# Halton Safeguarding Children Board

## Annual Report 2015-16

## and

## Business Plan 2015-17

**September 2016**

**Version 4.0**

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## Appendices

# 1. Independent Chair's Introduction

I am pleased to present to you the Halton Safeguarding Children Board (HSCB) Annual Report for 2015 - 2016. I hope you will find it useful in understanding the way all services in Halton work together to safeguard children who are suffering, or may be at risk of, harm. The Annual Report provides information on how many children in Halton require additional support, including protection from abuse and neglect, and how agencies have worked together to provide this support. The report highlights the achievements of the Board and identifies priorities for future work. It shows how we continue to scrutinise and challenge the work of partner agencies and promote a culture of openness and learning. By doing this we seek to improve the safety and wellbeing of the children of Halton. This report is intended to provide information for all who work with, or who are interested in, safeguarding children and young people.

The Board does not work in isolation and has defined governance and accountability agreements in place for how we work with other Strategic Partnerships in Halton. The Board has continued to develop its structure and membership to ensure that it can deliver effective scrutiny and challenge to promote improving safeguarding practice. We have worked with colleagues in Adult Safeguarding and the Faith Sector to establish the Halton Faith Safeguarding Forum made up of local Faith representatives. This group now enables the Board to more effectively listen to faith groups across Halton and to support them in improving safeguarding practice.

The Board recognises that the work of partners to safeguard children and young people is continuing against a backdrop of a challenging economic environment and fundamental reshaping of public services. Austerity challenges have led partners to review their financial support for Safeguarding Boards and in many cases reductions have been made; this has impacted on the small HSCB Support Team. Despite the reduced budget and other team resourcing challenges this year, the safeguarding scrutiny work led by the Board continues to ensure that safeguarding remains a priority for all partners. The Board has delivered a challenging multi agency audit programme including co-ordinating safeguarding audits from every one of Halton's schools.

The Board has continued to make progress against its improvement plans. Effective multi-agency training and communication has improved identification and reporting of children who are in Private Fostering arrangements [see 5.9]. Training in recognising the signs and risk factors of neglect, using a standard assessment tool, has been delivered to support practitioners in making more effective early interventions and reducing the level of harm in what is the most common cause of significant harm. The Board is seeing increasing numbers of multi-agency early intervention plans and will be closely monitoring how this is impacting on reducing the harm of neglect.

The Board has scrutinised processes and service outcomes for children at risk of, or suffering Sexual Exploitation, ensuring risks are identified and effective interventions are in place. Work with other Safeguarding Children Boards in Cheshire has strengthened arrangements for dealing with Child Sexual Exploitation and has provided information to young people and their families so that they can recognise

risk and abusive relationships. The Board is exploring further work with Pan Cheshire partners to improve strategy and policy in Domestic Abuse and harmful practices including Honour Based Violence and Female Genital Mutilation.

In December 2015 HM Government announced a review into the role and functions of Local Safeguarding Children Boards to be undertaken by Alan Wood CBE. The review made a number of recommendations and HM Government set out its response in a report in May 2016. Alan Wood's recommendations are being incorporated in the Children and Social Work Bill which will make some significant changes to the governance structures for children's safeguarding. The Board will be working closely with our principal partners to ensure that Halton continues to have strong and effective safeguarding arrangements in place.

Richard Strachan
Independent Chair
Halton Safeguarding Children Board

## 2. The Structure of the HSCB

The HSCB comprises of a Strategic Board, an Executive and a number of sub groups. All sub groups have defined terms of reference, work plans under the HSCB Business Plan and are accountable to the Strategic Board. The Main Board is the overarching decision making body and the Executive drives the business on behalf of the Board, with the sub groups reporting directly to it.

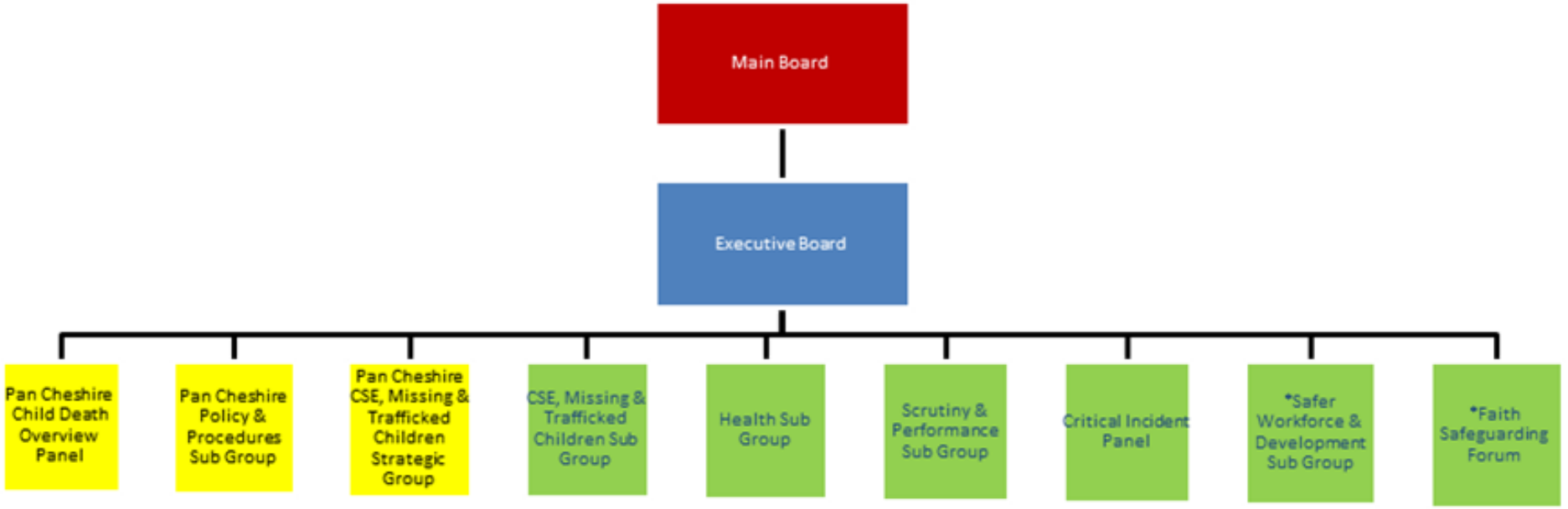
There are clear overlaps and common issues between children's and adults' services in relation to safeguarding vulnerable people, whatever their circumstances. Examples include: Sexual Exploitation, Cyberbullying and Female Genital Mutilation. The behaviours and personal situation of a vulnerable adult in a family can impact significantly on any children and young people in that family, and may impair parenting abilities. In addition, childhood experiences may have lasting effects into adulthood. For this reason, Halton has strong links between the Safeguarding Adults and Children Boards.

During 2015-16 an agreement was reached to merge the Learning and Development and Safer Workforce Development Sub Groups to form the Safer Workforce and Development Sub Group. This was agreed on the basis that it was a more efficient means of overseeing the priority 4 in the HSCB Business Plan: *Support the development of a safe and informed workforce, including volunteers in relation to the workforce.* This Sub Group sits jointly under both the Adults and Children Safeguarding Boards.

The Board has also worked with the Safeguarding Adults Board to develop a Faith Safeguarding Forum in Halton. The membership has grown over the year to include more denominations and local representation. This Forum helps the Board to promote safeguarding amongst those, including volunteers, who are coming into contact with some of the more vulnerable residents of the borough.

Three sub groups operate on a Pan-Cheshire basis: Child Sexual Exploitation, Missing & Trafficked Children; Policies & Procedures; and Child Death Overview Panel (CDOP). These Pan-Cheshire arrangements support the four LSCBs to work more effectively. The arrangement supports and enables improved information sharing arrangements to address issues which do not recognise local authority boundaries, such as Child Sexual Exploitation or Trafficking. Diminishing resources are also pooled to develop effective awareness raising campaigns such as Safe Sleep or Child Sexual Exploitation.

# HALTON SAFEGUARDING CHILDREN BOARD STRUCTURE

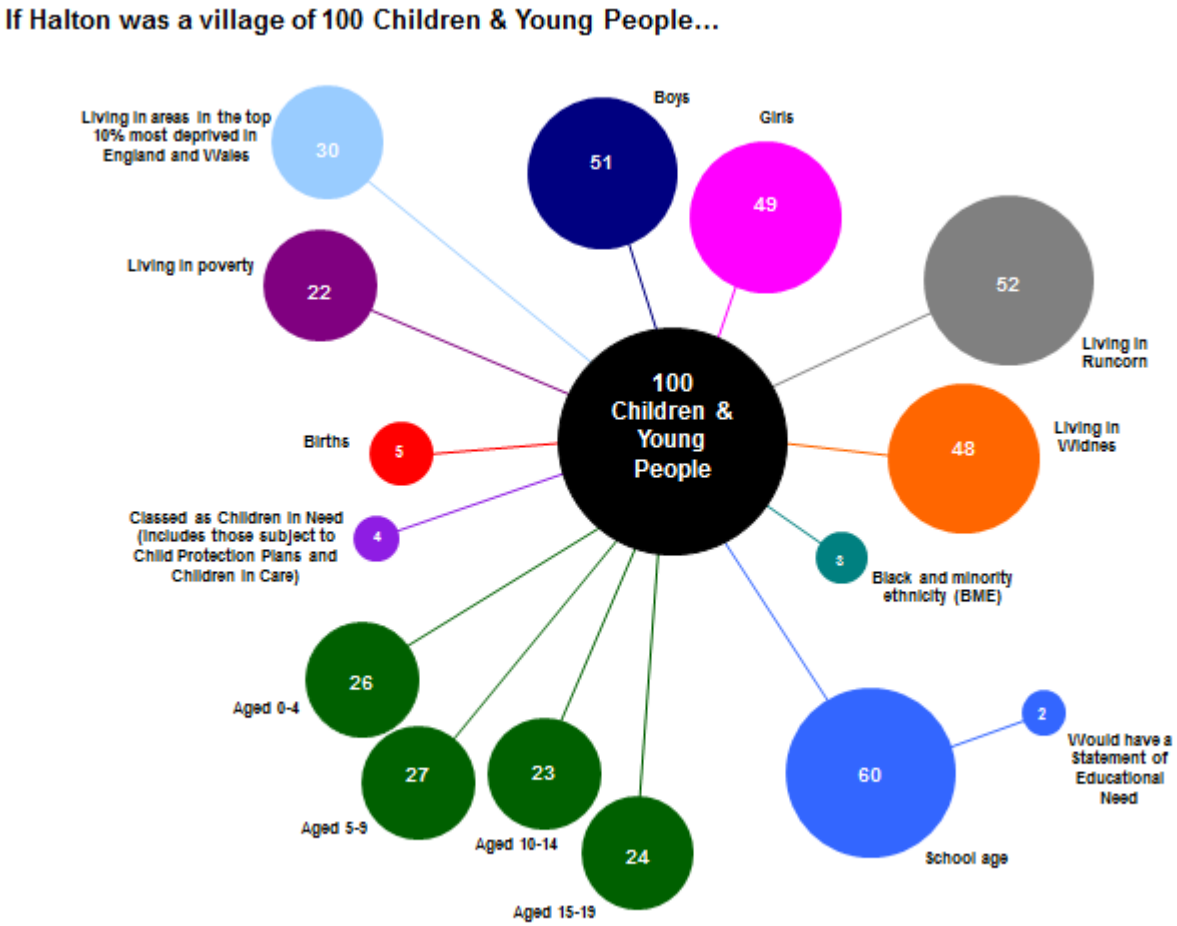



*Denotes joint Sub Group of the LSCB and Safeguarding Adults Board

## 3. Demographics of Halton

Halton has an estimated population of 126,400, of which approximately 29,700 children aged between 0-18 years are living in the borough. (Source: ONS, 2014 Population Estimates). The population is largely White British, with only 3.2% of the population identified as being from a minority ethnic group. (Source: 2011 Census)

Halton is the 27th most deprived local authority area in England out of 326. 26% of the population live in areas that fall in the top 10% most deprived nationally. (Source: Index of Multiple Deprivation, 2010) In 2014, 22% of children and young people were living in poverty. (Source: DWP, Out of Work Benefit Claimant Households, 2014)



## 4. Key Priorities 2015-16:

The LSCB's 2015-17 Business Plan identified five strategic objectives:

1. Identify and prevent children suffering harm.
2. Protect children who are suffering or at risk of suffering harm.
3. Ensure that children are receiving effective early help and support.
4. Support the development of a safe and informed workforce, including volunteers.
5. Engage with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding.

In addition to the strategic objectives, the LSCB identified five areas of focus to be considered across all of the strategic objectives:

a) Neglect
b) Early Help and Support
c) Children in Care
d) Child Sexual Exploitation and Missing Children
e) Domestic Abuse

The five areas of focus were identified from the information collated through performance monitoring, audit of practice, the outcome of reviews, feedback from frontline staff and engagement work with children & families. Progress against these priorities is detailed in the body of the Annual Report.

## 5. How Safe are our Children and Young People in Halton?

## Safeguarding Activity 2015-16

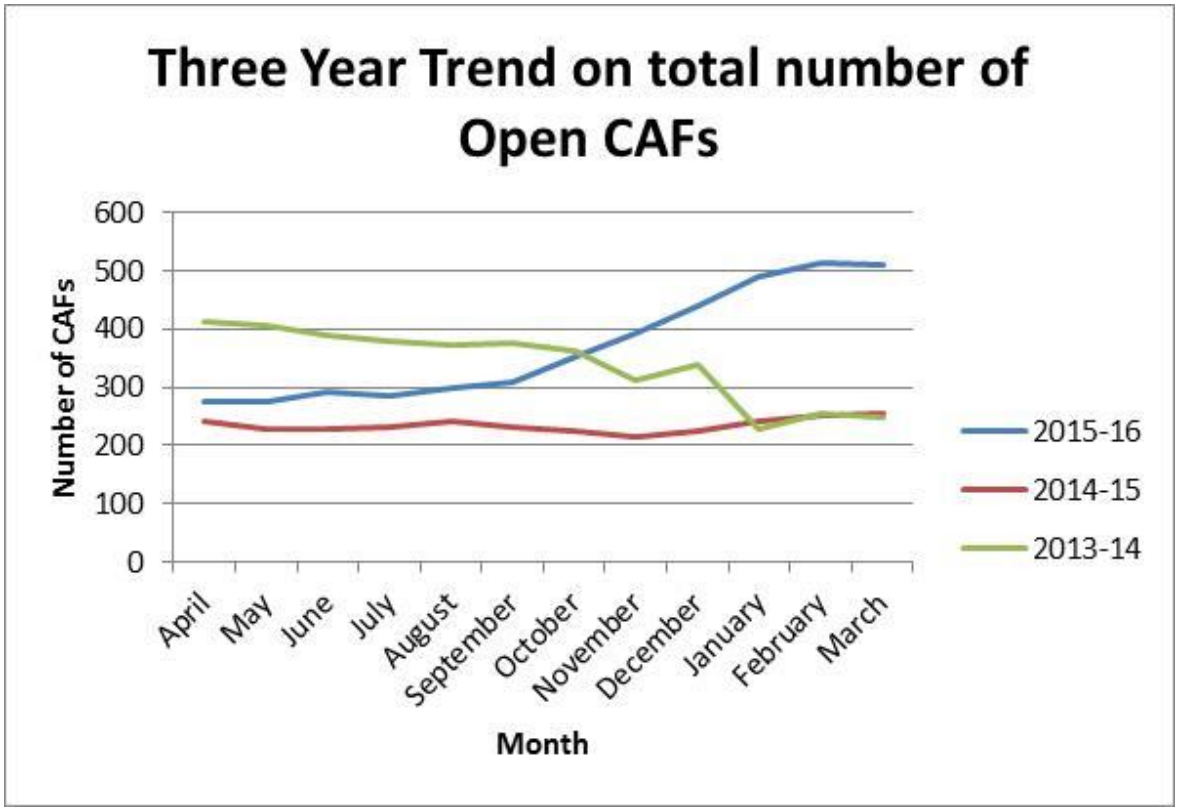
### 5.1 Early Intervention

Halton's Early Intervention Strategy ensures that identified and assessed needs of children and families are met at the lowest, safe level of service possible. In some instances children may have additional needs which if addressed at an early stage will prevent the need to refer to Children's Social Care at a later point. The child and family may need a range of supportive services to address these additional needs. The Board and its partners have agreed the use of the Common Assessment Framework (CAF) which is a voluntary assessment process, requiring informed consent of the family or young person, dependent upon age and understanding. The child's needs are assessed holistically, services delivered in a coordinated manner and progress and outcomes reviewed regularly.

The CAF may also be used when the level of risk has been reduced so that families no longer need a service from Children's Social Care. This is to ensure that any ongoing needs of families continue to be met and/or that families and young people are supported to access universal services.

At the end of 2015-16 there were 510 open CAFs in Halton. This was a 144% increase from 2014-15 which ended the year with 209 open CAFs. The number of open CAFs in 2015-16 saw an increase each quarter, with quarter 3 showing the greatest increase. This increase is due to both the implementation of a more robust

recording system, the eCAF, and the work being undertaken to promote early intervention via the integrated frontdoor. It is expected that numbers will continue to rise into 2016-17 as the eCAF system is implemented across all partners and with the establishment of the multi-agency Integrated Contact and Referral Team (ICART) under the Complex Dependency project.




## 5.2 Children in Need and Child Protection

All services and the community in Halton need to be vigilant and have the confidence to report concerns where they think that a child may be at risk of harm. We also need to ensure that children have opportunities to speak out when they are at risk, or are being harmed. Specialist services such as Children's Social Care and the Police can only intervene to protect children if they are alerted to concerns. The Board promotes messages to both the public and staff regarding what to do if concerned about a child's welfare. In addition, specific campaigns are also promoted by the Board; such as recognising Child Sexual Exploitation, or how to keep safe using social media and the Internet.

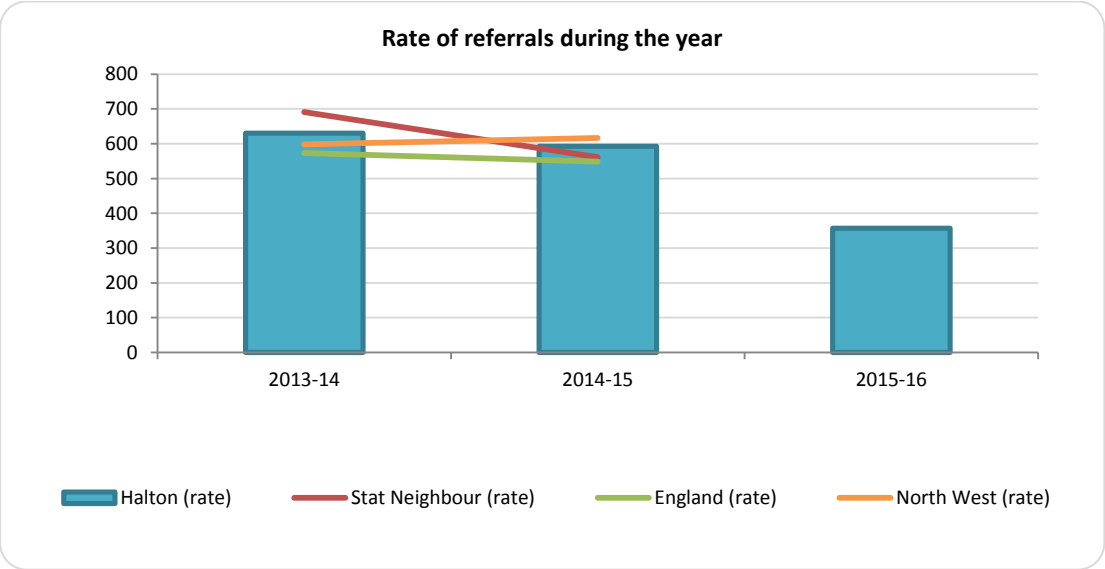
The following information is about children and young people in Halton who have been identified by the Local Authority and partner agencies as being in need of safeguarding.

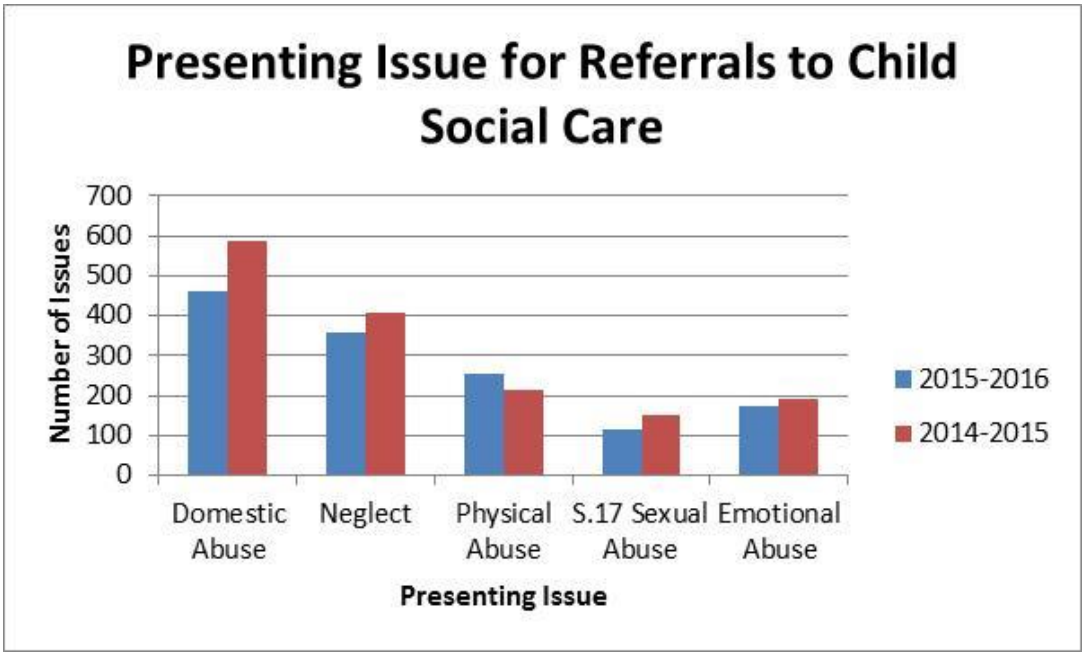
The rate of Children in Need in Halton on 31st March 2016 was 424 per 10,000 population based on those children and young people who have been involved with Social Care across the Levels of Need Framework (see Appendix B Halton Levels of Need Framework). This includes those receiving an assessment, subject of Child Protection Plans, Children in Need and Care Leavers. The latest available data

from 2014-15 shows that the average for Halton's statistical neighbours was 442 per 10,000 population.

## 5.3 Referrals

A referral is information received by Children's Social Care where there are concerns about a child. The response may be to provide advice, a single agency response, sign post to early intervention or to undertake a Social Worker led single assessment.




The rate of referrals to Children's Social Care has reduced in comparison to last year quarter on quarter. The latest available data for 2014-15 shows that statistical neighbours had a rate of referral of 561 per 10,000 population. In Halton the data shows we are still seeing high levels of referrals in relation to Domestic Abuse and Neglect as seen in previous years.

## 5.4 Re-Referrals:

In 2014-15 the Board was concerned by the percentage of re-referrals to Children's Social Care within 12 months of the previous referral; the rate was 17%. Work was undertaken in order to understand the reasons for this. Children's Social Care introduced a process of monthly scrutiny by the managers at both early intervention and social care levels with case by case reporting to senior managers. This resulted in re-referral rates falling significantly. Considering this alongside other performance reporting the Board was satisfied that the reduction was not due to an issue in applying the levels of need framework and that children were receiving the appropriate level of support in relation to their needs and risk of harm. By the end of 2015-16 the re-referral rate was 13%, a 4% decrease on the previous year.

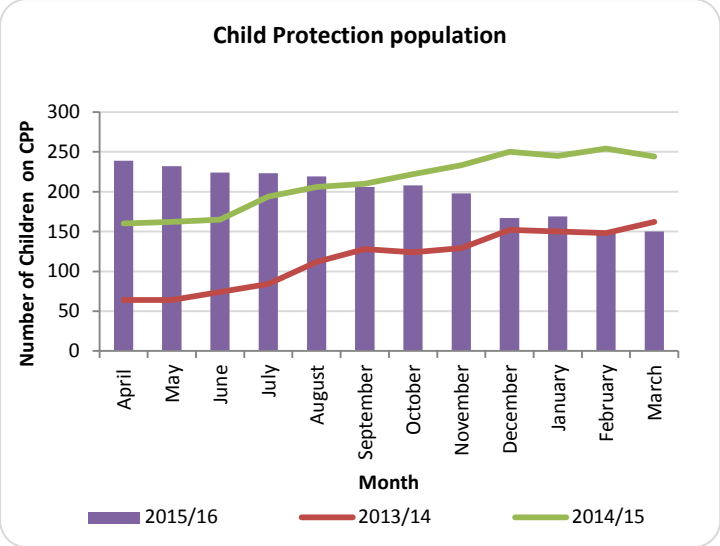
## 5.5 Assessments:

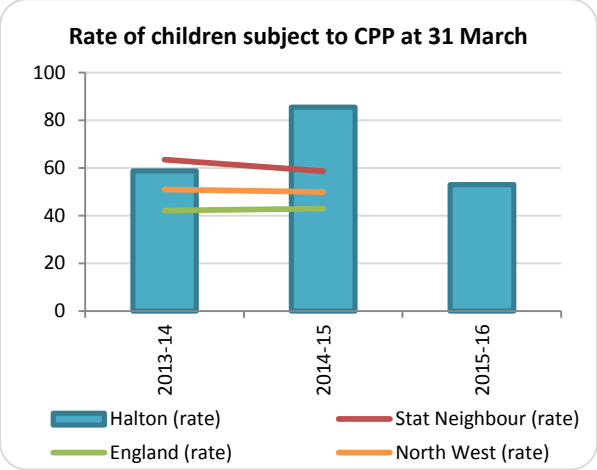
When Children's Social Care accepts a referral an assessment is undertaken by a Social Worker. Checks are built into the process to ensure that the child is seen in a timely manner and that the assessment is progressing to timescale. Social workers have up to 45 working days to complete their assessment and determine what services, if any, are appropriate for that child/children and family. At the end of 2015-16 84% of assessments had been completed within the 45 day timescale, an improvement on the previous year's average of 74%. Positively end of quarter 4 data showed that 91% of assessments were completed to this timescale. This shows the positive impact of measures put into place by Children's Social Care to improve management capacity and oversight.

The Board was concerned at the high percentage of social work assessments closed to no further involvement by Children's Social Care. An audit was undertaken on behalf of the Board by the Safeguarding Unit to look at the reasons for this; in addition Children's Social Care also undertook their own audit of referral information received from partners. The findings of both were reported to the Board. It was identified that referrals were appropriate as was the decision to proceed to social work assessment. The decision to close to social work involvement at the end of assessment was also appropriate. What was not clearly evidenced in the reporting was the amount of work being undertaken with families during the social work assessment which meant that there was no ongoing need for social work involvement. Children's Social Care are looking at how the direct work undertaken can be captured in reporting. The learning from the audit highlighted a need for partner agencies to ensure that they provide supporting information at the point of referral to support decision making and that they have sought consent from families prior to referral.

## 5.6 Children Subject to Child Protection Plans:

Children become the subject of a Child Protection Plan when it has been identified that they are in need of protection from either neglect, physical, sexual or emotional abuse. Only the most vulnerable children have child protection plans.




The rate of children in Halton who were subject of a Child Protection Plan at 31st March 2016 per 10,000 population was 53. The latest available data from 2014-15 shows that the average for Halton's statistical neighbours was 59 per 10,000 population.

Last year's HSCB Annual Report highlighted a significant increase in the number of children subject of a Child Protection Plan. This began to plateau at the end of last year. This continued during the first half of 2015-16 before the rate fell in the second half of the year. The rate is now similar to the North West average for last year.

## Category of Abuse for Child Protection Plans:

The category of abuse reflects the most significant risks to the child.

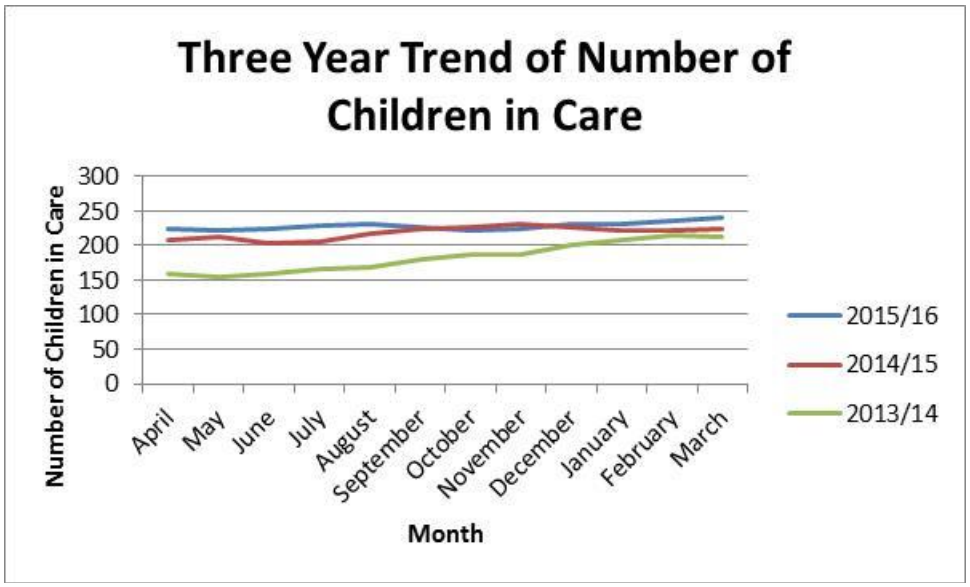
| | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|
| **Neglect** | 54% | 54 % | 58% |
| **Sexual** | 13% | 10% | 7% |
| **Physical** | 5% | 5% | 2% |
| **Emotional** | 28% | 31% | 32% |

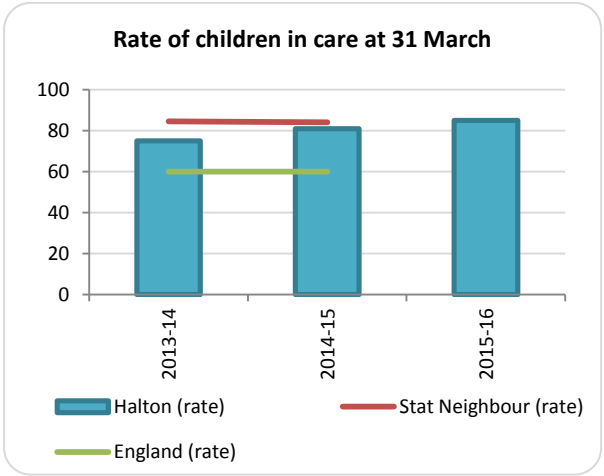
*NB Children may change category of abuse during the course of the Plan and therefore may appear in more than one category.*

Neglect remains the most common reason for children to become subject of Child Protection Plans. There was a decrease in the proportion of Child Protection Plans for physical harm and a slight decrease in plans where likelihood of sexual harm was identified. The Board was concerned about the low proportion of Plans under these categories and asked for further scrutiny. The Safeguarding Unit undertook an audit on behalf of the Board which identified that in some cases plans may be categorised under either neglect or emotional abuse when there is evidence that there are risks in relation to likelihood of physical or sexual abuse and it would have been more appropriate to categorise under these risks. As we respond to these findings the Board would expect to see the impact over the first quarters of 2016-17 as plans are reviewed in line with the child protection process.

At the end of the year 10% of children had become subject of Child Protection Plans for a second or subsequent time. This was a 50% decrease on last year, reflecting the reduction over the year of larger families where children become subject of Child Protection Plans.

## 5.7 Children in Care



At 31st March 2016 there were 240 Children in Care. This was similar to the previous year. This is a rate of 81 per 10,000 population. The latest data in relation to statistical neighbours shows a similar rate of 84 per 10,000 population in 2014-15.

The Board receives reports form the Local Authority's Children's Commissioning Team on the quality of residential placements for Halton children placed within or outside the borough. There is a clear process in place for reviewing any provision that falls below the Ofsted "good" judgement whilst a Halton child is placed there. In addition arrangements are in place whereby the Commissioning Team receive information from local authorities in the North West, North East and Pan London on the quality of independent placement providers which inform decisions on where to place children.

## 5.8 Children in Care of Other Local Authorities (CiCOLA)

Some children living in Halton are Children in Care of other local authorities (CiCOLAs); this means that they live in foster care placements, independent children's homes or within a Leaving Care/Semi Independent placement where the placement has been arranged by another local authority.

Each local authority is required to maintain a current list of the children placed into its area.

On 31st March 2016 there were 177 children on the CICOLA list, a slight increase on last year. Five neighbouring local authorities - Cheshire West & Chester, Knowsley, Liverpool, St Helens and Warrington account for 63% of those placements. 87% of placements overall come from North West local authorities.

The commissioner responsible for the oversight of notifications attends the Children Missing from Education meetings to support information sharing and confirm the school/educational placement of these children. The Commissioning Team also support the Placement Provider Forum which has developed links between the independent providers in the borough and multi-agency partners such as the Local Authority, Police, Health Services, Missing & CSE Service and young people's Drug & Alcohol Service. The forum provides an opportunity for local providers to share good practice on themes such as Missing from Care, CSE, Health Improvement offer and LADO procedures.

## 5.9 Private Fostering

Private fostering is an arrangement, usually made by a parent, for a child under 16 years (or under 18 years if they have a disability) to be cared for by someone other than a close relative (ie grandparent, brother, sister, aunt or uncle) for 28 days or more. It does not apply to children who are looked after by the Local Authority.

LSCBs are expected to ensure that effective processes are in place to promote the notification of private fostering arrangements in their local area. This includes raising awareness amongst staff and the public of what constitutes a private fostering arrangement, and the requirement to notify Children's Social Care. The local

authority is required to provide an annual Private Fostering Report to the LSCB, which the LSCB reviews and responds to any findings as necessary.

The Board has undertaken some targeted work in relation to the Ofsted review in 2014 as it had identified that more needed to be done to raise awareness, identification and notification of private fostering in Halton. The Private Fostering Operational Group was reviewed, with membership and terms of reference refreshed. This included the addition of two young people as members.

The Operational Group has reviewed the awareness raising message, focussing upon "Looking after someone else's child" and revised the communication strategy. The young people and local children from a Halton school have been involved in developing new leaflets. Partners have been asked to report on Private Fostering as part of the S11 and S175/157 audits. The Safeguarding Children in Education Officer has also discussed at network meetings with the safeguarding leads in schools, and Private Fostering is included in both single and multi-agency training.

Despite increased awareness raising activity only one new referral was received during the year. This may be due to targeting the wrong staff groups; national research has identified a high proportion of children becoming privately fostered due to their parents being hospitalised due to substance misuse or mental ill health. Further staff briefings are planned for 2016-17 and are targeting these staff groups.

Improvements in recording mean that we know that 21 notifications were received in 2015-16 which did not proceed to assessed placements. When families in Halton are experiencing difficulties intensive support is provided either via the CAF process or by Social Care; extended family members are considered as possible carers for children and young people and family meetings are convened to consider who in a family is able to care for a child in the event a parent may not be able to. If significant concerns about the welfare of the child are identified during the initial Private Fostering screening process, this may lead to the Local Authority commencing court proceedings or requesting consent from parents to accommodate their child. In some instances the young person turns 16 thus ending the Private Fostering arrangement.

In 2015-16 there were 7 notifications of which 5 became Private Fostering arrangements. 3 arrangements carried forward from the previous year. By the end of 2015-16 5 arrangements were still in place. All had visits in the required timescales.

## 5.10 Children who are Adopted

The number of adoptions from care during the reporting period was 17, 14 of whom were placed with prospective adopters within 12 months of the decision to adopt. The government sets two threshold measures for adoption:

A1: Average time between a child entering care and moving in with its adoptive family. This threshold is 426 days and Halton's forecast is 501 days suggesting an improvement from the previous three year period, but not below the threshold.

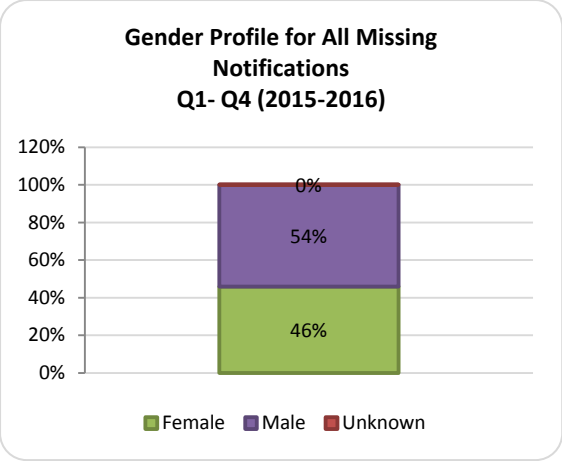
A2: Average time between a local authority receiving court authority to place a child and the local authority deciding on a match to an adoptive family. This threshold is 121 days and Halton's forecast is 198 days which represents further increase and decline in performance.

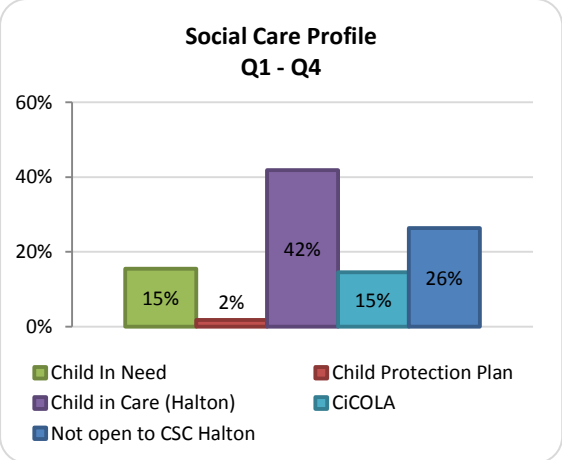
Despite an improvement in the A1 indicator Halton did not meet either indicators. Of Halton's comparator authorities only one met the first indicator and none met the second. As Halton's adoption cohort is small, performance can be significantly impacted by individual children's circumstances. For example, in relation to the A2 indicator, the average time was increased where children had significant health needs meaning it takes longer to find a suitable match.

## 5.11 Missing Children

Catch22 is the commissioned service which has been providing the Missing from Home Service across Cheshire since 2012. Staff from Catch22 work closely with the police Missing from Home Coordinator and other partners. They undertake return interviews and assessment, followed by direct intervention work as required. They also undertake independent return interviews with children in care, placed outside Cheshire, but living within a 20 mile radius.

### Missing Children Data April 2015 – March 2016




The graph above shows 60% of children subject to missing, absent, away notifications

received during the period 1 April 2015 – 31 March 2016 are known to Halton Children's Social Care, 26% are children placed in Halton by other Local Authorities (CICOLAs) and the remaining 15**%** are not open to Social Care.

During 2015-16 there was a noted increase in 16 and 17 year olds going missing from semi-independent placements. As a result Care Plans have been reviewed to ensure they are informed by information from the Return Interviews. We have also seen occasions whereby there have been a number of Cicolas who have gone missing from the same placement. The Commissioning Team has worked with the placement and challenge has been made to the placing local authority regarding the suitability of placements.

As highlighted in last year's Annual Report, Halton's Ofsted inspection report published in February 2015 identified a priority action for the Local Authority to ensure that all children and young people who go missing from home and care have a Return Interview, and that information is made available to relevant professionals in a timely manner to inform risk assessment, management and planning. The CSE, Missing and Trafficked Children Sub Group scrutinises the data in relation to missing children. The delay in completing Return Interviews has been challenged during the year with Catch22 and Children's Social Care working together to address. Catch22 have visited the social work teams to ensure that staff are clear as to their responsibilities in relation to notification, particularly with regards to Children in Care of Halton placed within 20 miles of Cheshire. In addition, the Sub Group ensured that partners are aware of their responsibilities in relation to undertaking Return Interviews where Catch22 may be unable to complete.

Catch22 undertook an audit of Return Interviews which led to changes to recording practices and improved information sharing with Children's Social Care following completion of direct work. Children's Social Care audited missing children cases and briefed staff on the learning identified. The Commissioning Team has undertaken monitoring of any Return Interviews taking 5 days or more to complete, and all partners have agreed to undertake Return Interviews where necessary.

There has also been a notable impact upon notifications being received in a timely manner following the Police Missing from Home Coordinator going on maternity leave at the end of 2015. Notifications have been sent to Catch22 in batches which has impacted on their capacity to complete the Return Interviews. Both Catch22 and Children's Social Care escalated their concerns with the Police but did not see sustained improvement, the Police were challenged at the Board. The Board also challenged the Police directly on this and the performance continues to be closely monitored by the Sub Group.

## 5.12 Child Sexual Exploitation (CSE)

Sexual exploitation can happen to boys and girls from any background. Any child under the age of 18 may find themselves in a situation that makes them vulnerable to CSE. Perpetrators can be male or female, adults or other young people.

Halton continues to be part of the Pan Cheshire approach to tackling CSE. A Strategic Group, chaired by Halton Borough Council's Chief Executive, consisting of the Chairs of each LSCB Sub Group, the Lead Commissioner for the CSE and Missing Service, Police and NHS England (Cheshire & Merseyside) oversees the Pan-Cheshire multi-agency CSE Strategy which all 4 LSCBs and partners have

agreed to work under. This consistent approach supports partner agencies who operate across local authority boundaries.

During 2015-16 the Strategic Group has:

- Reviewed the Pan Cheshire CSE Strategy
- Reviewed the CSE screening tool following consultation with staff and young people
- Promoted the 'Know and See' campaign
- Implemented a Pan Cheshire multi-agency CSE dataset

After the audit under the Jay Report framework in 2013-2014 the Board agreed to develop a multi-agency CSE Team for a period of 6 months to determine the level of CSE within Halton. The team was set up in March 2015 and concluded in September 2015. The findings from evaluation of the team related to children identified as vulnerable to CSE or at risk of CSE, in all but one case it was apparent that there were pre-determining factors that contributed to the vulnerability of the child leading to the risks of CSE. In one instance there were no pre-determining factors and the child appeared to have been targeted.

The team was decommissioned in September 2015; the lessons learnt were carried forward in order to develop responses to CSE across the multi-agency partnership. The Board has seen a steady increase in the number of CSE screening tools completed and where quality is determined to be a concern the agency is supported by the commissioned service, Catch 22, to address the issue.

CSE Champions have been identified across partner agencies. Those who do not sit on the Sub Group attended a development session to brief them on their role and to signpost them to a range of supporting information. The CSE Champions are a central point of dissemination of resources, learning and local information on CSE in Halton to frontline staff. They report to the Sub Group on the work they have undertaken to promote CSE awareness; examples during the year include:

- A regional event for independent children's home and fostering agencies relating to information gathering, signs of potential CSE and managing risk within local communities.
- Presentation to YOS staff on their development day by young people on sexting.
- National Probation Service included discussion on use of internet/grooming and any lifestyle activities linked to hotspots or vulnerable children into High Risk meetings on violent and sexual offenders under supervision.
- Practitioner Guidance booklets given to all staff at Whiston Hospital.
- YOS staff using "Wud U" app with children and young people, and Exploited/Exposed BLAST interventions.
- YoungAddaction delivering CSE sessions to young people as part of Amy Winehouse Foundation, youth clubs and outreach.
- Warrington & Halton Hospitals Trust foyer event for staff, patients and visitors on national CSE Awareness Day, supported by social media campaign on run up.
- NHS England North (Cheshire & Merseyside) included CSE within standard national contract from April 2016, which requires all NHS Trusts to have an

identified CSE lead to support implementation of national guidance and ensure voice of child is central to health services.
- Distribution of 80,000 NHS England CSE pocket guides to all frontline health staff including GPs, Pharmacists and Dentists.

Further detail of CSE work in Halton is set out in the section on the CSE, Missing and Trafficked Children Sub Group.

## 5.13 Domestic Abuse

The multi-agency audit in July 2015 focussed upon cases considered by the Multi-Agency Risk Assessment Conference (MARAC). The MARAC is a multi-agency meeting which discusses high risk cases of domestic abuse. The audit identified that frontline staff were not receiving information discussed at MARAC. However a further finding showed that where staff were aware of this they were not accepting their responsibility to follow up and escalate. The learning and recommendations from the audit were shared with Halton Domestic Abuse Forum who was then tasked to report on findings to the Board via the Scrutiny and Performance Sub Group. Partner agencies duly reported on their feedback processes from MARAC to the staff who submitted the original referral to MARAC and the staff currently working with the victim which showed that processes were now in place.

Operation Encompass which had been piloted across schools in Widnes was rolled out to all schools from January 2016. Riverside College has also been included. The purpose of Operation Encompass is to safeguard and support children and young people who have been involved in a domestic abuse incident. Following any such incident, the Police contact a trained member of staff at the school/college who then offers appropriate support to the child. This has led to a better understanding of the impact Domestic Abuse has on children and young people by schools and opened up discussions between the family and school in order to identify the appropriate level of support.

# 6. The Work of the Sub Groups

## 6.1 Scrutiny and Performance Sub Group

The role of this Sub Group is central to the monitoring and evaluation function of the LSCB. The Sub Group oversees actions from a programme of audit activity across the Levels of Need Framework including the Common Assessment Framework, Child in Need and Child Protection Plans, Children in Care and Care Leavers.

During 2015-16 the LSCB coordinated three Multi-Agency audits and from this good practice and areas for improvement were identified. Briefings on the learning were circulated to frontline staff and face to face learning from practice workshops are planned as regular activity for 2016-17.

Key Achievements:

- 100% return on S175/157 audits of schools to demonstrate the effectiveness of their safeguarding arrangements.
- Revision of the audit process to improve attendance at focus groups by frontline staff to improve learning.

Priorities for 2016-17 include:

- Looking at innovative ways in which children and families can be involved in the audit process.
- Reporting from partner agencies on safeguarding audit activity and its impact.
- Improved multi-agency performance reporting on a thematic basis.

## 6.2 Child Sexual Exploitation, Missing and Trafficked Children Sub Group

There has been significant activity around CSE and MFH within this reporting year and the main themes are highlighted below.

Key achievements:

- Piloting a multi-agency CSE Team for 6 months which improved quality of CSE screening tools and understanding of CSE.
- The CSE Operational Group has been re-launched and is chaired by the police looking at themes and hotspots.
- The Pan Cheshire CSE Strategy and Missing from Home Protocol have been updated, and the CSE screening tool reviewed.
- Training has been delivered across all partner agencies for CSE awareness and additional Advanced CSE training developed for practitioners involved in investigations.
- Audits have been undertaken by the multi-agency partnership and across Cheshire to look at the quality of the missing children Return Interviews; changes were made to both the form and practice as we shared good practice across the four areas.
- Our commissioned service has been recognised via the Children & Young People awards for the partnership work that they do on a Pan Cheshire footprint.
- The Pan Cheshire CSE Communication Strategy developed and resourced visual and practical aids to support awareness raising across the partnerships within the community.
- CSE Champions have been evidencing the work they have been doing within their organisations in order to continue to promote CSE and responsibilities within their agencies.

Priorities for 2016-17 include:

- Developing a Pan Cheshire Trafficking Strategy and Practice Guidance for frontline staff.
- Delivering Trafficked Children training across the workforce to embed pathways and good practice.

## 6.3 Health Sub Group

The Health Sub Group continued to develop over the year and provided assurance to the Board on a range of activity in relation to the Health sector in Halton.

The Sub Group achieved the following in 2015-16:

- Standardised reporting from Health partners on their Annual Safeguarding Reports.
- Identification of the range of early help work undertaken by Health partners.
- Ensuring Named GP in place and supporting multi-agency work to safeguard children in Halton.
- Information Sharing Protocols in place between Health partners and the Board.

Priorities for 2016-17 include:

- Developing the Sub Group to report to both the Safeguarding Adults and Children Boards.
- Ensuring Designated Doctor in place.
- Improved reporting on the health of Children in Care.

## 6.4 Safer Workforce & Development Sub Group

The Safer Workforce & Development Sub Group was established this year by amalgamating the Safer Workforce and Learning & Development Sub Groups. This Sub Group reports to both the Safeguarding Adults and Children Boards in Halton. Both membership and terms of reference have been revised.

The Sub Group achieved the following in 2015-16:

- Improving attendance at multi-agency safeguarding training by staff from the Probation Services and Primary Care.
- Development of multi-agency Training Pool.

Priorities for 2016-17 include:

- Revision of the joint safeguarding adults and children Training Needs Analysis.
- Ongoing development of the Training Pool to ensure continued capacity to deliver the multi-agency training programme.
- Undertaking quality assurance of the LADO process.

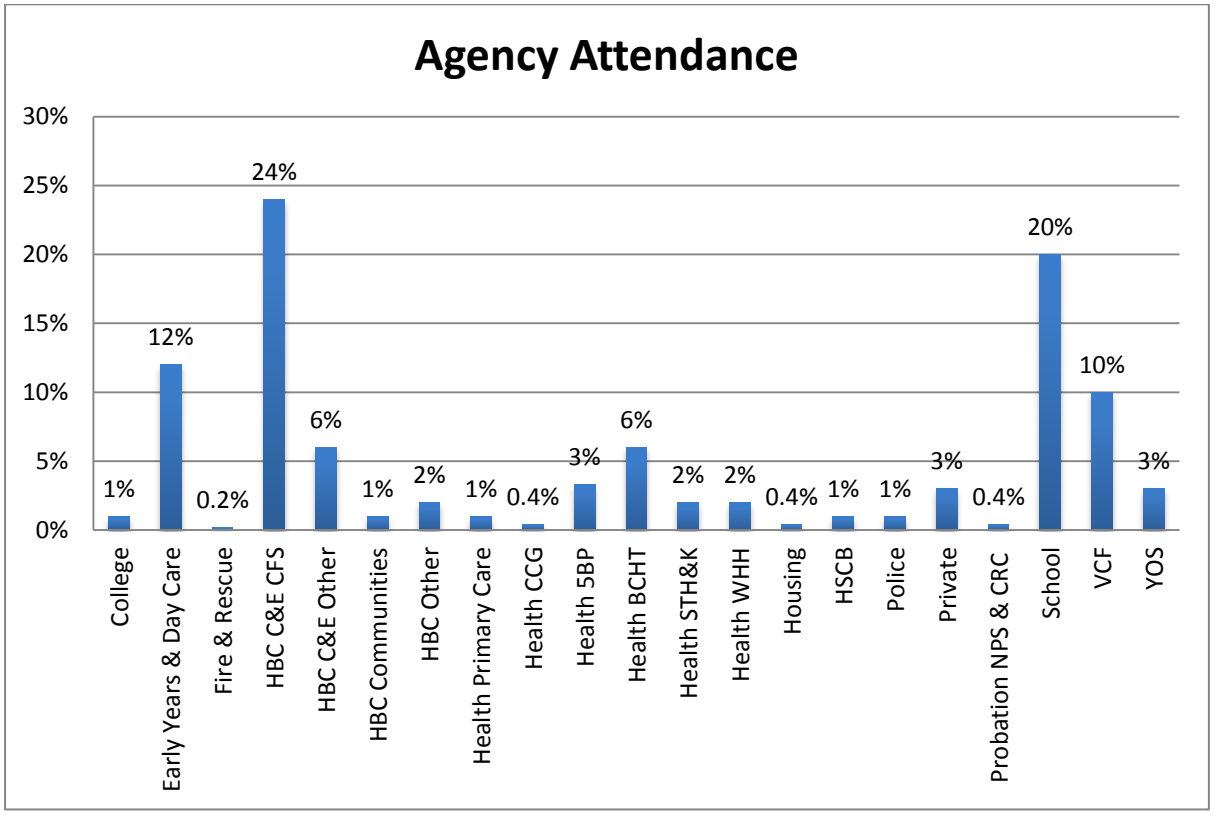
## 6.5 Training Activity 2015-16

The LSCB has a responsibility to ensure that appropriate safeguarding training is available to the workforce across the borough. This work is led by the Safer Workforce & Development Sub Group.

The 2015-16 training programme saw 42 courses delivered with 915 participants attending. The LSCB also promoted a range of local and national e-learning. In addition bespoke training was delivered by the Board to: School Crossing Patrol staff, Salvation Army, YMCA, Registrars, Alternative Providers and Children's Social Care.

**Overall Agency Attendance on HSCB Courses 2015-16:**

Between 1st April 2015 and 31st of March 2016 14 different courses were offered in the HSCB Training Programme. Delivery ranged from 2 hours to four day face to face courses. In addition a range of local and national e-learning courses are also available. The graph below indicates the overall distribution of training places by agency and across sectors.




All courses are subject to immediate post course evaluation which is collated and used to develop delivery of future courses. In addition members of the Safer Workforce & Development Sub Group undertake post course impact evaluation telephone interviews with a sample of participants. The telephone interviews provide an opportunity for reflective interviews with course participants in order to identify how learning has made a difference to their day to day practice with children and families.

Examples of how training had made a difference to practice include:

- A worker in the 14 -19 Team who provided advice to a young person's Coach of the KOOTH online counselling service, the young person subsequently told them how they had accessed online counselling for a month and intended to continue accessing this support as it was more accessible to them.
- A Nursery Worker who now felt confident in speaking to parents about what happens at Child Protection conferences, can reassure the families and in turn support the children effectively because of this knowledge.
- Whiston Hospital staff who were subsequently able to identify Young Carers and get them assessments which led to respite opportunities.
- A Portage Worker who now uses the Graded Care Profile to help to identify neglect, or provide evidence when there is a conflict of opinion, and to support making referrals into iCART.

- A worker from Whiston Hospital who used the Graded Care Profile to challenge decision making with another colleague which helped identify areas for improvement in home conditions, which helped the family to demonstrate improved home conditions.
- A Pre-School Worker who introduced a 'child's diary' after attending Domestic Abuse training which provided evidence to make a referral to iCART.
- An Adult Services Worker who used the Managing Allegations training to inform their investigation of an historic allegation leading to better support for the person who had made the disclosure.

During 2016-17 our Learning and Development Officer will be exploring further opportunities to deliver training across the Pan Cheshire footprint, supporting consistency in practice for those staff who work across neighbouring LSCBs.

## 6.6 Local Authority Designated Officer (LADO)

Each local authority has a Designated Officer (LADO). The LADO must be informed of all allegations relating to adults who work with children whether they are a paid member of staff, foster carer or volunteer, where there is concern or an allegation that the person has:

- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

The LADO's role includes providing advice and guidance to employers and voluntary agencies; management and oversight of individual cases; monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process. This is part of the process of ensuring that safer workforce practices are in place to safeguard children from individuals and practices which may be harmful. This process also safeguards staff by ensuring that malicious or unsubstantiated allegations are thoroughly investigated and resolved in a timely manner.

In 2015-16 the LADO received 73 consultations which was a slight increase on 67 consultations in 2014-15. Of these 33 were dealt with as allegations that resulted in strategy meetings, this compares with 30 in 2014-15 and 39 in 2013-14. The proportion of consultations resulting in strategy meetings is consistent with the North West region.

CICOLAs have generated over a third of the LADO strategy meetings this year which remains a consistently high number. The LADO has experienced difficulties with these LADO strategy meetings resulting in a number of outcomes being agreed virtually. This is not a process that Halton's LADO would condone. It is accepted that the distance for some authorities to travel for the LADO meeting is vast and time consuming. However the question of whether a Local Authority considers this prior to placement should be asked. The LADO will continue to insist that the allocated Social Worker attend at least the initial strategy meeting, with conference calls being agreed for reviews where appropriate.

Following on from last year's Ofsted inspection recommendation the LADO has reported on how quickly strategy meetings are convened from point of referral. 5

strategy meetings were convened outside of the agreed 7 days from referral. This was due to factors including: the ability to contact the senior person in the organisation, capacity of professionals to come together and awaiting significant information prior to convening. This is an identified area for improvement in the forthcoming year.

The Board has also agreed to develop a process for quality assuring the LADO investigations which will be undertaken by members of the Safer Workforce & Development Sub Group.

The Department for Education has determined that LADO can now use the outcome "unfounded" again; in 2013 guidance was issued that this should not be used for teachers. In Halton we took the decision that the outcome categories should be the same for all agencies and therefore we stopped using unfounded for everyone. The Board has agreed that the LADO will reinstate the "unfounded" category from 2016-17.

Following recommendations from last year's LADO report training was delivered to frontline staff in addition to the training for designated managers. 242 multi-agency staff attended across three sessions. As planned the theme was on public enquiries and Serious Case Reviews which focussed upon developing safe environments for children. Feedback from those attending the events was positive; therefore briefings for frontline staff will be included in the 2016-17 training programme.

## 6.7 Policy & Procedures Sub Group

The Pan Cheshire Policy & Procedures Sub Group was reviewed. The group now consists of the LSCB Chairs and Business Managers who oversee the following priorities:

- Revision of the Pan Cheshire LSCB Multi-Agency Safeguarding Children Procedures Manual
- Identification of topics which can benefit from a Pan Cheshire procedures approach

The Sub Group is currently coordinating the transfer and update of the Pan Cheshire LSCB Multi-Agency Safeguarding Children Procedures Manual onto a new online format. They are also in the final stages of ratifying a Pan Cheshire Female Genital Mutilation Protocol.

Priorities for 2016-17 are:

- LSCB Escalation Policy
- Guidance for Bruising in Non Mobile Babies and Children
- Sexually Harmful Behaviours Protocol
- LADO Procedures

## 6.8 Child Death Overview Panel (CDOP)

All Boards have a statutory requirement to review the circumstances of the deaths of every child under the age of 18 years, who normally reside in the borough. This is in order to identify any potentially preventable child deaths.

Preventable child deaths are defined as those in which “modifiable factors” may have contributed to the death. These are factors which, if changed, could help to reduce the risk of injury or death in other children, although we cannot say that they would have prevented this particular child from dying.

The review of child deaths for Halton is undertaken by the Pan Cheshire Child Death Overview Panel. The Panel has an Independent Chair, Hayley Frame. During 2015-16 across Cheshire there were 64 child deaths which was an increase from 48 deaths in 2014-16. The numbers for Halton were 6 deaths in 2015-16 compared with 11 deaths in 2014-15. Across Cheshire 12 deaths had modifiable factors identified; this included 2 cases from Halton.

The Pan Cheshire CDOP met on five occasions between April 2015 and March 2016. A total number of 51 child deaths were reviewed of which 6 were children who had lived in Halton. Of the Halton child deaths reviewed 2 had occurred during 2013-14 and 4 during 2014-15. Going forward into 2016-17 the Panel has 12 cases outstanding for review from Halton; 6 from 2014-15 and 6 from 2015-16. There is an expectation that reviews take place within 3-4 months of the death wherever possible. In some cases this may not be possible due to awaiting the outcome of reports from post mortem or where there is to be a Coroner’s inquest. However during 2015-16 the Panel was dealing with a back log of cases from 2013-14 which were a priority to complete. In addition there were delays in receipt of information being returned to CDOP by practitioners in relation to Halton’s cases which the Panel did not escalate to the Board. The process for escalation has since been reviewed with the Panel reporting an improvement in receipt of information from Halton resulting in a number of outstanding cases being due to be reviewed in the first quarter of 2016-17.

The Pan Cheshire CDOP Annual Report is published on the LSCB’s website.

## 7. Learning and Improvement Activity:

The Board has been undertaking a Serious Case Review which will conclude in 2016-17. Serious Case Reviews are undertaken where

The learning from the Serious Case Review highlights the vulnerability of adolescents in relation to neglect; the treatment of adolescents with chronic health conditions; and the urgent care system response to acute life threatening episodes. The findings from the case are being addressed by partners and the Board will oversee actions undertaken to address, then test the impact made under its Learning and Improvement Framework.

In addition a Practice Learning Review was undertaken on a case which did not meet the criteria for a Serious Case Review, but which the Board agreed would benefit from a review of multi-agency working by an independent reviewer. The learning from this review focusses upon mental health services for young people and the Child in Need process. The Board has drawn up an action plan to provide assurance that the learning has been addressed.

An audit schedule including the CAF, Children & Families Services and the Multi-Agency practice audits continued. Additional thematic audits were undertaken on Missing Children, Return Interviews, Child Protection Plans in place for 12 months or more and Child Protection Plan categorisation. The Youth Offending Service

submitted both its safeguarding audit and audit against the Youth Justice Board National Standards. CAMHS submitted its audit on Early Intervention. For 2016-17 all partners have been asked to provide the Board with their audit schedules in order to plan reporting on the learning and actions undertaken. The learning from the audit schedule continues to be used to inform practice.

## 8.0 Key Priorities 2016-17:

The Board has focussed its key strategic priorities for 2016-17 on the following:

1. Identify and prevent children suffering harm.
2. Protect children who are suffering or are at risk of suffering harm.
3. Support the development of a safe and informed workforce, including volunteers.
4. Children and Young People, their Families and Communities Participate and Engage in developing and raising awareness of Safeguarding.

| 1.0 | **Identify and prevent children suffering harm** | | | | |
|---|---|---|---|---|---|
| | Outcome | Performance Measurement | Lead | Key Milestones in year 1 | Timescale |
| 1.1 | Ensure that all partner agencies have an appropriate understanding of private fostering arrangements and that effective processes are in place to promote the notification and understanding of private fostering arrangements across the partnership. | Reports from the Private Fostering task Group evidence the impact of the Communication Plan and notifications provided by staff across multi-agency partners with arrangements identified at the earliest opportunity and notifications reported to Children's Social Care.<br><br>Private Fostering Annual Report evidences that partners have effective processes in place to identify, record and provide notification of private fostering arrangements. | HSCB Executive | • Private Fostering task group refreshed Communications Plan. Leaflets are being designed with input from young people as a digital document.<br>• Numbers remain low but equivalent to highest reporting previously made to Board (see HSCB Performance scorecard.)<br>• Annual Report to be presented at July's Main Board.<br>• S11 Audits have identified that Private Fostering is not embedded across all agencies. | July 2016 |
| 1.2 | Work with pan-Cheshire partner LSCBs to ensure effective operation of Pan-Cheshire Child Death Overview Panel. | Quarterly and annual reports from the Pan Cheshire Child Death Overview Panel (CDOP) inform the Board of learning, trends and themes from child death reviews, and measure the impact of any publicity campaigns undertaken by | HSCB Chair and Business Manager | • Independent Chair in post April 2015.<br>• Quarterly reporting has improved but still needs to provide more detail on trends and themes. CDOP development day taking place in April. | March 2016 |

| | | | | | |
|---|---|---|---|---|---|
| | | CDOP. | | | |
| 2.0 | **Protect children who are suffering or at risk of suffering harm** | | | | |
| | Outcome | Performance Measurement | Lead | Key Milestones in year 1 | Timescale |
| 2.1 | Reduce the emotional and physical impact of harm including the risk of sexual exploitation, missing and trafficking on our most vulnerable children's health and development. | Audits provide evidence that staff across the multi-agency partnership have provided well timed, good quality involvement and practice with the outcome that children were effectively safeguarded.<br><br>Quarterly performance reporting against the CSE and Missing Children datasets provide evidence of activity across the multi-agency partnership which has effectively safeguarded children. | CSE, Missing and Trafficked Children Sub Group<br><br>Scrutiny & Performance Sub Group | • CSE Operational Group established; first meeting beginning April 2016.<br>• CSE Screening Tool Audit being completed in April 2016<br>• CSE dataset still being developed as Pan Cheshire comparator dataset.<br>• Pan Cheshire Strategic CSEMTC Group developing framework for CSE & Missing Peer Review.<br>• Trafficking thematic review underway Pan Cheshire; to be completed end of April.<br>• MFH return interview audit took place in March 2016 by commissioned service | March 2016 |
| 2.2 | Children and young people who go missing from home or care have a return interview, and that information is made available to relevant | Quarterly performance reporting provides evidence that return interviews are taking place; audits evidence that the return interviews are informing risk assessment, management and planning. | CSE, Missing and Trafficked Children Sub Group | • MFH Audit completed and reported to sub group 2016<br>• Development of the return home interview form is being completed to support partner agencies to undertake the interviews | September 2015 |

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| | professionals in a timely manner to inform risk assessment, management and planning. | | | when children who won't engage with Catch 22 | |
| 2.3 | Children and young people subject of Child Protection Plans have improved outcomes supported by the consistency of core groups in analysing the impact of actions on intended outcomes. | Audits evidence that core groups analyse the impact of actions on outcomes demonstrating the impact of revised guidance and multi-agency training on professional practice. | Safer Workforce and Development Sub Group<br><br>Scrutiny & Performance Sub Group | • Review of CP plan template and Core group template to support the creation of outcome focused planning<br>• Audit of CP plans and categories | March 2016 |
| 2.4 | Children and young people at risk of harm are protected by strategy discussions with SMART actions and contingencies recorded. | Audits evidence that strategy discussions have SMART actions and contingencies recorded demonstrating the impact of revised guidance and multi-agency training on professional practice. | Safer Workforce and Development Sub Group<br><br>Scrutiny & Performance Sub Group | • Evidence from Multi-Agency Audits that Strategy Meetings are multi-agency; and plans are clear and effective.<br>• Contingency planning could improve; Scrutiny & Performance Sub Group to look at this.<br>• CSC audits to look at their SMART planning as one of three priorities | March 2016 |
| 3.0 | **Ensure that children are receiving effective early help and support.** | | | | |
| | Outcome | Performance Measurement | Lead | Key Milestones in year 1 | Timescale |
| 3.1 | Early Intervention meets the needs of | Audits and quarterly performance reporting provide | Scrutiny & Performance | • Despite widespread training, staff are not | June 2016 |

| | | | | | |
|---|---|---|---|---|---|
| | children and families. | evidence that staff across the multi-agency partnership have provided well timed, good quality involvement and practice with the outcome that children received effective early intervention. | Sub Group | completing Graded Care Profile; staff in universal services to be contacted to understand reason for this as part of impact evaluation of training.<br>• Increased number of CAFs at end of 2015-16.<br>• Health Sub Group identified range of early help work being undertaken by health partners.<br>• SCR identifying key learning in relation to early intervention.<br>• Early Intervention Audits reported to Scrutiny & Performance Sub Group broadened to include early help contacts and pre-CAF. | |
| 3.2 | There is a prompt and assured response when referrals are made or new information is received about child care concerns. | Audits and quarterly performance activity show how integrated front door arrangements improve information sharing and ensure that referrals are dealt with within timescales. | Scrutiny & Performance Sub Group | • Implementation of iCART in March 2016<br>• Performance is scrutinised by CSC and reported to sub groups. | March 2016 |
| **4.0** | **Support the development of a safe and informed workforce, including volunteers** | | | | |
| | Outcome | Performance Measurement | Lead | Key Milestones in year 1 | Timescale |
| 4.1 | Ensure that relevant staff from all partner agencies attend | HSCB Learning & Development Activity Reports evidence that staff across | Safer Workforce and Development | • HSCB Learning & Development Activity Annual Report 2015-16 | May 2016 |

| | | | | | |
|---|---|---|---|---|---|
| | regular multi-agency training to maximise opportunities for learning to support professional development. | multi-agency partners attend multi-agency safeguarding training and provide evidence of the impact of training on outcomes for children and families. | Sub Group | details attendance on multi-agency training.<br>• Impact of training on outcomes informs future learning & development activity.<br>• LADO has provided training specifically for front line practitioners and creating safer working environments and will provide training for front line staff annually | |
| 4.2 | The workforce is informing learning and improvement. | Audits evidence a link between quality assurance and feedback from the workforce. | Scrutiny & Performance Sub Group<br><br>Critical Incident Panel | • Audit process is not including staff feedback due to reduction in attendance at focus groups. Recommendations for revised audit process presented at March Main Board for implementation in 2016-17.<br>• Workforce has been involved in PLR and SCR via conversations with reviewers and Case Group meetings.<br>• Impact of training on outcomes informs future learning & development activity.<br>• Frontline visits to take place May & June 2016. | July 2016 |

| 5.0 | **Participation and Engagement with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding.** | | | | |
|---|---|---|---|---|---|
| | Outcome | Performance Measurement | Lead | Key Milestones in year 1 | Timescale |
| 5.1 | There are opportunities for children and young people to inform the LSCB's work. | Business Plan evidences a link between priorities and engagement work with children and young people. | Lay Members<br><br>HSCB Business Manager | • 2 young people are informing the work of the Private Fostering task group.<br>• Crucial Crew 2016 provided an opportunity to engage with Yr5 children on things which made them feel unsafe across the borough. This will be reported to May's Safer Workforce & Development Sub Group.<br>• The Board is currently scoping a commission on participation with children across Halton to identify their safeguarding priorities and to test the impact of campaigns such as CSE.<br>• UTV have been commissioned to undertake work with Yr 6 & Yr8 pupils across Cheshire from Sept 2016 to create adverts on sexting, inappropriate relationships and legal highs. | September 2016 |
| 5.2 | The views of children, | Audits evidence a link between | Scrutiny & | • Young people and their | March 2017 |

| | | | | | |
|---|---|---|---|---|---|
| | young people and families are contributing to learning and best practice. | quality assurance and feedback from children, young people and families. | Performance Sub Group<br><br>Critical Incident Panel | families have been involved in PLR and SCR via conversations with reviewers.<br>• Audit process is not including child and family feedback due to reduction in their involvement over time. Recommendations for revised audit process to improve this to be presented at March Main Board. | |
| 5.3 | Parents, carers and the public have an improved understanding of the work of the LSCB and safeguarding in Halton. | LSCB Communications Plan implemented. | Lay Members<br><br>Learning & Development Sub Group | • Improvements made to social media activity of the Board by amendments to website and use of HSCB twitter account. | September 2016 |
| **5.4** | The workforce has an improved understanding of the LSCB. | LSCB Communications Plan implemented. | Learning & Development Sub Group | • Frontline visits to take place May & June 2016. | March 2016 |
| **5.5** | An effective working partnership is established with local faith-based organisations to improve their | LSCB Communications Plan implemented.<br><br>Faith Sector Safeguarding Forum in place and Work Plan implemented. | Faith Sector Safeguarding Forum | • Faith Safeguarding Forum in place chaired by local faith rep. | October 2016 |

| | | | | | |
|---|---|---|---|---|---|
| | understanding of the LSCB and provide opportunities for faith-based organisations to inform the LSCB's work. | | | | |

## 9.0 Budget Information

| **Income 2015-16** | |
|---|---|
| HBC – Children & Enterprise Directorate | 45, 817 |
| HBC - Schools | 28, 500 |
| NHS Halton Clinical Commissioning Group | 45, 817 |
| Cheshire Constabulary | 20, 000 |
| YoungAddaction | 3, 500 |
| Public Health | 1, 400 |
| National Probation Service (NPS) | 1,615 |
| Community Rehabilitation Company (CRC) | 1,615 |
| Cafcass NW | 550 |
| Carry Forward 2014-15 | 22, 208 |
| **Total Income:** | **171, 022** |

| **Expenditure 2015-16** | |
|---|---|
| Staffing | 137,646 |
| Multi-Agency Training | 16,757 |
| Supplies & Services | 43,089 |
| Support Services | 13,050 |
| Premises | 1,930 |
| **Total:** | 212,472 |
| Carry Forward 2016-17: | 17,261 |

## Appendix A
## Halton Safeguarding Children Board Membership & Attendance 2015-2016

| Attendance Log | | | % Attendance | Meetings 2015-2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | 14.07.2015 | 15.09.2015 | 02.10.2015 | 08.12.2015 | 29.03.2016 |
| **Independent and Overseeing Members** | Richard Strachan, Independent Chair | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Cllr Ged Philbin, Lead Member Children & Young People (Participant Observer) | | | D | ✓ | | ✓ | ✓ |
| **Lay Members** | Marjorie Constantine, Lay Member | | | ✓ | A | ✓ | ✓ | A |
| **Local Authority** | Gerald Meehan, Strategic Director, Children & Enterprise | | | ✓ | ✓ | ✓ | A | A |
| | Ann McIntyre, Operational Director, Education, Inclusion & Provision | | | ✓* | ✓* | ✓* | ✓* | ✓ |
| | Tracey Coffey, Operational Director, Children & Families | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Katherine Appleton, Senior Manager Safeguarding & Quality Assurance | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Lindsay Smith, Divisional Manager, Mental Health, Communities Directorate | | | ✓ | ✓ | R | ✓ | ✓ |
| | Eileen O'Meara, Director of Public Health | | | ✓ | D | D | A | ✓ |
| **Health** | Dot Keates, Associate Director Safeguarding, Bridgewater Community Healthcare Trust | | | ✓* | ✓* | ✓* | ✓* | R |

| Attendance Log | | | | Meetings 2015-2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | % Attendance | 14.07.2015 | 15.09.2015 | 02.10.2015 | 08.12.2015 | 29.03.2016 |
| | Lisa Cooper, Deputy Director, Quality & Safeguarding, NHS England North (Cheshire & Merseyside) | | | ✓ | A | | A | A |
| | Gary O'Hare, Clinical Lead Children's Safeguarding, Halton CCG | | | A | ✓ | | R | A |
| | Ann Dunne, Designated Nurse, Safeguarding Children, Halton CCG | | | R | R | ✓ | R | A |
| | Jan Snoddon, Chief Nurse, Halton CCG | | | A | R | ✓ | ✓ | A |
| **Police** | Nigel Wenham, Detective Superintendent, Cheshire Police | | | A | ✓ | ✓ | A | ✓ |
| **Criminal Justice Services** | Donna Yates, Assistant Chief Executive, Cheshire & Greater Manchester Community Rehabilitation Company | | | A | A | A | D | D |
| | John Davidson, National Probation Service | | | A* | A* | ✓* | A* | D |
| | Gareth Jones, Head of Service, CWHW YOS | | | ✓ | ✓ | ✓ | A | A |
| **CAFCASS** | Tom Cheadle, Service Manager | | | ✓ | ✓ | | A | A |
| **Schools and Colleges** | Dee Denton, Head Teacher, Lunts Heath Primary, Primary Headteacher Rep | | | A | ✓ | ✓ | A | ✓ |

| Attendance Log | | | % Attendance | Meetings 2015-2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | 14.07.2015 | 15.09.2015 | 02.10.2015 | 08.12.2015 | 29.03.2016 |
| | Secondary Headteacher Representative | | | - | - | - | - | - |
| | Paula Mitchell, Programme Manager, Riverside College | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **VCF Sector** | Donna Wells, Service Manager Young Addaction, Voluntary Sector Rep | | | A | ✓ | ✓ | ✓ | ✓ |
| **HSCB** | Tracey Holyhead, Business Manager | | | ✓ | ✓ | ✓ | ✓ | ✓ |

Key:
A – denotes apologies received, but no-one attended in their place.
R – denotes a representative attended in their place.
D – denotes no apologies received and no-one attended in their place.
*Denotes attendance of previous Sub Group Member in this role

## Appendix B
## Halton Levels of Need Framework

The Halton Levels of Need Framework aims to support agencies to meet the needs of children, young people and their families to ensure the best possible outcomes. It aims to assist practitioners and managers in assessing and identifying a child's level of additional needs and how best to respond in order to meet those needs as early as possible to prevent needs escalating further.

Halton Levels of Need Framework was revised and launched in April 2013. The framework sets out three levels of additional needs above Universal Services that captures the full range of additional needs as they present. Universal Services remain at the heart of all work with children, young people and their families and are in place for all whether additional needs present themselves or not.

The fundamental relationship between Universal Services and the three levels of additional needs is captured in the diagram below:


The key principles of the Framework include:

- Safeguarding runs throughout all levels.
- Provide early help and support at the first possible stage and meet needs at the lowest possible level.
- The focus is on Halton's more vulnerable groups and directing service responses at preventing vulnerability.
- Builds on existing good multi-agency working and formalises shared responsibility for meeting all needs.
- Supports work of all agencies and is equally applicable to all agencies.
- Flexible and fluid, allows free movement between levels as additional needs increase or reduce.
- Clear and understandable
- Focus on the needs of the child and family to ensure the best outcomes for all.

Working Together 2015 seeks to ensure that all local areas have effective safeguarding systems in place and sets out two key principles that should underpin all safeguarding arrangements:
**SAFEGUARDING IS EVERYONE'S RESPONSIBILITY:** for services to be effective each professional and organisation should play their full part; and

**A CHILD CENTRED APPROACH:** for services to be effective they should be based on a clear understanding of the needs and views of children

The Halton Levels of Need Framework has been developed in line with this guidance and meets the requirement for the publication of a 'thresholds document' for Halton. It is based on a robust application of the Framework for the Assessment of Children (underpinned by the Children Act 1989), Team around the Family procedures and is consistent with LSCB procedures. The Halton Levels of Need Framework can be used as a central focal point to bring the right agencies together at the right level.

In terms of the **Children Act 1989**, our responsibilities include:

Where a child is accommodated under section 20 (when parents retain the parental responsibility for the child), the local authority has a statutory responsibility to assess the child's needs and draw up a care plan which sets out the services to be provided to meet the child's identified needs.

Under section 31A, where a child is the subject of an Interim Care Order or a Full Care Order, the local authority (who in these circumstances shares responsibilities, as a corporate parent, for the child and becomes the main contact around the child's every day needs) must assess the child's needs and draw up a care plan which sets out the services which will be provided to meet the child's identified needs.