010 audit.

Eighteen Schools submitted an audit. However 19 schools have not yet completed the audit and none of the identified agencies associated with the Board.

NHS Tees have also completed and submitted an audit.

Section 11 Audit 2011 Findings

Standard 1 – Senior management commitment to the importance of safeguarding and promoting children's welfare.

NHS Tees are fully compliant with regard this standard, however they have advised of work being undertaken to further improve their monitoring processes.

All of the schools meet the essential requirement to have a designated lead with overall responsibility for safeguarding through the organisation, with all designated leads being named and their role and responsibilities being clearly defined in their job descriptions. It is clear all school staff are made aware of who their designated lead is. All schools have clearly evidenced the promotion of a culture within their agency of listening and engaging with children by senior management, and all agencies have confirmed that section11 compliance is considered in the commissioning of services from another organisation, although evidence of this wasn't provided by all schools.

Standard 2 - A clear statement of the agency's responsibilities towards children is available for all staff

NHS Tees and all schools have clearly evidenced that they have policies and procedures in place that are regularly renewed. It has also been documented that several agencies currently have procedures being reviewed, audited or identified as

needing updating. All agencies state and evidence, that they bring these policies and procedures to the attention of staff and volunteers. High Tunstall Secondary School have a Team Tunstall handbook which is shared with all staff and holds all policies, procedures, and advises on responsibility and accountability framework. It has been clearly evidenced that all schools have complaint procedures in place for service users and staff. Section 11 standards are considered by all when commissioning services and have them written into contracts and Service Level Agreements, although some schools did not provide evidence of this.

Standard 3 A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children

There is a clear line of accountability within all agencies and that staff and volunteers understand their personal responsibilities and to whom they are directly accountable with regards a child's welfare. Evidence to support this includes service structures, induction, handbooks, websites and ongoing training processes

Standard 4 Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families**.**

Again, all of the schools and NHS Tees confirmed they had safeguarding children incorporated into service development and delivery and that there is a culture of listening to and engaging in dialogue with children and families to inform service development plans and individual case decisions. It was noted that this standard could only be fully implemented where family members are willing to participate. This was evidenced through Ofsted reports following inspection, inclusion systems and procedures, pupil /parental voice activities, questionnaires and Throston Primary Advice Service (TPAS).

NHS Tees has ensured there is a culture of listening to and engaging in dialogue with children and young people both when developing services and when making individual case decisions. Additionally ensures engagement activity to identify and improve the patient experience, and that local people, including children and young people, are involved in decision-making. Information about experiences of health services is used to inform commissioning decisions and improvements to services. Engagement is undertaken using a wide variety of mechanisms and opportunities, such as concerns, complaints and compliments, they can also make suggestions about future plans / improvements through the participation schemes such as MY NHS and Local Involvement Networks (LINKS).

Using social media is also a key part of NHS Tees communication and engagement, and part of their commitment to ensure that health improvement messages and engagement opportunities are promoted to as broad a section of the local community as possible.

Standard 5 Staff training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in and contact with children and families.

All agencies offer an induction process to staff who have contact with children. This includes the familiarisation with child protection policies, they also offer regular basic child protection training that includes how to recognise signs of abuse and neglect, and covers how to respond to any concerns. This has to be accessed by a member of staff every 3 years. With both single agency and HSCB multi agency training accessed in this process, with many schools now using the HSCB multi agency training for their 3 year update training.

It is stated that child protection supervision is available in NHS Tees and most schools, all have some sort of supervision policies and procedures in place. It is suggested that supervision whilst available, is not always provided in the traditional

way, evidence suggests that child protection supervision if required is provided by a counselling service at High Tunstall Secondary School. Golden Flatts Primary School has a Team Around meeting to discuss concerns and complex cases and, Lynnfield Primary school have weekly Child Protection Meetings. Statutory requirements and recommendations from serious case reviews are circulated through all schools when required, through learning events, briefings, and staff meetings

Standard 6 Safer recruitment / allegations management

All schools confirmed that they have a safer recruitment policy in place. All have copies of the policy available, Throston Primary School have the policy located on the learning platform for easy access.

Safer recruitment training has been undertaken by some staff or / and governors in all schools, St Peters VA school has recently identified the need for training a governor. CRBs are compulsory in all schools for anyone who has any contact with the children and are renewed every three years. This was evidenced through recent inspection reports. Generally the maintenance of the CRB process is through an agency's recruitment process and the records with regard to this are kept in the recruitment files. Probationary periods for staff are in place in all schools.

NHS Tees has identified that they do not currently have a safer recruitment and selection policy, this has been brought to the attention of HR and a new policy will be in place by July 2012.

The name of the senior officer with responsibility in respect of allegations against staff and volunteers is available in all agencies, as are the written procedures for handling such allegations. Evidence suggests that many schools have adopted the HSCB Managing Allegations Policy. All schools have documented these incidents are recorded appropriately. Induction training is given to all staff regardless of temporary or agency status which makes clear their responsibility in relation to safeguarding. Although all agencies confirmed this point, two agencies provided no supporting evidence. Lynnfield Primary identified that their Safer Recruitment Policy needs to made more available and the requirement for safer recruitment training is formalised and documented

Standard 7 Effective inter-agency working to safeguard and promote the welfare of children

NHS Tees are fully compliant with regard this standard.

Attendance at HSCB meetings is confirmed by all agencies, most schools confirmed representation by Alison Darby and confirmed that they see the meeting minutes. It is clear the schools and health are waiting to adopt the updated LSCB procedures which will go live in May 2012. Participation in multiagency meetings and forums to consider individual children is confirmed by most agencies with many highlighting the different meetings they attend. It is stated that the CAF process is widely embedded by the schools, most confirmed the use of the CAF documentation and that appropriate training had taken place. The referral process into Child and Adult Services is clear to all schools and is well evidenced through training, procedures, processes and access to service documents. Serious Case Reviews (SCRs) participation is not confirmed as being in place by all schools with some schools advising that serious case reviews and the associated information sharing is not applicable to them. Other schools confirmed participation when it is required, and have confirmed processes are available to them to ensure SCR activity from completing reports to the embedding of recommendations is in place. However, it is clear these in many cases are untested as some schools advised systems are in place but provided no evidence. The audit has highlighted that Private Fostering responsibilities need further clarification. Several schools advised awareness, but did not provide evidence. Private Fostering is included in the safeguarding training all

school staff are offered by HSCB, and all schools recently took part in a publicity campaign with regard to private fostering.

Standard 8 Information sharing

NHS Tees and most schools have specific guidance available on information sharing, through detailed policies and the use of ECM materials, confirming this guidance is widely available to both existing and new staff, with Stranton Primary School identifying this as a new requirement. The purpose of information sharing is clear throughout all organisations and all agencies are clear that staff have confidence in what they can legally do, including obtaining consent and the actual sharing of information. This is evidenced through the use of training programmes, policies and handbooks. Many schools have agreed that there is an understanding within their agencies, but have provided no evidence.

Standard 9 eSafety

All schools have confirmed that they have a named lead officer for eSafety. Whilst some schools have identified the written eSafety policies and procedures need to be reviewed all schools have confirmed that they are in place. Not all schools have a policy regarding appropriate use of mobile technologies and personally owned devices and the use of social media, but those that do not, have confirmed they will be putting one in place. All schools have acceptable use policies for staff that detail how staff and children/young people can use digital technology.

Not all schools are recording eSafety incidents (including cyber bullying). All organisations must have an agreed form of action to deal with any situation where users do not comply with the acceptable use policy. Any violations of systems or network security may result in the user facing criminal and civil action. All schools confirmed they have a policy in place to deal with this – indeed, some further evidenced that both parents and carers also agree to this policy on an annual basis. eSafety awareness training is available for staff. Not all schools confirmed they were receiving eSafety training; some advised 'support' was available for staff; some schools agreed training was available but failed to evidence this further. No schools referred to the HSCB eSafety training or to CEOP ambassador training although one school confirmed training attendance and the cascading of the learning.

Self assessment action Plan

The self assessment action plan for each agency highlights the standards where additional evidence or action is required to become compliant with section 11, or where work is identified or needed to improve section11compliance. These have been completed by each agency during the full audit and will be returned to each agency. Completion of the action plan will be monitored by the HSCB.

Conclusions

The section 11 audit 2010 action plans have been effective in ensuring those agencies that took part in the audit have actioned the identified areas of concern for agencies where practices were not section 11 compliant.
The action plans have provided clarity and some guidance on the issues that required action for an agency, and will allow agencies to set in place mechanisms to ensure compliance with section 11 requirements.

The action plan audit has provided evidence that standards continue to be met, and of sharing best practice between partner agencies.

The action plan audit has allowed agencies the opportunity to think differently. Notably, NT&HFT previously looked at their use of digital technology and the associated risks as not their problem as the equipment often belonged to the patient. The introduction of HSCB eSafety strategy has seen the Trust implement an

acceptable use policy which applies to all people in their care using digital technology regardless of who owns it. Tees, Esk and Wear Valley NHS Trust have also taken the opportunity to look at eSafety across the Trust, implementing several policies and procedures to keep those using digital technologies safe, and also identifying where additional work will be undertaken with respect to digital technology.

The action plan audit has also shown that working together to implement the actions identified is a useful mechanism to achieve section 11 compliance. Examples include Hartlepool Further Education College approaching Child and Adult Services with regard to CAF implementation, and most agencies are now looking at HSCB training with regard to Private Fostering.

While there are still actions identified where evidence of compliance has not been provided by an agency and there are also actions where work is still to be completed, agencies confirm that they are still giving them suitable priority.

The full section 11 audit 2011 completed in this instance by schools across Hartlepool, has identified areas of concern where current practices are not fulfilling their statutory obligations about safeguarding and promoting the welfare of children under Section 11 of the Children Act 2004 or section 175 or 157 of the Education Act 2002.

The NHS Tees audit showed almost full compliance. All demographic information and organisational structures showing lines of accountability were included. Assurance processes are in place and a full quality assurance framework is also available. Where gaps or further improvements were identified the action plan has been completed.

The audit has highlighted concerns that some schools state they are fulfilling a function, however in practise their methods or policies may not be fully compliant, examples include the provision of child protection supervision for staff and the use of the Common Assessment Framework.

The action plans will clarify many of these issues that require action for schools, and will allow schools to set in place mechanisms to ensure compliance with section 11 legislation.

The 2011 audit has provided improved evidence to show that standards are being met, which HSCB are able to share with all partner agencies. However, some schools, whilst confirming compliance with an audit standard, did not provide evidence of how this was being achieved.

Agencies have identified and recorded the need to improve practices with regard to many of the standards, and this will be reflected in the action plans.

Participation in the audit was poor, and there must be concern as to why some schools did not complete an audit and why the 5 identified agencies did not complete the audit in either 2010 or 2011. It might also be asked how effective the section 11 audit is with regard to individual agencies. Please see appendix 1 for record of submission.

Whilst the number of agencies submitting a completed audit has increased in the 3 years of this audit tool being used, there are some disadvantages of using this tool. One of the disadvantages is the difficulty in challenging agencies in what they have submitted by fellow Board members. The information covers the important areas for demonstrating safeguarding but the arrangement for dealing with the submissions does not support the Board in demonstrating diligence in scrutinising the performance of other member agencies.

Recommendations

That the Section 11 audit tool be completed by all agencies in May 2012, and annually thereafter to ensure compliance and commitment to section 11 of the Children Act 2004.

The timing of the audit at this time will permit direct comparison with other Tees Boards where the same audit will take place in the same timescale. This will also enable agencies that deliver services across the boundaries of several Boards to complete only one audit per year and submit it to the relevant Boards.

Consideration is given to the Performance and Quality sub group to examine alternative methods of measuring the effectiveness of safeguarding across the agencies represented on the Board.

CAFCASS

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
Cafcass works with families in public and private law applications to court. The primary role is:

1. To safeguard and promote the welfare of children.
2. To give safeguarding advice to any court about any application made to it in such proceedings.
3. To make provision for the children to be represented in such proceedings.
4. To provide information, advice and other support for the children and their families.

Key Safeguarding Arrangements and Achievements:

Cafcass measures its safeguarding performance against a number of key performance indicators (KPIs). A2 data for 1.4.2011 until 31.3.2012 shows:

1. Significant improvements in the allocation of cases within target dates .e.g. 100% of public law cases were allocated to a Children's Guardian at month end exceeding target of 97%; 99.8% of cases were allocated to a Children's Guardian by the Case Management Conference exceeding target of 97%; 99.9% of private law cases were allocated to a Family Court Advisor at month end exceeding target of 97%; These improvements have been made in spite of an increase in public and private law work within A2.
2. 99.9 % of section 7 reports were filed by the date agreed with the court.

Nationally 96% of safeguarding assessments were rated as satisfactory or higher by Cafcass management narrowly missing the target of 97%.

Contribution to Multi Agency Working:

Cafcass in liaison with the Local Authority and police to ensure that the court is provided with the necessary safeguarding analysis.

Cafcass and the LAs are developing a protocol for public law work.
Attendance at multi-agency training and developmental events as appropriate.

Effectiveness and Performance including Inspection Outcomes:
The A2 area has not had an inspection by Ofsted in the last year. There has been significant improvement in service effectiveness as identified by the KPIs.

Areas for Development / Improvement:

- To continue to improve the quality of work undertaken in both private and public law.
- To further develop understanding of role and responsibilities between agencies.
- To improve the timescale for safeguarding checks being undertaken.

- To implement the Operational Framework.

Challenges that Still Remain:
The primary challenge is to maintain the level of service intervention and improve the quality of work undertaken with the same staffing resource, but with an increasing workload.

CHILD & ADULT SERVICES – ADULTS

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
Hartlepool Borough Council (HBC) has a responsibility to safeguard vulnerable adults and has governance arrangements in place through the Hartlepool Safeguarding Vulnerable Adults Board (HSVAB) and Teeswide Safeguarding Vulnerable Adults Board (TSVAB).

Contribution to Multi Agency Working:
It is recognised that many cases involving safeguarding of children also involve vulnerable adults and the involvement of a HSVAB representative on the HSCB aims to strengthen links between the two Boards so that processes work effectively to safeguard both children and vulnerable adults.

Challenges that Still Remain:
There are opportunities to further improve partnership working between the HSVAB, HSCB and Safer Hartlepool Partnership through initiatives such as Team Around the Household and Troubled Families. Our challenge will be to work effectively across agencies to reduce duplication and target limited resources to maximise outcomes and ensure that children and vulnerable adults are safeguarded.

CHILD & ADULT SERVICES – CHILDREN

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
The local authority has responsibility for the safety and welfare of children and young people and have specific duties in respect of children under the Children Acts 1989 and 2004 including a general duty to safeguard and promote the welfare of children in need in their area, to promote the upbringing of such children by their families (providing that this is consistent with the child's safety and welfare) and to provide services appropriate to the child's needs. This should; be undertaken in partnership with parents, consider the child's race, religion, culture and language and take into account the child's views, wishes and feelings. . In order to carry out this role the local authority works in partnership with other public organisations, the private and voluntary sector, and service users and carers.
Local authorities act as the principal point of contact for children about whom there are welfare concerns. The may be contacted directly by children, parents or family members, by concerned members of the public, or by professionals from statutory agencies or voluntary organisations.
Where child protection concerns arise the local authority has a duty to make enquiries to consider what action needs to be taken and where necessary, following such enquiries, to put in place a multi-agency plan of protection.

Key Safeguarding Arrangements and Achievements:
Hartlepool Child and Adult Services is regulated by Ofsted and in the past three years has received two unannounced safeguarding inspections and a full inspection of safeguarding and services for looked after children. All of these inspections have judged services to safeguard children in Hartlepool as good with significant areas of strength.
In September 2011, Hartlepool Child and Adult Services took part in a survey undertaken by Ofsted into effective support for front line practitioners. It was selected as one of 23 local authorities in the country to participate and is cited in the

publication High Expectations, High Support, High Challenge which highlights national good practice.

Child and Adults Services have a stable and consistent workforce and is successful in its recruitment and retention of good staff who are committed to working to improve the lives of children and their families. The department works in an integrated way ensuring that the workforce benefits from specialist support and advice from safeguarding professionals, for example through the provision of reflective child protection supervision to staff in schools. Joint protocols are in place across the department for example between children's social care and the Youth Offending Service and this includes a safeguarding practice guidance developed specifically for youth offending staff.
The department effectively commissions services from the independent and voluntary and community sector to ensure the right services are in place at the right time to support children and their families. The department has recently reviewed and reshaped its early intervention services and has developed an Early Intervention Strategy which outlines the vision for the future and the delivery of 0-19 integrated services for children. All commissioned services have been subject to robust commissioning processes which includes ensuring that safeguarding is effectively embedded in the organisation, that the organisation complies with safer recruitment requirements and safeguarding is linked to outcomes for children and young people Child and Adult Services takes lead responsibility for the coordination of the Council wide Safer Workforce Group and provides specialist support to Safe Recruitment training.

Contribution to Multi Agency Working:

Hartlepool Child and Adults Services works in collaboration with multi agency partners to provide services to children. Where children require social care services, they are allocated a social worker who takes lead practitioner responsibility for an assessment of need and the provision of services to meet the identified needs. This work is led by social care, but delivered in partnership with other agencies that are also providing services to the child. The service is currently leading a pilot on preparation of multi agency reports for child protection conferences where the conference will receive one integrated report from the core group. This pilot is in its early stages and the effectiveness of this process will be evaluated to inform future planning around child protection conferences.
Children's services take a lead role in the work of Hartlepool Safeguarding Children Board and are represented on and contribute to the work of all of the Board sub groups. In the past year, the service has led the work of the Task and Finish Group looking at the Arrangements for Safeguarding Adolescents, arranged and facilitated a multi agency conference on Hidden Harm and contributed to the development of the web based Tees Child Protection Procedures. The service takes the lead role in the coordination of the Safeguarding Users Group which brings together operational managers from all key agencies working with children and their families to ensure the effectiveness of the child protection arrangements and develop local services to deliver continuous improvement.
Officers from Children's Services are actively involved in the delivery of multi agency safeguarding training through the HSCB training programme and facilitate a number of courses across all levels of multi agency safeguarding training.

Effectiveness and Performance including Inspection Outcomes:

Children's services are subject to substantial regulation through the Ofsted inspection programme. In 2010, the local arrangements for safeguarding and services for looked after children were inspected by Ofsted and performance was judged to be good. The most recent unannounced safeguarding inspection of the service highlighted good performance and areas of strength with only one identified area for development linked to the implementation of the Common Assessment Framework across services for children. The 2011 Children's Services Assessment judged that Children's Services in Hartlepool Borough Council perform well. Good performance was sustained from 2010 to 2011 and the majority of services, settings and

institutions continue to be good or outstanding. No setting is judged to be inadequate and almost all provision helps children and young people learn well and stay safe. Child and Adult Services are required to provide statutory returns on its annual performance against the National Indicator Set. Within the local authority, these returns are reported on a monthly basis to all managers to ensure that performance is monitored and remedial action taken quickly where any concerns emerge. Most recently Hartlepool Borough Council Adoption Service has been highlighted as one of the best performing services in the country.

Areas for Development / Improvement:
Children's services look to deliver continuous improvement in its services to children, young people and their families. The service is currently developing an integrated performance management framework to embed the integration of services and ensure that children's circumstances are seen across their whole journey through services not considered separately in different services areas. New practice emerging as a consequence of the performance management framework will be the implementation of a revised quality assurance framework, the introduction of practice clinics for case consultation and an integrated workforce development plan.
The Child Protection Conference system is being reviewed with improved reporting arrangements around the engagement of young people, parents and significant others in conferences, preparation of reports by agencies and the sharing of these reports with families prior to the day of the conference. Work is also underway to improve the way conferences are managed with a strengthened focus on robust planning linked to outcomes for children.
A review of the social care duty team was undertaken in 2011/12 and as a result a service restructure is planned. As part of this process, a new Safer Referral Tool to support effective decision making when referrals are being made to social care is being introduced and the Access to Services document is to be reviewed and updated. Parallel to this is the development of a first contact information hub offering support, advice and guidance to multi agency professionals and access into services.
In 2012/13 Hartlepool Borough Council Children's Services will launch an e CAF system and deliver training and awareness raising across the children's workforce.
A Review of the Council's Youth Service is also underway and the findings and recommendations of this review will be implemented in 2012/13.

Challenges that Still Remain:
The Munro Review of Child Protection continues to inform service development in children's services as it considers its structures, practice and performance seeking to embed new ways of working and ensuring that social workers have the skills, support and infrastructure to strengthen their daily work with children and their families.
Over the past year, children's services have seen an increase in the numbers of referrals, children in need and children looked after and responding to this demand and managing capacity remains a challenge. The Early Intervention Strategy will be implemented in June 2012 when services will be reconfigured into an integrated 0-19 locality based team around the family service. The aim of the strategy is to provide services to children, young people and their families at the point that need first emerges to prevent these from escalating resulting in the need for more specialist services at a later time. As part of the strategy the service will move to an electronic Common Assessment Framework which provides a case management system for children and young people in early intervention services. The re-launch of the common assessment framework and the embedding of the electronic system will be a significant challenge for the service in the year ahead.
Ofsted from June 2012 will be implementing a revised inspection framework for which services will need to prepare. As part of this process, a Safeguarding Peer Review has been arranged to be undertaken in September where the service and partner agencies will be scrutinised on the effectiveness of its safeguarding arrangements and partnerships to support children.
Children's services strive for continuous improvement in the provision of services to children, young people and their families. Throughout the year, therefore there will remain a strong focus on reviewing and improving the arrangements to assess, plan and review services for children and examining their journey through these.

Improving services for children can also be achieved through strengthening the integration of services so that children do not need to tell their stories more than once and the service provided to them talk to each other and do not duplicate one another. During the year the service plans to further integrate the Youth Offending Service with the Integrated Youth Support Service and strengthen the links between both of these services and children's social care.

DURHAM TEES VALLEY PROBATION TRUST

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:

Durham Tees Valley Probation Trust provides high quality, timely advice to sentences and the Parole Board. Our supervision of offenders in the community helps protect the public from harm, reduces reoffending, attempts to rehabilitate offenders and supports victims. By working with offenders to change their lifestyles and enable them to change their behaviour, offender managers safeguard and promote the welfare of offenders' children. The Trust is governed by the Durham Tees Valley Probation Board.

Key Safeguarding Arrangements and Achievements:

All offender managers have been trained to consider the issues and risks associated with children who live in families where offending occurs. Emphasis within training and in on going staff supervision is on the issues associated with Neglect , Misuse of Drugs and Alcohol , Mental Health and Domestic Violence . The recent offender management inspection by HMIP reflected the positive role we undertake managing risk of harm including safeguarding children. Offender Managers work to local Safeguarding Children Board procedures in respect of early recognition of needs within a family through to actions required to safeguard children in need of protection. All staff understands and complies with the Common Assessment Framework to highlight needs at the earliest point of contact

Contribution to Multi Agency Working:

Durham Tees Valley Probation Trust contribute to multi agency working through Director commitment to LSCB, management involvement in local discussions with social care colleagues, individual offender manager contributions to case conferences and core groups. Additionally the Trust has a responsibility under Multi Agency Public Protection Arrangements to manage in partnership with others those people who pose the highest risk of harm. The Trust also plays a full part in the MARAC process to manage victims of domestic violence. Developments this year include the contribution to the troubled family's agenda, working in partnership with all organisations to change behaviour within households and a particular emphasis on Domestic Violence as a key issue which affects families and particularly children. The Trust have played a part in promoting the links between parents in prison and the impact on children and how contacts can be established at an early point with the prison and the family with the aim of dealing with any safeguarding issues but also to promote the continuation of parent /child relationships during a prison sentence if this is in the best interests of the child.

Effectiveness and Performance including Inspection Outcomes:

Case sampling within the organisation has demonstrated best practice in identifying families where risk is a particular issue and also recognising neglect. Contributions to case conferences and core groups are effectively monitored through monthly case record checks by the Probation Manager Also the introduction of a process to share information, the CPP3 process has been implemented successfully and evidence is available from the most recent inspection to verify this has worked well.

Areas for Development / Improvement:
Recognising the challenge of parenting skills work with offenders being provided by appropriate agencies as well as tackling the issues of neglect with families in Durham Tees Valley.

Challenges that Still Remain:
Ensuring continued focus on early intervention with families and recognising the agencies who can contribute to work with offenders and their families.

NHS TEES

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
NHS Tees has statutory duties under the Children Act 1989 and Section 11 of the Children Act 2004 to safeguard and promote the welfare of children. It is accountable for improving the health and wellbeing of the population of Hartlepool, which includes assessing the health needs of the town's children and young people and planning the kind of health services they need. NHS Tees is under a legal obligation to work with Hartlepool local authority in carrying out this responsibility. NHS Tees commissions health services from a range of providers and holds the providers of these services to account via contracts. NHS Tees Chief Executive is responsible for ensuring the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole of Hartlepool health economy. NHS Tees is a statutory partner of Hartlepool Safeguarding Children Board (HSCB.)

Governance arrangements for NHS Tees are via its Patient Safety, Quality and Safeguarding Committee, which provides assurance to NHS Tees Board, external audit i.e. Audit North NHS, the Special Health Authority, (previously the Strategic Health Authority) the Care Quality Commission and HSCB.

Key Safeguarding Arrangements & Achievements:
- NHS Tees has a Board Lead to take responsibility for governance and organisational focus on safeguarding children and a Senior Nurse and Consultant Paediatrician (designated senior professionals) to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local health economy. This is in accordance with statutory requirements.
- NHS Tees has significantly improved its quality assurance framework for safeguarding children with the development of the Clinical Quality Review Group (CQRG) which enables NHS Tees to scrutinise and robustly challenge the professional safeguarding children practice of its NHS Foundation Trust providers.
- Robust safeguarding children quality indicators are embedded into NHS Foundation Trusts and other provider contracts and by routinely monitoring contracts NHS Tees is able to assure itself that providers are meeting the required safeguarding children standards.
- All GP Practices have an up to date Child Protection Policy in place, which incorporates the child protection quality standards required of GPs. 14 out of 15 of Hartlepool GP Practices have received a support visit from NHS Tees, which includes discussing Practices' compliance with the policy.
- NHS Tees provides safeguarding children training to Hartlepool GPs, of which 93% have been trained to date. GP appraisers now address any non-compliance
- NHS Tees provides each Hartlepool GP and GP Practice with feedback on their rate of return of information to child protection conferences. This enables GPs/Practices to see their success, identify areas for improvement and also challenge any incorrect data. Since this system has been put into place there has been a significant improvement with an average of 80% return during the last year and in the final quarter of 2011 100% return as compared with 53% the previous year.

- NHS Tees has commissioned holistic paediatric assessments for all children who become subject to a child protection plan for neglect so as to identify and plan for any unmet health and development needs.

Contribution to Multi Agency Working:
NHS Tees is an active participant on Hartlepool Safeguarding Children Board, Executive Committee and its Task Groups including the Tees wide Groups i.e. the Child Death Overview Panel, Procedures and Training Groups. NHS Tees co-ordinates the health input into Hartlepool serious case reviews and management reviews and monitors the compliance of providers with action plans to better safeguard children, for example the T gamily review of 2011. NHS Tees contributes funding to Hartlepool Safeguarding Children Board and in 2011/12 contributed additional funding to support multi-agency training and the development of safeguarding children guidance developed by Hartlepool Children's Social Care.

Effectiveness and Performance including Inspection Outcomes:
The Care Quality Commission and Ofsted last undertook a Safeguarding and Looked After Children Inspection of Hartlepool in 2010, which concluded that the overall effectiveness of the health safeguarding services was good.
NHS Tees undertakes quarterly safeguarding children self-assessments, which are reported to the North East Strategic Health Authority. The assessments continue to show compliance with Section 11 of the 2004 Children Act and the overall effectiveness of NHS Tees safeguarding children arrangements.
In liaison with the SHA, NHS Tees has produced an action plan identifying areas for improvement and development within safeguarding children for 2012/13. Examples are given below:

Area's for Development / Improvement:
- To ensure outcomes measured are the ones that matter most to children, young people and their families.
- Improvement in the active involvement of children, young people and families in the planning and evaluation of safeguarding services.
- Training post Munro
- Think child, think parent, think family approach.

Challenges that Still Remain:
- To continue to help Clinical Commissioning Groups prepare for their safeguarding responsibilities and help them to be fit for purpose at authorisation.
- To continue to strive to constantly improve the quality of our arrangements for safeguarding children

NORTH TEES & HARTLEPOOL NHS FOUNDATION TRUST

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
NT&H NHS FT delivers the standards as defined by the Care Quality Commission (CQC), Section 11 arrangements and the local LSCB audit requirements; ensuring that children are protected from harm and comply with the principles laid down in the Children Act (1989 and 2004), Working Together to Safeguarding Children (HM Government 2010), and the Local Child Protection Procedures of, Hartlepool.

Key Safeguarding Arrangements & Achievements:
A mnemonic has been created 'ACHILD' which is used as a trigger to alert staff to a concern in A&E; Major improvements to the identification and referral pathways are ongoing including sharing of information; identifying concerns about parenting if the adult has care of children; and will inform the work going on across Tees; Quality audit record panels are now embedded in children's services

Contribution to Multi Agency Working:
Named Nurse and Named Doctor represent on Procedures & Practice; Performance and Quality and Workforce Development; Learning lessons review T-Family with joint recommendations (including proposed pilot of joint supervision with social care in some areas); multi-agency group reviewing 'rough guides' for all staff.

Effectiveness and Performance including Inspection Outcomes:
CQC inspection took place as part of the integrated inspection of safeguarding and services for looked after children took place in 2010. At the same time the Trust had

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
identified as part of a health management review that policies and procedures were not in place for looked after children. This policy has now been developed and at the same time the Trust will identify those children who are looked after with a flagging system to ensure appropriate provision of services and consideration of risk.

Area's for Development / Improvement:
Implementing recommendations from Eileen Munro's review of Safeguarding Children working in partnership with LSCB's including of revision of Working Together 2010, Further development of the quality assurance framework including observational audit; Safeguarding supervision for medical staff

Challenges that Still Remain:
Implementation and evaluation of Family Nurse Partnership and the impact of the Health Visitor. Expansion plan; Ensuring that children and young people in Hartlepool remain safe as Health Services continue to be in a period of transition with national and local change including the introduction of clinical commissioning.

POLICE

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
Cleveland Police's primary role in safeguarding is to work with partners to protect children from harm and to bring to justice those who commit crimes against children.

Cleveland Police is committed to being an active member of Hartlepool LSCB, in July 2009 the Force established "Vulnerability Units" with one team (North Tees) covering Hartlepool and Stockton and the other team (South Tees) covering Middlesbrough and Redcar and Cleveland.

The Vulnerability Units are dedicated teams of detectives and police staff bringing together specialist investigators in the fields of domestic abuse, child abuse, honour based violence and vulnerable adult abuse.

The team's child abuse investigators work closely with partners from other agencies to ensure children are safeguarded. This includes attendance and contributions at multi agency strategy meetings, joint investigations, serious case review panels and committees and joint training with partners to ensure a co-ordinated approach is taken to safeguarding.

Detectives conduct rigorous joint investigations into allegations of physical abuse, sexual abuse and neglect. The safeguarding of victims is paramount in all such investigations and the Vulnerability Unit is a point of contact and source of advice to any police officer in relation to issues of safeguarding.

Each Vulnerability Unit has a Detective Inspector reporting to the Detective Chief Inspector responsible for public protection who is a member of Stockton LSCB.
The Chief Inspector responsible for Neighbourhood policing for Hartlepool District is also a board member. This ensures that safeguarding issues are core business for all

police officers and staff working in Hartlepool and not just the specialist Vulnerability Units.

Key Safeguarding Arrangements and Achievements:

Through a risk assessment process conducted at all reported domestic abuse incidents Cleveland Police identify safeguarding issues with young people and act accordingly to protect young people from harm, abuse and 'hidden harm'. The domestic abuse reports are risk assessed by staff within the Vulnerability Units which

Key Safeguarding Arrangements and Achievements:

strengthens our approach to tackling child abuse linked to domestic abuse.

The majority of police officers and police staff in Hartlepool have now completed an E learning package on safeguarding children which should assist them in spotting signs that a child is being abused and knowing what to do about it.

District officers are alert to safeguarding issues as part of their day to day business and will often highlight poor home conditions and other concerns, ensuring immediate issues are addressed and referrals are made to the Vulnerability Unit.

Contribution to Multi Agency Working:

Cleveland Police are represented on Hartlepool LSCB and a number of its sub groups including the DCI for Public Protection chairing the SCR sub Committee. The DCI for Public Protection is also chair for 3 other LSCB SCR sub groups which helps to share the learning from SCR's across Tees.

Officers from the Vulnerability Units attend child protection strategy meetings, Initial Child Protection Conferences and LADO meetings. Attendance by this small number of officers ensures a consistent approach is taken by Cleveland Police. Attendance at these meetings is a performance measure for the Vulnerability Units to ensure we continue to effectively contribute to partnership working in safeguarding children.

Neighbourhood officers work closely with HARBOUR and conduct joint revisits to repeat victims of domestic violence, ensuring full support packages are offered. Neighbourhood Inspector, in conjunction with YOS, delivered a workshop on risky behaviour of young people at the LSCB development day in March. Several neighbourhood officers also took part in the event.

Effectiveness and Performance including Inspection Outcomes:

A monthly audit is carried out by each of the vulnerability unit Detective Inspectors to ensure crimes are recorded ethically (NCRS), victims are kept informed of the progress of investigations (VCOP) and that we work effectively with partners using multi-agency policies and procedures. The above audit contributes to a robust performance management system which exists within Cleveland Police to ensure we are working towards our goals and fully contributing to partnership working to ensure children are safeguarded.

Areas for Development / Improvement:

The process for carrying out SCR's is likely to be subject to change following recommendations in the Munro report. It is important that the subsequent process implemented is fit for purpose and robust. As chair of the SCR Committee the DCI responsible for Public Protection will have a key part to play in this.

Challenges that Still Remain:

Introduction of Police and Crime Commissioners
Impact of current financial climate

TEES, ESK AND WEAR VALLEY'S NHS FOUNDATION TRUST

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:

- To provide mental health and learning disabilities services
- To meet the requirements of the Care Quality Commission Essential Standards of Safety and Quality and the responsibilities of 'Working Together' in safeguarding the population that services are provided to .
- Safeguarding is governed by:
  - Ensuring an executive safeguarding lead on the Board of Directors
  - Representation on all LSCBs in the localities where the Trust provides services
  - Internal Trust Safeguarding Groups that are assurance working groups to the Quality and Assurance Committee (QuAC) – which is the sub-committee of the Board of Directors that is responsibility for monitoring assurance of the provision of safe and effective services and compliance, together with regulation and legislation
  - Regular audit, assurance and performance reports to the QuAC and to commissioners

Key Safeguarding Arrangements & Achievements:

- Safeguarding is administered and led by a team managed within the corporate Directorate of Nursing and Governance, supported with a Trust wide network of operational staff in the role of Safeguarding Link staff. The team comprises of a Named Doctor (1 session) An Associate Named Doctor (1 session) A Named Nurse (1.0 wte) Senior Nurses (3.0 wte) First contact trainer (1.0 wte) and team administrator (1.0 wte) with management provided by the Associate Director of Nursing and Compliance .
- Safeguarding is a key activity for the Trust - this year there has been expansion in the team , compliance with training targets has increased significantly, safeguarding audit programme has been implemented and the training strategy has been reviewed. All training programmes have been fully implemented and new systems have been developed to track concerns and referrals . The Trust has participated fully in LSCB activity and maintained all the internal assurance requirements. There has been an annual programme for Trust Board involvement established and seminars have been held.

- All Section 11 assessments have been completed and quality indicator requirements have been met for the commissioners of services.
- The Trust has established good systems for the involvement in MARAC process, has contributed to the development of Teeswide procedures and is a key player in the development of a Think Child Think Parent Think Family protocol for us e in MH/LD with the Tees Designated Nurse.

Contribution to Multi Agency Working:

Contribution to multi agency training programmes and working groups

Effectiveness and Performance including inspection Outcomes:

All objectives and annual plan priorities have been met for safeguarding children. Quarterly performance reports have been submitted to commissioners that include training compliance and last quarter safeguarding case file audits. Commissioners have been satisfied with assurance of performance provided.

Area's for Development / Improvement

- Further development of compliance audits
- Implementation of new Level 3 training requirements
- Full compliance with Think Child, Think Parent, Think Family system across all services

Challenges that Still Remain:
Working across 7 LSCB areas with local authorities that all have different referrals systems, initiatives, priorities and procedures.

FIRE SAFETY

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
Cleveland Fire Brigade's primary role is to protect the local communities it serves; however we aim to not only protect those communities but to truly make a positive difference to the quality of people's lives and the places where they live and work.

Within Safeguarding we work with partners without out four local authority areas to protect children from harm. We deliver a number of targeted services to those determined as vulnerable in their local communities to support the improvement of their individual situations. We work to ensure that the understanding of all our staff and our working practices contribute positively to this.

We have a small dedicated team that work with young people across the area to ensure a co-ordinated and consistent approach is taken to safeguarding. These staff regularly participates in multi-agency training to ensure their practices are in line with those promoted through local safeguarding children's boards.

Cleveland Fire Brigade is governed by Cleveland Fire Authority; the authority is responsible for setting the strategic direction, policies and priorities of the Brigade. In doing so it aims to take into account the views of our stakeholders and keep them fully informed of Fire Authority plans. The authority comprises of 23 elected members from the Borough Councils of Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees.

Key Safeguarding Arrangements and Achievements:
Cleveland Fire Brigade has robust safeguarding policies in place which are reviewed annually in line with local safeguarding board guidance. Safeguarding arrangements are in place linked to our brigade duty systems which provide round the clock service.

The majority of staff within our service have completed e-learning packages on safeguarding; however our dedicated children and young person's team have received extensive training through local safeguarding children boards on a number of topics pertaining to safeguarding.

Contribution to Multi Agency Working:
Cleveland Fire Brigade are represented on a number of partnership boards within the Hartlepool area. Specifically safeguarding related we sit on the Hartlepool LSCB. Our staff contribute to CAF referrals and participate in child protection meetings are required.

Effectiveness and Performance including Inspection Outcomes:
There were no child fatalities in house fires in Hartlepool during the year.
Our performance is monitored formally on a monthly basis by internal managers and then reviewed by our Fire Authority on a quarterly basis. The findings of these quarterly reviews by Cleveland Fire Authority published publicly on out Brigade website.

Areas for Development / Improvement:
Involvement / further support to be given to Brigade staff to Hartlepool LSCB and its subgroups.

Challenges that still remain:
Impact of current financial climate which affects our capacity to contribute to multi agency work.

HOUSING SERVICES

Agency's Primary Role, Safeguarding Responsibilities & Governance Arrangements:
Council's strategic responsibility for housing services and homeless & advice services, these services often have service users who are families with children. Safeguarding responsibilities and governance arrangements are all those cover by all Council services.

Key Safeguarding Arrangements & Achievements:
All issues reported immediately to partners and within the council, regular training and team briefings. A number of the Housing services team have undertaken refresher training in Safeguarding during the year.

Contribution to Multi Agency Working:
This is fundamental to the way in which the housing service undertakes its operations, as a strategic housing authority.

Area's for Development / Improvement:
Continued refresher training and briefing sessions will take place and a training update is scheduled for June 2012.

Challenges that Still Remain:
Ongoing refresher training and reminder briefings.

LICENSING

The Licensing Act 2003 was introduced in November 2005 and brought about a fundamental review of licensing laws – most significantly the introduction of the concept of '24 hour drinking'.

The Act also consolidated a number of older licensing laws that were specific to individual activities such as the playing of live music, recorded music, cinema and indoor sports.

Local authorities became 'licensing authorities' and, as such, the administration and enforcement of the Act is now undertaken by the Council's Licensing Team (and Cleveland Police).

The Act also introduced the requirement that all licensing decisions must be based on the promotion of one or more of the four 'licensing objectives' which are: -

- Prevention of crime and disorder
- Public safety
- Prevention of public nuisance
- Protection of children from harm

The Licensing Act identifies a number of 'Responsible Authorities' that must be consulted whenever an application for a licence is made. One such responsible authority is identified as: -

'a body which –

1. represents those who, in relation to any such area, are responsible for, or interested in, matters relating to the protection of children from harm, and
2. is recognised by the licensing authority for that area for the purposes of this section as being competent to advise it on such matters.'

In Hartlepool the local Safeguarding Children Board has been identified as the appropriate body and, as such, is consulted whenever a licence application is submitted.

In 2011/12 a total of 41 applications were received by Hartlepool Borough Council and were considered by the officers representing the Safeguarding Children Board.

In addition to the work carried out by the Board a number of other responsible authorities work to ensure that licence applications will do nothing to undermine the safety of children. The Council's Trading Standards Service reviews every licence application and regularly asks the applicant to introduce additional measures to ensure the protection of children. This will often include the requirement for the adoption of a 'Challenge 21' age verification policy, refusals book, till prompts (to remind staff when they are selling an age restricted product) and the display of posters to remind staff and customers that alcohol cannot be sold to children.

Trading Standards officers also carry out 'underage sales' operations whereby child volunteers work with officers to test the resilience of licensed premises. Children ask for alcohol and, if they are sold it, officers may prosecute the premises and/or review the alcohol licence which could result in it being revoked.

In 2011/12 a total of 56 premises were tested this way with 5 (all on-licensed premises) that willingly sold to the 15 and 16 and 16 year old volunteers. This resulted in a number of 'Simple Cautions' being issued (a formal admission to the commission of a criminal offence that can be used in court in future).

Contact Officer: - Ian Harrison, Principal Trading Standards & Licensing Officer, Hartlepool Borough Council, Bryan Hanson House, Hanson Square, Hartlepool, TS24 7BT (01429) 523349. E-mail ian.harrison@hartlepool.gov

ROAD SAFETY

Hartlepool Borough Council has the statutory duty under the Highways Act to investigate the occurrence of injury related road collision and implement measures and initiatives to prevent death, serious and slight injury on our roads.

Hartlepool Borough Council also has a Statutory Duty under the Education and Inspections Act (2006) to promote sustainable modes of travel for school journeys.

The Councils Road Safety and Sustainable Travel Team, located in the Integrated Transport Unit of the Transportation and Engineering Division delivers a comprehensive range of road safety/sustainable travel initiatives and interventions in partnership with a number of agencies to discharge the above statutory duties.

The Road Safety and Sustainable Travel Team has a remit for:

- Delivery of road safety education, training and publicity initiatives.
- Marketing and promotion of safer and active travel
- Road Safety education interventions in schools
- Bikeability Cycle Training
- The School Crossing Patrol Service
- Driver Development Training
- Delivering Walking / Cycling to School promotions and initiatives
- Installation of cycle parking at schools
- Safer Routes to School engineering schemes
- National Driver Offender Retraining Schemes
- Safety Camera Partnership operation
- Promotion of safer road user behaviour through publicity and marketing.

A significant proportion of time is spent delivering schemes aimed at:

- improving the safety of children
- reducing road danger and casualties
- encouraging safer road user behaviour
- educating parents,
- encouraging use of active travel modes to bring health benefits for pupils and parents, and
- improving the environment through smarter travel choices
- The team delivers an annual programme of activities, initiatives projects and awareness events to address safety concerns amongst children of all ages.

Below is an overview of our areas of work:

School Crossing Patrol service management and provision

- 44 School Crossing Patrol Wardens employed to assist children, parents and other pedestrians to cross the road safely.

Road Safety Training in Schools.

- The Road Sense Scheme is predominately delivered in wards with the highest incidence of disadvantage/health inequalities. The scheme involves a whole school approach to Road Safety and has been delivered in 8 schools.
- Over 150 nursery and reception children have benefited from general road safety awareness projects.
- To date over 1100 Year 3 children were trained in practical on road child pedestrian training.
- To date over 1000 Year 4 children have been trained to level 1 of the National Cycling Standard Bikeability.
- Over 1400 Year 5 and 6 Children were trained to level 2 of the National Cycling Standard Bikeability
- Over 40 children have been trained to level 3 of the National Cycling Standard Bikeability.
- 10 children and young adults with special education needs/mobility impaired were trained in independent travel training.
- Bus behaviour and safety projects delivered to 600 pupils.

Targeted Road Safety Training – child seats, seatbelts etc

- Delivery of safety initiatives at events organised in supermarkets, community centres, libraries and other public buildings.

Publication of road safety articles in the media to target parents

- Regular articles in the Hartlepool Mail, various health publications relating to child seats, seat belts and restraints.
- Editorial has appeared in Primary Times school publication, Retired and Living in the Tees Valley and Hartbeat – the HBC magazine delivered to all homes in Hartlepool.

Crucial Crew targeted at Y6 primary pupils

- Management of this multi-agency initiative delivered to over 1100 Year 6 pupils

Secondary school safety events

- Crime and Safety Events in partnership with the Police and the Prison Service.
- The pre-driver 3D (Drink, Driving and Drugs) initiative.

Environment Roundabouts

- Delivery of sustainable travel themed environmental education to over 500 Year 5 pupils. Education focuses on the benefits of walking / cycling to school to improve the environment, increase safety, and benefit health.

Theatre in Education initiatives

- Theatre companies used to promote sustainable travel and modal shift in Schools.

Learn and Live – Fire and Rescue

- The Road Safety Unit has assisted the Fire and Rescue Service in delivering their Young Driver presentation to over 800 pupils at the College FE

PCT funded schemes

- 500 cycle helmets purchased through a PCT grant and distributed to schools as a loan based scheme during Bikeability cycle training schemes.

Safer Routes to Schools

- Numerous 20 mph zones introduced outside schools and safety schemes aimed at speed reduction, accident prevention and promotion of walking and cycling.

Education/Enforcement Initiatives

- Targeted school gate parking initiative involving the Sustainable Travel Team delivering safety messages and the Parking Enforcement Team enforcing parking restrictions. This help to promote more walking and cycling to school by making the area around the school safer.

Surestart Events

- Initiatives/events held within the communities and attended by Road Safety staff targeting child seats, seat belts and general road user behaviour/awareness.

Active Travel Promotion

- Promotion of walking to school through events such as Walk to School Weeks, establishment (in conjunction with Living Streets) of Walk once a Week (WoW) scheme in 9 primary schools in the town, Walking Bus projects, car free days, vehicle exclusion events at schools, walking zones and engineering projects..
- Promotion of national events to encourage cycling to school such as the Sustrans Big Pedal.
- Installation of secure cycle parking at schools around the town.

- The Road Safety and Sustainable Travel Team also distribute road safety literature on a community wide basis to schools, children, parents, residents etc in support of any safety initiatives. This is done in addition to the delivery of presentations to schools, businesses, communities and driver training groups.

The Road Safety Unit annually details collisions involving all road users with particular reference to child casualties. Road Safety performance in relation to child casualties is shown in the following table:

Year	Cyclists			Pedestrians			Car passengers		
	0 - 15 yrs			0 - 15 yrs			0 - 15 yrs		
	F	S	SI	F	S	SI	F	S	SI
1996	0	0	13	0	8	54	0	0	7
1997	0	1	13	0	9	35	0	2	19
1998	0	2	7	0	12	35	0	0	12
1999	0	3	14	0	5	24	0	1	18
2000	0	1	4	0	3	27	0	0	6
2001	0	0	14	0	9	23	0	2	21
2002	0	4	7	0	8	25	0	0	11
2003	0	5	10	0	9	20	0	0	10
2004	0	0	11	1	7	20	0	2	11
2005	0	0	10	0	3	22	0	1	23
2006	0	3	6	0	8	17	0	0	20
2007	0	0	4	0	8	19	0	3	16
2008	0	2	4	0	1	11	0	0	8
2009	0	2	6	0	2	12	0	0	2
2010	0	1	4	0	4	13	0	0	4
2011	0	2	8	0	4	7	0	0	3

Child Casualties 0-15 years 1996-2011 – All User Group
F = Fatal S = Serious Injury SI = Slight injury

The data contained in the table above reflects the work of a number of partner agencies including the Police, Fire Service and communities including Hartlepool Borough Council, to promote safer road user behaviour.

In general, casualties amongst children of school age are at low levels and have been kept relatively low through the initiatives and interventions detailed in this report. However, in order to sustain these levels and reduce casualties further existing partnerships must be reinforced and new partnerships formed with other agencies including the civil sector.

Recommendations
The Hartlepool Safeguarding Children Board note the report.

WATER SAFETY

Since 2004 with the reintroduction of the Beach Lifeguard Service the Beach Safety Team have organised and delivered various water safety initiatives.

A rookie training week is organised annually, this involves groups of primary school children doing a mini beach lifeguard competition. The activities include a water safety talk, rope throw to a target, flag race, use of rescue board and a wading rescue. There is a trophy for the school with the most points at the end of the week. The sessions were delivered from July 4th – 8th; 140 children participated, the event is planned again for July.

St Joseph's Primary School 4/7/2011

Occasionally when requested we will deliver a beach safety talks at the beach for school groups, also providing lifeguard cover for some school events, in or around open water. The Beach Safety team delivered water safety talks to the Sea Cadets; two sessions were delivered, one session for the younger age groups and one session for the older age groups. We will be delivering a talk on water safety and the role and responsibilities of a Beach Lifeguard to the Cubs in May.

All the work we undertake around water safety is promoted through the local media; all initiatives will be subject to a press release, or press campaign, including the rookie lifeguard training and the competition winning team. Last year the rookie lifeguard training received national press coverage on Newsround, they showed footage of the water safety talk and all other activities.

Every year we do a press release for the start of the lifeguard service which starts for the Whit holidays, this includes advising people to swim where the lifeguards are; we also do a water safety follow up prior to the Summer Holidays.

We work very closely with Hartlepool Mail, reporting any incidents the Lifeguards have dealt with on a weekly basis; if appropriate we will do a press release for some incidents to emphasise the safety message at the beach.

Much of the work we do is repeated annually, as the work is seasonal and needs to be promoted year on year.

Recommendations
Hartlepool Safeguarding Children Board is requested to: note the contents of the report

Hartlepool safeguarding children board

Business Plan

April 2012 – March 2013

CHILDREN LIVE SAFELY IN HARTLEPOOL

To support that overarching outcome, the following outcomes remain priorities of the Board

1. Children and young people live in households where they are properly cared for, all of their needs are met and they are free from the impact of neglect.

2. Children and young people live free from the impact of Domestic Violence.

3. Adolescents in Hartlepool are supported to make safer choices and are safeguarded from significant harm.

4. Children and young people safely access and use existing and emerging technologies to aid their enjoyment and achievement.

5. Staff working with children and young people are suitably trained to meet their needs.

Contents

At the Board Development Day in January 2012, the priorities determined by the Board two years ago were agreed as still remaining as the priorities of the Board. Consequently, they also limited the Business plan to those priorities as described in the attached action plans. The action plans have been devised in their current format to increase the opportunity to demonstrate impact on children and their safety.

It was also recognised that the Board should limit the volume of actions to be pursued to a level where there is a realistic expectation that they can be achieved in a relatively short timescale without imposing unrealistic demands on the staff of the various agencies involved. It was also agreed that reporting back on progress in the action plans would happen regularly during the year and if appropriate addition actions agreed by the Board – particularly if new issues are presented to the Board.

One particular challenge will arise from the Munro report whose recommendations will be taken forward by the Board as developments unfold from Central Government. The revision of Guidance will have an impact on the work of the Board and will need to be addressed. The change from a perceived over dependence on procedures to an increase in professional judgement will present a challenge to the agencies involved and they will look to the Board for support and training. However, no specific action plan has been devised for this work as it will be devolved in response to guidance as it is issued.

Actionplan: Adolescents

Milestone 2012/13	How will it be delivered	Group responsible for delivery	Time for completion	How will impact be demonstrated	RAG Ratin
Local young people will have an increased understanding of the local 'Youth Offer' and how to access safe places to go and things to do alongside how they can access further help and support if they (or their families) are experiencing difficulties.	All opportunities and support available for young in Hartlepool will be collated on the 'Youth Offer' website. The 'Youth Offer' website will be linked to 'Fronter' in all Secondary Schools to increase exposure. The 'Youth Offer' website will be formally launched to raise awareness across the local adolescent population.	Early Intervention Central Information Hub in partnership with the local town wide Youth Work group. Early Intervention Central Information Hub in partnership with Secondary Heads. Early Intervention Central Information Hub in partnership with the local town wide Youth Work group.	July 2012 July 2012 July 2012	Increased uptake of local youth provision and youth support arrangements.	
Local young people will have an increased understanding of the risks and harm associated with substance misuse, sexual relationships, offending, anti-social behaviour and dietary choices.	Establish and deliver a coordinated PSHE curriculum across local Secondary Schools that is in line with local need.	Task and Finish Group to be established containing representation from across local Secondary Schools, Public Health and Youth Support Services.	January 2013	Reduction in the number of young people requiring specialist intervention relating to risk taking and harmful behaviours. Particularly in relation to Substance Misuse, offending and anti-social behaviour,	

				teenage conceptions, Sexually Transmitted Infections and Eating Disorders.	
Enforcement agencies have an increased awareness of the emphasis local young people place on belonging to large groups when using public spaces as a key safety measure.	Deliver sessions to Police and Anti-Social Behaviour Officers to raise awareness.	Integrated Youth Support Service in partnership with the Young Inspectors and Youth Advisory Team.	January 2013	Collaborative approaches are developed to manage concerns relating to large groups of young people across Hartlepool neighbourhoods.	

Actionplan: Domestic Violence

Milestones for 2011-12	**How will it be delivered**	**Group responsible for delivery**	**Time for completion**	**How will impact be demonstrated**	**Progress RAG Rating**
Domestic Violence forum to develop from the Domestic Violence Strategy and LSCB Reps actionplan.	HSCB to hold and monitor the DV forum actionplan	PQA Sub Group on behalf of the HSCB	May 2012		
Multi agency audit of Domestic Violence cases undertaken	Through HSCB partner involvement in audit	PQA Sub Group on behalf of the HSCB	March 2013	To highlight the effect of DV in families	
Outcome	**Output**	**Actions**	**Who**	**Time scales**	**Progress RAG Rating**
Schools are informed of all reported DV incidents pertinent to children in their school, in order to understand and support the children and young people effected	To support and protect those children where incidents of DV have taken place	Information HUB staff to inform a school if a an incidence of DV has been reported in the household of one of their children	Information HUB with regular feedback into HSCB		
All frontline staff receive training to work effectively with recognition and addressing domestic violence and managing risk to contribute to the safety of victims and children.	Training provided single agency and multi agency to all frontline staff	Agencies represented on LSCB to ensure single agency training in place. LSCB Training Group to ensure Domestic Violence training provided multi agency	HSCB Partners HSCB Training Group		

Identification of early intervention needs of children living in households where domestic violence is occurring.	Agencies to work to a common assessment tool which identifies children in households where domestic violence is occurring	Agencies represented on LSCB to ensure frontline staff complete CAF as early as possible where domestic violence is occurring and follow safeguarding procedures	HSCB Partners		
Improvement of co-ordination between services around risk assessment, delivery of services and shared working.	Agencies will share relevant information and work jointly wherever possible to reduce the risks of domestic violence to victims, including children	Agencies represented on LSCB will ensure staff are aware of the need to share information and contribute to risk assessment and work jointly to deliver services	HSCB Partners		
Improvement in services to, and preventative work with, children and young people.	Services will be delivered which meet the needs of children and young people	LSCB will seek the views of children and young people to determine what they consider the relevant services should be Information on Domestic Violence will be disseminated to children and young people Education Services will be supported to integrate issues around domestic violence into the existing curriculum Explore how a resilience approach which focuses on equipping children and young people to cope with	HSCB Partners		

		living with domestic violence can be developed Review models for providing confidential support for young people affected by domestic violence through 1:1 or group work and commission relevant services			
Once Domestic Violence is identified victims, including children and young people, will be supported to remain within the system.	Agencies to consider how they can continue to work with victims through follow-up contact and ongoing contact following the first identified domestic violence incident	Agencies to review responses to follow-up contact and continued delivery of services	HSCB Partners		
Preventing the cycle of violence repeating itself with those children and young people living with domestic violence.	Appropriate targeting of resources to children and young people who may become perpetrators of domestic violence	Consider approaches to educate children and young people, specifically those in vulnerable families	HSCB Partners		
Perpetrators will be encouraged to engage with voluntary and statutory perpetrator programmes.	Perpetrators will be processed through the CJS to engage with perpetrator programmes and also if not convicted, to attend voluntary perpetrator programmes.	Agencies to ensure staff are aware of available programmes and promote their use with perpetrators. Appropriate support to victims to be in place alongside perpetrator attendance at programmes	HSCB Partners		

Actionplan: Learning and Development 2012/13

OUTCOME: Children Live Safely in Hartlepool

Priorities	Action	Who	Time	Progress	Review	RAG
Develop a HSCB Interagency Learning and Development Strategy for 2012/13	• Review current practice and produce a Learning and Development Strategy which is fit for purpose.	HSCB Learning & Development Coordinator	To be completed by May 2012			
Develop an HSCB Learning and Development Programme for the 2011/12 learning and development plan providing detailed course information.	• Produce and distribute via email and publish an electronic version on the HSCB website.	HSCB Learning & Development Coordinator / HSCB Learning and Development Subgroup.	To be completed by May 2012			
Ensure single agency learning and development is implemented and effective and of a quality to meet the HSCB's standards.	• Undertake quality assurance of all single agency safeguarding and child protection learning and development activities in Hartlepool.	Working Group	To be completed by March 2013			

Establish if any duplication of single agency training can be delivered in partnership between agencies.	• Liaise with all agencies in Hartlepool who access single agency safeguarding and child protection learning and development activities in Hartlepool to work in partnership with other agencies to ensure more inter agency learning and development is undertaken.	Working Group	To be completed by March 2013			
Contribute to the work of the Teeswide Group to combine Teeswide Learning and Development.	• Attend Teeswide Group and undertake direction from DSC & HSCB Chairs.	Clinical Director of Community Services, North Tees and Hartlepool NHS Foundation Trust/HSCB Business Manager/HSCB Learning & Development Coordinator	To be completed by March 2013			
Evaluate the effectiveness of learning and development on working practices.	• Analyse responses from Impact Evaluations received for all inter-agency learning and development activity. • Liaise with managers within all agencies to encourage more responses to impact evaluation requests.	HSCB Learning & Development Coordinator Working Group	To be completed by March 2013 To be completed by March 2013			
Ensuring appropriate staff access courses.	• Audit – twice yearly • Ongoing Investigation of agencies attendees relating to	HSCB Learning & Development Coordinator/HSCB Learning & Development Subgroup HSCB Learning & Development Coordinator/HSCB Learning	To be completed October 2012 To be completed by March 2013			

	job roles throughout HSCB Inter-agency Learning and Development Programme 2011/12.	& Development Subgroup				
Identify the course requirements and volumes for the 2013/14 inter-agency learning and development plan.	• Consultation with Safeguarding Team, Organisational Managers and all HSCB member agencies. • Undertake a Learning and Development Needs Analysis to scope number of employees requiring HSCB Inter-agency learning within all of children's workforce organisations via questionnaires and focus groups, etc. • Consider learning and development recommendations from Analysis of Serious Case Reviews 2001 – 2007 Report and Taking Action: Ofsted's Evaluations of Serious Case Reviews 1st April 2007 to 31st March 2008 and recent local Serious Case Reviews, Management Reviews and Learning Reviews. • Establish expected costs and request funding from Hartlepool HSCB for Inter-agency Learning and Development Programme 2013/14.	HSCB Learning & Development Coordinator Working Group HSCB Learning & Development Coordinator	To be completed by December 2012 To be completed by January 2013			

Actionplan: Neglect

Milestone 2012/13	How will it be delivered	Group responsible for delivery	Time for completion	How will impact be demonstrated	RAG Rating
Children's workforce will have an increased understanding to recognise and identify neglect leading to early intervention to prevent a child from suffering harm	Deliver brief (2 hours) Master Classes on neglect under HSCB learning and development programme Deliver sessions on self and professional challenge either set up under HSCB or through pre existing forums Provide guidance to children's workforce on escalation processes for HSCB where practitioners consider their concerns are not being listened to or they remain concerned about the welfare of a child. Develop a mechanism to report escalation activity to HSCB Review graded carer profile as a tool to support identification of neglect and if compatible with work local practice, implement use of tool across children's workforce.	Task and finish group of multi agency professionals to be created	All actions to be implemented and where possible embedded by March 2013	At least 50% of children referred to specialist services will have received early intervention support. Reduction in the numbers of children becoming subject to a child protection plan under the category of neglect.	

Actionplan: Quality Assurance

Milestones for 2012-13	How will it be delivered	Group responsible for delivery	Time for completion	How will impact be demonstrated	Progress (RAG)
Assure Board on quality of work in complex cases Develop staff experience in Case Review skills	Undertake a "Learning Review" type analysis of one multi-agency complex case each quarter	P & QA with input from relevant agencies	Report to Board 3 times per year	A cross section of complex cases will be analysed and input made if required with any lessons to be learnt identified for implementation across all cases	
Board demonstrating that it is holding agencies accountable for auditing their safeguarding practice	Agencies to adopt a multi-agency element into their agency safeguarding audit processes and report evidence of their safeguarding audits to the Board	Each Board member agency	Each agency to present annually –consider a whole day event	The common format to be used will include specific sections where impact on the safety of children will be addressed	
Board to provide opportunity for reflective practice and effective learning from previous Reviews	Establish regular forums where front line staff from all agencies can explore practice, discuss complex cases and share learning. These would be supported by senior staff from agencies	Safeguarding User group	Forums to be in place before September 2012	Changes to be fed into Executive Group for information	
Board to satisfy itself that the requirements of Section 11 of the Children Act 2004 are met by the Board	Review of how the requirements are checked and implement agreed new format	P & QA with input from relevant agencies, including neighbouring Boards	Should be in place by October 2012	The reporting will give more direct evidence of how requirements actually safeguard children	

Board to involve children & young people in the development & review of services	Commission Young Inspectors to undertake research into how children & young people can make the most effective contribution.	Executive Group with the assistance of the Young Inspectors	Final report and recommendations to be presented to September meeting of the Board	The Young Inspectors will be asked to review the impact of the implementation of the recommendations after 6 months.	