Halton Children and Young People Safeguarding Partnership

Memorandum Of Understanding

JUNE 2019

Contents

1. Introduction and Context

What is Halton Children and Young People Safeguarding Partnership (HCYPSP)?

The HCYPSP replaces Halton's Local Safeguarding Children Board. This is because the law changed in the Childrens and Social Work Act 2017. The statutory guidance on how the new safeguarding arrangements should work and be delivered are outlined in Working Together to Safeguard Children 2018.

Who are members of HCYPSP?

The new arrangements have been determined by the three key safeguarding partners – Halton Borough Council, Cheshire Constabulary and NHS Halton Clinical Commissioning Group, these arrangements will be published on the new Halton Children and Young People Safeguarding Partnership website once developed. Relevant agencies are named by the three partners, and all have a legal duty to co-operate with the arrangements. Further details can be found in the **List of Relevant Agencies** and **Relevant Agencies – Organisational Responsibilities.**

Partnership working is at the centre of our safeguarding arrangements, Halton has a strong commitment to working together to improve outcomes for children, young people and families in the area.

This Memorandum of Understanding outlines the commitment of the three safeguarding partners and their organisations to fulfil their statutory duties to safeguard and promote the welfare of children and to work under the auspices of these new arrangements.

In Halton, the safeguarding partner organisations lead representatives are:

- **Halton Borough Council – Chief Executive**
- **Halton Clinical Commissioning Group – Accountable Chief Officer**
- **Cheshire Constabulary – Chief Constable**

All three safeguarding partners have equal and joint responsibility for local safeguarding arrangements, which are underpinned by an equitable and proportionate partnership funding formula including contributions from relevant agencies.

The three safeguarding partners have delegated their functions to the:

- Strategic Director People, Halton Borough Council
- Chief Nurse, Halton Clinical Commissioning Group
- Chief Superintendent/Superintendent, Cheshire Constabulary PPU

The three safeguarding partners have the responsibility and authority for ensuring full participation with the HCYPSP arrangements, though the lead representatives remain accountable for any actions or decisions taken on behalf of their respective agency.

This **Memorandum of Understanding** provides clarity regarding:

2. Values and Principles

Children, young people and families have said that they need:

- Vigilance: to have adults notice when things are troubling them
- Understanding and action: to understand what is happening, to be heard and understood and to have the understanding acted upon
- Stability: to be able to develop an ongoing stable relationship of trust with those helping them
- Respect: to be treated with the expectation that they are competent rather than not
- Information and engagement: to be informed about and involved in procedures, concerns and plans
- Explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- Support: to be provided with support in their own right as well as a member of their family
- Advocacy: to be provided with advocacy to assist them in putting forward their views
- Protection: to be protected against all forms of abuse and discrimination and the right to special protection and help if a refugee

HCYPSP arrangements encompass all aspects towards enabling and empowering children and young people to be more resilient and safeguarded within their families, peer groups, schools and communities and to find resolutions for themselves.

Where children and young people face issues and circumstances that have or may have a detrimental impact of their experiences and outcomes, safeguarding partners and their organisations are committed to early help and timely intervention that secures children and young people's safety and increases the chance of achieving their potential. We are committed to working in a risk facing, not risk averse environment and across our workforce, safeguarding practitioners contribute to improving outcomes by demonstrating their professional judgement and decision-making.

Within Halton, we have developed our own risk analysis framework to underpin key single and multi-agency decisions. The HCYPSP arrangements supports practitioners and managers involved in child protection and safeguarding to manage risk and enhance their ability to respond to good

evidence-based assessment to underpin actions and not 'trigger events' unnecessarily. Practitioners must ensure that this ethos is at the forefront of assessments, plans, interventions and reviews and that multi-agency practice is grounded in this ethos and not upon a risk averse culture, which safeguards the organisation and does not necessarily meet the needs of an individual child. This approach supports the principles that underpin the Children Act 1989 that recognise that a child's welfare is paramount

Risk Management Principles

The risk management principles endorsed by safeguarding partners, are as follows:

Those involved in working with people and communities have to support children, young people and families to live independently, to stay in their own home and community and where necessary be supported to do so. This will involve a balanced risk assessment framework. Therefore, we need to look at 'balanced risk' or being 'risk sensible'.

Risk can also occur beyond immediate families for example, in peer groups, within the community and through exploitation by other adults and young people.

These principles have been adapted from the Association of Chief Police Officers with the aim of being a step towards encouraging a more positive approach to risk by openly supporting decision-making and building confidence in our staff in taking risks.

1. Maintaining or achieving the safety, security and well-being of individuals and communities is a primary consideration in risk decision making
2. The standard expected and required of those working in our communities is that risk decisions are consistent across the services and professions and consideration is given to ensuring that risks are not just passed to other services to take responsibility
3. Harm cannot be totally prevented - it is the quality of the decision making that a person is judged on
4. Good risk-taking should be identified and celebrated and staff that make decisions consistent with these principles should be encouraged and supported
5. All partners agencies should consider and assess their decisions and impact on other services/agencies before action is taken and inform partners of strategic decisions
6. There should be openness and transparency in decisions that impact on others

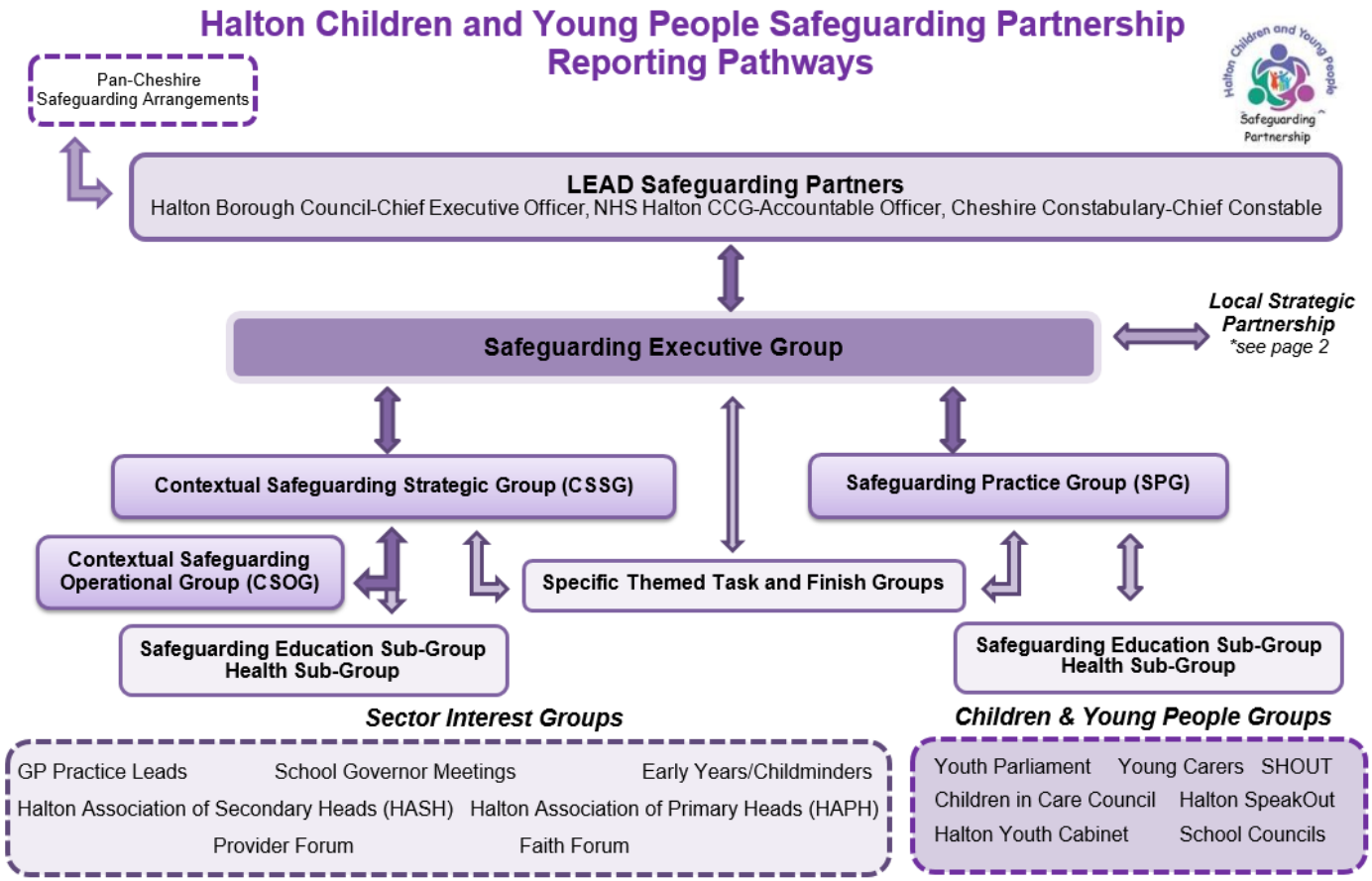
3. Wider Strategic Partnerships

The HCYPSP arrangements have been established in the context of wider strategic partnership arrangements and will link in with the work streams that support children, young people and families. These include the Health and Wellbeing Board, Halton Safeguarding Adults Board, Halton Community Safety Partnership Board, Pan-Cheshire Channel Panel, Multi-Agency Public Protection Arrangements (MAPPA) and the Local Family Justice Board.

The HCYPSP reporting pathways/structure is subject to the agreement that the Child Death Review Process will report to the Health and Wellbeing Board, who will be the accountable Board.

An overview of the role and functions of the key partnerships is detailed in Section 6.

The HCYPSP reporting pathways/structure is detailed below.



4. Safeguarding Partnership Arrangements

All three safeguarding partners have equal and joint responsibility for local safeguarding arrangements underpinned by equitable and proportionate partnership funding formula. The lead representatives and those they have delegated their authority to, are able to:

- Speak with authority for the safeguarding partner they represent
- Take decisions on behalf of their organisation or agency and comment on policy, resourcing and practice matters
- Hold their own organisation or agency to account on how effectively they participate and implement the local arrangements

Safeguarding partners will agree on ways to co-ordinate their safeguarding services, act as a strategic leadership group in supporting and engaging others and implement local and national learning including from serious child safeguarding incidents. To fulfil this role, the safeguarding partners must set out how they will work together with any relevant agencies.

Strong leadership is critical for the HCYPSP arrangements to be effective in bringing together various organisations and agencies. The arrangements will be strongly led and promoted by local area leaders. This includes lead representatives from safeguarding partner organisations and those to whom they have delegated their authority to, the Lead Member for Children, Education and Social Care and Chief Officers in all organisations and agencies. Details of Funding Arrangements and Responsibilities is detailed in Section 5.

Leadership

Working collaboratively to safeguard, promote the welfare of and provide better outcomes for children, young people and families is at the heart of our local arrangements. Through effective leadership, openness, transparency and effective professional challenge, there is a commitment to resolving any disputes locally between the safeguarding partners, selected relevant agencies and other organisations and agencies in a timely fashion.

If a clear, single point of leadership is required, safeguarding partners will agree the most appropriate partner, who will act on behalf of and in the interest of all three safeguarding partners. This will be done through a discussion at the HCYPSP or virtually by the three safeguarding partners depending on the urgency and circumstances involved.

Dispute Resolution and Escalation Process

The aim would be to resolve any disagreements or disputes at the lowest level of each safeguarding partner's organisation. The emphasis is on partners being respectful of each other's position and that as a joint and shared responsibility the onus is on each partner to communicate with each other any significant changes in their agency that may impact on the effectiveness of the safeguarding arrangements, consult with each other and listen to each partner's contribution.

If matters cannot be resolved through discussion and negotiation between first or middle line representatives, the issue should be placed on the Safeguarding Executive Groups' agenda where the named delegated senior officers for each partner should resolve any matters.

If the Safeguarding Executive Group cannot be resolve any matters of dispute this will be escalated to the accountable officers of the three safeguarding partners (Chief Executive – Halton Borough Council, Accountable Chief Officer – NHS Halton CCG and the Chief Constable – Cheshire Constabulary) for a final decision. These officers may choose to commission independent mediation if matters are not able to be resolved; if this is the case, the accountable officers must agree to abide by the final outcome.

Failure to comply by safeguarding partners with their statutory obligations under law, are held to account through a variety of regulatory and inspection activity for example, Ofsted, HMIC and CQC. Where necessary, legislation allows any non-compliance by agencies to be referred to the Secretary of State for enforcement action.

Relevant Agencies

Section 11 of the Children Act 2004

Places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Organisations and agencies who are not named in the relevant agency regulations, whilst not under a statutory duty, should nevertheless co-operate and collaborate with the safeguarding partners (HCYPSP), particularly as they may have duties under section 10 and/or section 11 of the Children Act 2004.

- Make sure the relevant agencies are aware of the expectations placed on them by the Halton Children and Young People Safeguarding Partnership arrangements;
- Consult with relevant agencies in developing the safeguarding arrangements to make sure the expectations take account of an agency's structure and statutory obligations;
- Be clear how they will assure themselves that relevant agencies have appropriate, robust safeguarding policies and procedures in place and how information will be shared amongst all relevant agencies and safeguarding partners;
- Determine how regularly their list of relevant agencies will be reviewed;
- Be clear on how agencies with a national remit should collaborate and take account of that agency's individual responsibilities and potential contributions towards a number of safeguarding arrangements.

Information and Communication

- Be aware of their own responsibilities under the relevant information law and have regard to guidance provided by the Information Commissioner's Office when issuing and responding to requests for information;
- Communicate regularly with their relevant agencies and others they expect to work for them.

Assessment and Services

Services will be provided in line with the agreed Halton Level of Need Framework published by the three safeguarding partners.

Information Sharing Agreement and Privacy Notice

The three safeguarding partners will deliver and monitor with relevant agencies the HCYPSP Information Sharing Agreement (ISA) and Privacy Notice. The ISA will ensure data is managed and secured appropriately, all relevant agencies will agree and share data.

All relevant agencies must have a Privacy Notice in place which will ensure that all children, young people and families are made aware of how their information will be used to inform the effectiveness of HCYPSP arrangements.

Data and Intelligence

- Use data and intelligence to assess the effectiveness of help being provided to children and families including early help;
- Use the Halton Joint Strategic Needs Assessment to help them understand the prevalence and contexts of need, including specific needs relating to disabled children and those relating to abuse and neglect, which in turn should help shape services;
- Use data that is already collected by individual agencies and analysis of themes, patterns and trends.

Training

- Review what training is needed locally and agree how to deliver;
- Monitor and evaluate the effectiveness of training commissioned;
- Identify how the training that is provided by agencies working with children, will be quality assured.

Scrutiny and Assurance

- Thematic audit themes and Peer Review themes to be agreed by the Safeguarding Executive Group on an annual basis;
- Independent audits to be commissioned to promote reflection and drive continuous improvement of HCYPSP arrangements;
- Agree and make arrangements for an independent person to write the annual report;
- The report will outline what has been done as a result of the arrangements, including practice learning reviews, and how effective these arrangements have worked in practice;
- Ensure that the report is widely available and published on the new HCYPSP website once developed;
- Provide progress updates to the published arrangements in their yearly report and the proposed timescale for implementation.

Safeguarding Rapid Review and Local Safeguarding Practice Learning Review

The responsibility for learning the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the three safeguarding partners (HCYPSP).

HCYPSP arrangements must have due regard to National guidance published by the Panel.
When further guidance is issued, it will be incorporated into the HCYPSP Policy and Procedures.

Serious child safeguarding cases are those in which:

- Abuse or neglect of a child is known or suspected and;
- The child has died or been seriously injured.

When a serious incident becomes known, Halton Borough Council must notify the Panel within five working days of becoming aware that an incident has occurred. The Council should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within five working days.

The Safeguarding Executive Group will be responsible for making the decision to undertake a Safeguarding Rapid Review and any Safeguarding Practice Learning Reviews, in line with any guidance published by the Panel.

<u>Safeguarding Rapid Review</u>
This is to enable safeguarding partners to:

- Gather the facts about the case, as far as they can be readily established at the time;
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately;
- Consider the potential for identifying improvements to safeguard and promote the welfare of children;
- Decide what steps they should take next.

The decision and rationale process should be transparent and communicated appropriately including to families.

The Safeguarding Rapid Review must take no longer than 15 working days to be completed and a copy of the Safeguarding Rapid Review report should be sent to the Panel. The Safeguarding Rapid Review will consider if it is appropriate to undertake a Local Safeguarding Practice Learning Review.

Local Safeguarding Practice Learning Reviews

The Safeguarding Executive Group must commission and oversee this process to ensure they:

- Have clear processes for how they will work with other investigations and work collaboratively with those responsible for carrying out those reviews;
- Agree with the reviewer(s) of Local Safeguarding Practice Learning Reviews, the method by which it is to be conducted;
- Seek to ensure that practitioners are fully involved in the Local Safeguarding Practice Learning Reviews and that families, including surviving children, are invited to contribute;
- Ensure the final report of a Local Safeguarding Practice Review includes a summary of recommended improvements and an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered in the report;
- Consider carefully how best to manage the impact of the publication of Local Safeguarding Practice Learning Reviews on children, family members, practitioners and other closely affected by the case;
- Safeguarding partners need to agree who will take the lead in managing and responding to communication and media;
- Send a copy of the full report to the Panel, the Secretary of State and Ofsted no later seven working days before the date of the publication. If it is decided to publish information only relating to the improvements to be made then in addition to a copy of the full report, a copy of this improvement information should also be sent;
- Depending on the nature and complexity of the case, the report/improvement information should be completed and published as soon as possible and no later than six months from the date of the decision to initiate a review;
- Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel, the Secretary of State and Ofsted of the reasons for the delay;
- Safeguarding partners should set out for the Panel, the Secretary of State and Ofsted the justification for any decision not to publish either the full report of information relating to the improvements;
- Safeguarding partners should have regard to any comments that the Panel, the Secretary of State and/or Ofsted may have in respect of the publication;
- Every effort should also be made, both before the review and while it is in progress, to (i) capture points from the case about improvements needed, (ii) take corrective action and (iii) disseminate learning.

Child Death Review Process (CDOP)

Revised statutory and operational guidance has been issued, the key changes include:

- The CDOP is led centrally by the Department of Health.
- Local arrangements will be undertaken by the Pan-Cheshire Child Death Rapid Review;
- Halton Health and Wellbeing Board will receive an annual report as the majority of child deaths are not safeguarding related (subject to agreement that this will be the local accountable body);
- The Pan-Cheshire Policy/Protocol is still to be developed. This will explain the relationship between the Safeguarding Rapid Review and the Child Death Rapid Review.

Further details including how lessons are learnt and embedded in practice are outlined in the HCYPSP Learning and Improvement Framework.

Multi-Agency Safeguarding Unit

The Multi-Agency Safeguarding Unit will be responsible for the development and implementation of the HCYPSP arrangements. The team will consist of posts that are multi-disciplinary and will operate under the ethos of agile working. Posts will be filled through a recruitment process led by a safeguarding partner as required.

The Unit will be responsive to need and demand and therefore take responsibility to ensure a collective delivery of the arrangements and prioritise developments agreed via the HCYPSP. They will also be linked to wider ambitions, for example, co-location and partnership approach to early effective intervention and demand management.

The Unit will be funded through direct funding or in-kind support from across the safeguarding partners. Moving forward, it is our intention to identify further opportunities for key officers in other agencies to be co-located in the Multi-Agency Safeguarding Unit to develop the effectiveness of the HCYPSP arrangements.

The Unit will be responsible for co-ordinating effective working relationships with staff from the three safeguarding partners and all other relevant agencies. There will be specific relationships with:

- Designated Doctor;
- Designated Nurse Safeguarding Children and Looked After Children;
- Designated Nurse Safeguarding Adults;
- Identified Police Officers.

Head of Safeguarding will:

- Facilitate the HCYPSP;
- Develop and implement HCYPSP arrangements;
- Work with safeguarding partners to develop one overarching strategic approach;
- Bring strategic leads together to drive forward these arrangements;
- Develop and promote best and innovative multi-agency practice to improve outcomes relating to children's resilience and safeguarding;
- Work with partners to develop and implement new ways of working and to identify opportunities to co-locate services that reduces duplication, improves practice and outcomes for children;
- Lead on local and national learning including from serious child safeguarding incidents,
- Develop an independent scrutiny framework to provide high levels of assurance across the safeguarding pathway;
- Lead on system change that allows partners to work together differently and more effectively across the safeguarding pathway;
- Lead on engaging with relevant agencies on safeguarding arrangements;
- Lead and develop statutory guidance (including child death review guidance), policies, procedures, strategy and other key documents;
- Work with others to develop a workforce that is fit for the future;
- Management and oversight of the child death review processes;
- Lead specific work streams.

Safeguarding Development Officer(s) will:

- Contribute to the development and implementation of the HCYPSP arrangements;
- Link with a safeguarding partner organisation and will contribute to practice and new ways of working;
- Act as strategic link to other board arrangements and underpinning planning regimes;
- Review and develop statutory guidance (including child death review guidance), policies, procedures, strategy and other key documents;
- Co-ordinate the child death review process including support for the child death review panel;
- Develop and facilitate the training programme;
- Be responsible for communication and engagement activity;
- Facilitate performance, data and needs analysis to inform the arrangements and measure impact;
- Contribute to the scrutiny and assurance process including through case audits;
- Meet expectations of other funding partners and the delivery of expectations in terms of training, support and guidance.

Admin Support will:

- Support and develop the HCYPSP structure and underpinning functions and work streams (including meeting co-ordination, sub and task groups, training, communications (including social media and website management), engagement and scrutiny and assurance framework.

5. Funding Arrangements and Responsibilities

Working in partnership means organisations and agencies should collaborate on how they will fund their arrangements. The three safeguarding partners will agree the level of funding secured from each partner, which should be an equitable and proportionate contribution from each relevant agency to support the local arrangements.

The three safeguarding partners will make payments towards expenditure incurred in conjunction with the local arrangements for safeguarding and promoting the welfare of children. Funding allocations are agreed by safeguarding partners through the HCYPSP.

The three safeguarding partners have agreed their funding contributions for 2018/19 and 2019/20 which is via direct funding or in-kind support as deemed appropriate. This funding will contribute to the costs associated with the implementation and ongoing development of HCYPSP arrangements.

The three safeguarding partners' funding contribution will increase each financial year, in line with inflation.

The funding contribution remains the responsibility of any successor organisation to the three safeguarding partner signatories named in this agreement.

In addition, individual safeguarding partners will contribute to the development and delivery of the training programme, communications, marketing, events and child safeguarding practice learning reviews and funding of independent scrutiny.

Specific relevant agencies have agreed their funding contributions for 2018/19. This funding will contribute to the costs associated with the implementation and ongoing development of the HCYPSP arrangements. In the future, relevant agencies will be expected to contribute to the scrutiny and assurance arrangements and also training delivery.

Funding arrangements will be subject to an annual review and there will be further consideration and discussion regarding future funding rounds. If any safeguarding partners do not fulfil their funding responsibilities as identified in the HCYPSP arrangements, the dispute resolution process below will be deployed.

6. Key Partnerships - Role and Functions Overview

Halton Children & Young People Safeguarding Partnership - LEAD Safeguarding Partners

The membership of the HCYPSP LEAD Safeguarding Partners are representatives from the three safeguarding partners, as follows:

- Halton Borough Council – Chief Executive
- NHS Halton Clinical Commissioning Group (CCG) – Accountable Chief Officer
- Cheshire Constabulary – Chief Constable

Lead officers for underpinning partnership sub-groups shall be required to attend to present reports alongside other officers that will be invited to attend as required.

- Strategic Director of People, Halton Borough Council
- Chief Nurse, NHS Halton CCG
- Chief Superintendent/Superintendent, Cheshire Constabulary PPU

The Head of Safeguarding and Multi-Agency Safeguarding Unit will be responsible for co-ordinating the Partnership's business and will facilitate the meetings to ensure safeguarding partners are enabled to contribute equitably.

Halton Borough Council's Lead Member for Children's Services (LMCS) has a statutory role in ensuring the Council fulfils its duty for safeguarding children; in partnership with education, childcare and health services, the Police and communities. Halton's LMCS will be briefed through the Halton Borough Council's, Safeguarding Quality Assurance Meetings.

The HCYPSP Annual Report will be reported to Halton Borough Councils' Executive Board, NHS Halton CCG Governing Body, Cheshire Constabulary Chief Officers Group and the Health and Wellbeing Board.

The role and functions of the HCYPSP is outlined in the terms of reference, which will be reviewed on a regular basis.

Safeguarding Executive Group

This group brings together the lead officers from the three safeguarding partners including other relevant officers to oversee the HCYPSP arrangements and make decisions regarding local implementation. In addition, schools, colleges and other education settings will be represented as necessary by an appropriate senior representative (e.g. Operational Director for Education, Inclusion and Provision, Halton Borough Council).

The key role and functions are assessment of need, strategy, planning and delivery, establishing performance targets, quality and performance monitoring, compliance and oversight of child safeguarding practice learning reviews.

This group will be responsible for oversight and quality assurance of multi-agency working specifically within the 'safeguarding pathway' for children between early help services and statutory safeguarding processes.

Thematic audit themes and Peer Review themes will be agreed by this group on an annual basis. The group can direct attendance required at meetings of any other relevant agency or officer(s) from safeguarding partners' organisation depending on the relevant theme/issue.

This group will be responsible for making the decision to undertake a Rapid Review and any Safeguarding Practice Learning Reviews, in line with any guidance published by the Panel.

The three safeguarding partners will rotate the chair on an annual basis. During the first year, this group will be chaired by the Strategic Director People, Halton Borough Council.

The Safeguarding Executive Group will meet on a quarterly basis.

Contextual Safeguarding Strategic Group (CSSG)

This group brings together senior officers from the three safeguarding partners with responsibilities for child criminal exploitation, child sexual exploitation and modern slavery. It is responsible for the development, implementation and oversight of the Child Exploitation Strategy and underpinning action plans and associated work streams. Activity pertaining the CSSG will be feed into the Halton Children & Young People Safeguarding Partnership Annual Report.

This group reports to the Safeguarding Executive Group, the chair of the CSSG will attend the Safeguarding Executive Group and when required will attend the HCYPSP.

The three safeguarding partners will rotate the chair on an annual basis. During the first year this group will be chaired by the Operational Director Children's Social Care, Halton Borough Council.

Safeguarding Practice Group (SPG)

The group will have senior officer representation across the three safeguarding partner organisations and other selected relevant agencies. The group will be responsible for co-ordinating the outcomes of scrutiny and assurance activity and will review, monitor and implement areas for development to ensure we positively impact on our commitment towards continuous improvements to front line practice.

This group will also conduct any safeguarding practice learning reviews and disseminate learning from these and other local/national child safeguarding practice reviews, other national reports and research.

In the event of a serious child safeguarding case, a rapid review meeting is undertaken, overseen by the SPG which is made up of safeguarding partner representatives and facilitated by a member of the Multi-Agency Safeguarding Unit. This group will also facilitate communication with the national Child Safeguarding Practice Review Panel, Ofsted and the Secretary of State, Department for Education.

In the event of a serious child safeguarding practice review, the SPG would be responsible for overseeing the process, development and monitoring of the action plan. The SPG will continue to give oversight to the action plan until completion or with agreement from the safeguarding partners, the action plan will be monitored by the Safeguarding Executive Group. The action plan will be finally signed off by the safeguarding partners at the Safeguarding Executive Group.

This group reports to the Safeguarding Executive Group, the chair of the SPG will attend the Safeguarding Executive Group and when required will attend the HCYPSP.

The three safeguarding partners will rotate the chair on an annual basis. During the first year this group will be chaired by the Deputy Chief Nurse/Children's Clinical Lead, NHS Halton CCG.

Contextual Safeguarding Operational Group (CSOG)

This group brings together practitioners including Practice Leads, Case Managers, Service Managers Children Services, Police CSE and PVP officers, Police OCG Officers, Education Officers and Health Workers-Safeguarding. Leads share information and risk analysis on identified cases to identify connectivity, themes and trends to enable the group to identify further action that could be undertaken.

This work/responsibility of this group, does not replace the role of the child protection conference or core group process and procedure. It can add value and make recommendations for consideration. This group reports to the Contextual Safeguarding Strategic Group, the chair of the CSOG will attend the CSSG and when required the Safeguarding Executive Group and/or HCYPSP.

This group will be chaired by Cheshire Constabulary PPU and will meet on a 6-weekly basis.

Health Sub-Group

This group will be chaired by the Chief Nurse and/or the Deputy Chief Nurse/Children's Clinical Lead, NHS Halton CCG. This is a joint sub-group of children and adult health providers, which ensures engagement with safeguarding across the health economy.

Safeguarding Education Sub-Group

This group will be chaired by the Safeguarding Children in Education (SCiE) Officer, Halton Borough Council and will ensure engagement with schools designated safeguarding leads and support training, development and scrutiny (e.g. s175 audits) and intelligence reporting on emerging themes and trends within schools. This will also include 6th Form and FE Colleges.

Underpinning associated groups and meetings:

- **Multi-Agency Audit Group** - will meet on a quarterly basis for quality assurance of practice at key points along the safeguarding pathway. These will focus on safeguarding intervention within targeted services, the interface between targeted services and the work of children in need and child protection.

- **Multi-Agency Missing Children Meeting -** Brings together lead managers and named professionals from local agencies with responsibilities for missing children cases. Meets on a monthly basis and provides a focused opportunity to share information, intelligence and data and work collaboratively to prevent and reduce children going missing leading to better outcomes

and experiences. Accountable to Safeguarding Executive Group and will escalate issues to HCYPSP and CSSG as appropriate.

- **Protecting Vulnerable People Forum (Pan-Cheshire)** – Brings together the multi-agency representatives for children and adults at a strategic level. The purpose of the group is to share information and best practice and facilitate opportunities for joint working.

- **Child Death Overview Panel (CDOP) –** The Pan-Cheshire CDOP is chaired at Director of Public Health levels and meets on quarterly basis. It is responsible for reviewing all child deaths of children normally resident in the Cheshire area. A key function is to determine whether a death was deemed preventable or in which there were modifiable factors that may have contributed to the death and decide upon the required actions to prevent future child deaths. It is accountable to the Health and Wellbeing Board.

- **Education Strategic Partnership Board and SEND Strategic Group**
  These Boards are responsible for monitoring, challenge, support and intervention, with a focus on improving quality and standards leading to better outcomes. These Boards contribute to the HCYPSP Scrutiny and Assurance Framework and link to the Safeguarding Executive Group as appropriate.

  - The Education Strategic Partnership Board recognises that the accountability for overall education standards and outcomes (including the most vulnerable) is owned collectively, and not by any individual organisation or agency. The role of the Board is to provide the local framework for accountability for education standards and quality in Halton.

  - The SEND Strategic Group recognises the collective accountability for supporting children and young people with special educational needs and/or disabilities to achieve outstanding outcomes within Halton.

- **Children in Care Partnership** – The Board brings together multi-agency partners and young people themselves, in order to achieve improved outcomes of all children and young people in care or leaving care. The Board oversees the associated strategy and action plan.

- **Pan-Cheshire Channel Panel –** The Panel brings together multi-agency partners to consider referrals to the police regarding PREVENT and the radicalisation of children and young people. The aim is to identify opportunities for partnership action and reduce the impact on children and young people. The Panel has a relationship with the HCYPSP and exceptions reporting regarding the business of the Pan-Cheshire Channel Panel will be through the Multi-Agency Safeguarding Unit as required and through an annual report/statement.

Voice and Public Engagement Arrangements

The three safeguarding partners and other relevant agencies across Halton have established mechanisms in place, which are used to consult and engage with children, young people and families enabling them to have their say, share their views and experiences, challenge and support local decision makers, shape and influence strategic planning, commissioning and service provision at an individual, service and strategic level. These existing arrangements will continue and are endorsed by the three safeguarding partners.

Functions

The functions outlined above clarify the underpinning work streams which support and enable local safeguarding arrangements e.g. in relation to training and communications. There are also a range of reports that are required to be fed into HCYPSP arrangements and associated strategic partnerships/boards. This ensures compliance and provides opportunities to share information and learning, challenge and support as required and impact on improved practice across partners. Reporting through to the HCYPSP will be on an exceptions basis and the Partnership will seek assurance regarding children and area specific issues.

Scrutiny and Assurance Framework

There is an ongoing commitment to an open and transparent culture, where ongoing learning and improvement is fundamental to successfully implementing our organisational model leading to better outcomes for our children and families. The HCYPSP Scrutiny and Performance Framework provides more detailed regarding our local arrangements.

7. Endorsement

We the undersigned, endorse the content of this **Memorandum of Understanding** and accept responsibility for working under the auspices of the conditions outlined above.

David Parr
Chief Executive,
Halton Borough Council

Andrew Davies
Accountable Chief Officer,
Halton Clinical Commissioning Group

Darren Martland
Chief Constable,
Cheshire Constabulary