Annual Report 2021/22

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FOREWORD BY THE HALTON CHILDREN AND YOUNG PEOPLE SAFEGUARDING PARTNERSHIP CHAIR

It is with great pleasure that I have the opportunity as Chair of the Halton Children and Young People Safeguarding Partnership (HCYPSP) to introduce the annual report for the period 1 April 2021 to 31 March 2022.

The Halton Children and Young People Safeguarding Partnership provides the safeguarding arrangements required under the Children and Social Work Act 2017 and the statutory guidance contained within 'Working Together to Safeguard Children 2018'. The purpose of safeguarding arrangements is to support and enable local organisations and agencies to work together to safeguard and promote the welfare of children.

This report provides an update on progress made by the HCYPSP over the last 12 months and an assessment of its effectiveness, as well as outlining the development plans for the next 12 months.

The 2021/22 financial year remained challenging for local services, as we started to come out of the pandemic, with workforce shortages testing all agencies, increased referrals to early help and social care, and school attendance not returning to pre pandemic levels. It has also been a period in which the partnership has had to respond to a number of developments within child safeguarding. These developments, both national and local, have meant that the partnership has had to be clear on where it focuses the collective time and resources of our partners to strengthen and improve our multi-agency working to keep children and young people safe across Halton.

We are fortunate in Halton to have a strong partnership committed to safeguarding children and families. As a result of lessons learned from national and local audits and reviews, the HCYPSP continues to improve safeguarding arrangements for the protection of children and young people now and in the future. This report provides evidence of the robust work undertaken by all agencies during the year 2021/2022.

On behalf of the HCYPSP we hope you find this report to be informative, and open and honest in regard to our achievements and challenges over the last financial year.

Huge thanks as always are due to everyone in all agencies, statutory and voluntary, workers and volunteers, who work so hard to keep children and young people safe.

Denise Roberts, Chair, Halton Children & Young People Safeguarding Partnership.

INTRODUCTION

1) This is the second annual report for Halton Children and Young People Safeguarding Partnership (HCYPSP). Whilst the report covers the period 2021-22 it includes some references to before and after this period to provide context. The author is independent of any of the local agencies.[1]

2) Methodology for this report has been a desktop review of documents plus interviews with key partnership members (see appendix 1). Progress on implementing the recommendations of the first annual report for HCYPSP has been referred to where relevant.

LOCAL CONTEXT

3) Halton has a population of 130,000; with circa 30,300 children and young people (0-18 years). Halton shares many of the social and economic problems more associated with its urban neighbours on Merseyside. The Index of Multiple Deprivation (IMD) for 2019 shows that overall Halton is ranked 23rd nationally. All levels of unemployment are above national average with Universal Credit claimants being the highest in the Liverpool City Region. It is also estimated that over a quarter of children and young people in Halton live in poverty. Halton was severely affected by the covid pandemic in 2020-21 as one of the worse and longest affected places in the country. Covid continued to affect service delivery and capacity during 2021-22. Nationally cuts in budgets due to austerity have adversely impacted on a range of children's services making it more difficult for practitioners to secure or provide the support that children and families need.

4) Halton Borough Council is a constituent council of Liverpool City Region Combined Authority. The area is served by Cheshire Police who participate in three other safeguarding partnerships in the area. During 2021-22, in line with the Health and Care Act 2022, work has continued to replace the local Clinical Commissioning Group and transfer its responsibilities for planning and commissioning health care in Halton to a Cheshire and Merseyside Integrated Care Board by July 2022. The ICB serves eight safeguarding partnerships, although arrangements are in place at Associate Director level to relate to Halton and one other. There are also capacity challenges for officers from the local authority due to its small size. The recent Wood report[2] into the effectiveness of the new safeguarding partnership arrangements nationally concluded that partners who cover more than one local authority area are finding that this has a significant impact on their services' capacity to meet the demands on their resources. One simple practical solution to enhance capacity would be to try to agree with the three other Cheshire partnerships a dedicated day of the week when (some) meetings would be held to avoid clashes of

[1] The author has some prior knowledge of arrangements in Halton due to being the author of two CSPRs conducted during the period.

[2] Wood A (2021) Wood Report Sector expert review of new multi-agency safeguarding arrangements www.gov.uk/government/publications.

meetings for officers who attend key meetings for more than one partnership. **See recommendation B.**

5) The Wood report previously mentioned provides various examples of partnerships that have chosen to work across more than one local authority footprint. All four safeguarding partnerships in Cheshire have expressed a commitment to strengthening the pan Cheshire arrangements but achieving this is complex and there has been limited progress mainly due to lack of agreement between local authorities as to when this would add most value. One example of recent successes would be some pan-Cheshire policy and procedures e.g. on Fabricated Illness and Contextual Safeguarding[3] and Screening tools. As well as building capacity from economies of scale, learning what works from each other, reducing duplication (e.g. of data collection) and improving consistency of service for children and families that move between authorities, developing joint approaches pan-Cheshire might generate some income via applications for joint funding. **See recommendation B.**

LOCAL ARRANGEMENTS, LINKS TO OTHER PARTNERSHIPS AND RISK REGISTER

6) Chapter 3 of "Working Together to safeguard children" 2018[4] describes the statutory arrangements for multi-agency safeguarding arrangements. Many local organisations and agencies have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions. The responsibility for this join-up locally rests with the three safeguarding partners (local authority, Clinical Commissioning Group/Integrated Care Boards, and police) who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area.

7) Working Together specifies that the lead representatives for the three safeguarding partners (the local authority chief executive, the accountable officer of a clinical commissioning group, since replaced by Integrated Care Boards, and a chief officer of police) should 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. The three safeguarding partners, whose lead representatives are referred to as "Accountable Officers" in Halton, should make and publish local arrangements to support and enable local organisations and agencies to work together to overcome the challenges of the usual organisational constraints and boundaries, and make sure practitioners are supported to make longstanding and trusting relationships with children and families to safeguard children and promote their welfare. This includes agreeing funding contributions to support the work of the partnership and communication with local agencies including schools. Arrangements need to ensure that; partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children; organisations and agencies challenge appropriately and hold one another to account effectively; there is early identification and analysis of new safeguarding issues and emerging threats; learning is promoted and embedded in a way that local services for children and families

[3] Contextual safeguarding is an approach to identifying and responding to risks of significant harm for young people from outside their families.

[4] DfE (2019) Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children.

can become more reflective and implement changes to practice; and information is shared effectively to facilitate more accurate and timely decision making for children and families.

8) Accountable Officers may delegate their functions, but they remain accountable for any actions or decisions taken on behalf of their agency. If delegated, it is the responsibility of the lead representative to identify and nominate a senior officer in their agency to have responsibility and authority for ensuring full participation with these arrangements. This person must have a level of seniority which allows them to speak with authority and take decisions on behalf of their agency regarding policy resources and practice and hold to their agency to account without referring back to the accountable officer.

9) Halton Memorandum of Understanding (MOU) states that the Accountable Officers for safeguarding partners are the local authority chief executive, the accountable officer of the Clinical Commissioning Group (which has since been replaced by Integrated Care Boards), and the chief constable of police. To fulfil their responsibilities during 2021-2 the Accountable Officers relied heavily on their senior officers particularly those who attend the Executive and/or chair subgroups. The terms of reference (2019) specified two meetings for Accountable Officers a year. The partnership agreed three meetings per year in response to last year's annual report for an increased number. However, the lead representatives have only met all together once during 2021-22, the author was told this was due to difficulties getting all three together. They did not attend the partnership development day, their deputies did.

10) There is evidence that each lead representative was briefed by their senior staff and that they communicate about key issues between meetings, including the Chief Executive of the local authority and the Chief Officer of the CCG having 1 to 1 meetings during which safeguarding issues have been discussed. However, meeting in person reduces the risks of silo thinking and potentially adds capacity by providing benefits of consideration of issues from a multi-agency perspective. Because of this and a change in two out of the three Accountable Officers during 2021-2 there is a need for a stronger sense of a shared understanding of their role and how they operate together as a triumvirate. In his recent report into the implementation of the new arrangements Wood[5] identified that one of the main areas of weakness was a consistent and deep understanding of the role of the three statutory safeguarding partners. Wood reaffirmed an expectation that lead representatives should meet together. He suggested the new arrangements are not operating as the legislation and guidance intends if the individual safeguarding partners hold to account their own deputy but do not meet with the other two partners to determine key strategic issues like quality of practice, outcomes for children, finance, and data sharing. At the same time, he acknowledged a lack of unambiguous formal guidance for the three safeguarding partners. At the time of writing, it is known that all three of the Accountable officers have changed which provides a good opportunity for developing a joint perspective on their roles in leading the partnership. **See Recommendation A**

11) The HCYPSP replaced the local Children's Safeguarding Board in July 2019. During 2021-22 some governance documents have been reviewed and refreshed. These include the terms of reference of the Executive and subgroups to the partnership. A briefing document

[5] Wood (2021) Sector expert review of new multi-agency safeguarding arrangements.

prepared for an accountable officers meeting in June 2022[6] includes a diagram describing the relationship between these. (See diagram in Appendix 2). The Local Arrangements Protocol has not been streamlined to include the Memorandum of Understanding. Both documents are signed by Accountable Officers two of which are no longer in post. A Risk Register has been drawn up. This is underdeveloped as it focuses too narrowly on only two key risks to the partnership and compliance with working together 2018. These are the closedown of the CCG (Clinical Commissioning Group) and transition of its functions to the Integrated Care Board and lack of independent Scrutiny. It does not recognise that the accountable officers have only met once during 2021-2, it does not have contingency plans should any of the officers funded by the partnership leave and it does not include consideration of the most critical safeguarding issues for children in the local area. For example, one issue could be the worsening impact of poverty in the local area. Another could be the impact of the covid pandemic in its current phase which could include the response to the increased number of children who are not in school and include assurance about whether any arrangements by agencies to work differently have been reviewed to check they remain beneficial for children and families. For example, are vulnerable children being seen face to face by health providers. **See Recommendations C and E**

12) A list of relevant local agencies has been published on the HCYPSP website. Section 11 of the Children Act 2004 requires 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. Halton was one of the areas nationally which aimed to embrace the new partnership arrangements rather than rebadging their existing safeguarding board. The disadvantage of streamlining attendance at meetings has been that agencies who were previously involved no longer attend and there is no mechanism for engaging these "relevant agencies" in the overall activity of the partnership. One strength in Halton is the engagement of schools and nurseries via the education subgroup Faith groups and voluntary organisations have a lot of contact with children and there has been limited contact with them, other than through the training offer. These issues are not unique to Halton. **See Recommendation M**

13) There are several other multi-agency partnerships in Halton focusing entirely or partially on children. These include: the Halton Special Educational Needs and Disability Partnership, the Children's Trust (which was paused during covid). There are other pan-Cheshire and/or all age strategic partnerships that are relevant to safeguarding children. These include the Child Death Overview Panel, the Safeguarding Adults Board, the Community Safety Partnership, Health and Wellbeing Board, Multi-Agency Public Protection Arrangements. These are represented in a diagram on the partnership website but there is a lack of clarity how the safeguarding partnership relates to any of them in practical terms. **See Recommendation M**

FUNDING ARRANGEMENTS

14) The partnership spent £198k during 2021-22, the majority of this (£171K) was on safeguarding unit staffing; a part-time Head of Safeguarding, a Training and Development officer, a Performance manager (both full time) and admin support (part time). Income was

[6] Which was cancelled at short notice because of change in Accountable Officers and clash with other commitments?

184k. The deficit (which was due to the need to commission two CSPRs during the year) was funded from reserves, which amounted to £17k at year end. Funding contributions are received from the three statutory partners. Schools, CAFCASS and Probation also contribute at levels (plus inflationary uplift) that were agreed within the partnership as described in the Memorandum of Understanding (MOU) when the partnership was set up in 2019. The intention was to review these contributions annually but due to covid and the CCG's being dissolved this has not yet happened. Income is also generated from training activities.

15) Government guidance does not specify how the amount of financial contribution to a partnership budget should be calculated. As in the case nationally partners in Halton also contribute resources in kind. These include acting as trainers. The MOU also recognises that there may be a need for additional contributions to support events, communication and marketing and scrutiny activity. More consideration could be given as to what support should be expected to partnership activity in terms of leading and supporting all the workstreams, from a practical point of view because the business unit is too small to do all this work and because of the benefits of visible multi-agency engagement and leadership.

16) There is a lack of clarity amongst senior officers who have become involved since 2019 as to what the budget funds, including a misunderstanding about the level of support funded within the Business Unit, for example that the Head of Safeguarding has responsibilities other than for managing and supporting the partnership for 50% of her role. Prior to the new partnership arrangements (where Working Together makes it clear that the triumvirate are equal partners) nationally local authorities were perceived as the leaders for strategic as well as for safeguarding cases. Perhaps because the business unit staff continue to be hosted by the local authority there is also evidence of some confusion about the impact of partnership nature of their roles on the way they work as individuals and whether and when they should be fielded as a local authority representative. Current arrangements require clarity about "which hat" staff are wearing, and not putting them in a position where they may have a conflict of interest. In addition, the other 50% of the Head of Safeguarding post gained extra responsibilities due to the Ofsted inspection and the fact and potential implications of this were not shared proactively with the two other partners within the triumvirate. At the time of writing, it was known that there is an opportunity to review and clarify roles within the Business unit. Early during 2022-23 the Performance Manager departed. That post is to be replaced by a full-time Partnership Manager who will be managed by the Safeguarding Manager who will continue to spend 50% of her time on partnership business. **See Recommendation D**

WORK OF THE PARTNERSHIP GROUPS

17) The chair of the Executive group is a senior officer from one of the tri-partite agencies, who changes by rotation each year. During 2021-22 the Executive met five times, four times for normal business, and once to consider two CSPR reports that had been completed during the year. Representation from health, education and social care was 100%. Representation from the police was 40%. A nominee from education does not seem to have been available until 2022 and he was not able to attend a meeting before the end of the year. During 2021-22 work of the partnership revolved around the Executive group which made recommendations to the Accountable Officers and kept them informed individually.

18) Standard agenda items for the Executive group included consideration of reports from each subgroup. There was some evidence of raising queries and issues and challenge between agencies, e.g. difficulties recruiting nurse for the Integrated Contact and Referral Team (ICART) and social work vacancy levels, but there is limited evidence of subsequent checking that these had been followed up/resolved. During the year there was evidence of scrutiny of policy and procedures, the learning from audits (outcomes and processes) also of the annual report, which appears to have been signed off by the accountable officers before it came to the Executive. It is positive that there was a recognition that what might at first sight appear to be single agency issues (e.g. the workings of the Public Law Outline[7]) had a multi-agency dimension. It is also positive that there was evidence of a rresponse to emerging issues (e.g. the safety of asylum seekers) **See Recommendation H**

19) Reviewing the terms of reference of the subgroups has assisted in making sure discussions are held in the right place. For example, that the Safeguarding Practice Group should focus on learning and emerging issues, whether these are concerns about local practice or services, or new local or national initiatives, should initially be presented to the Executive for consideration. There are two other subgroups which lead on priorities for service improvement: on local approaches to neglect and contextual safeguarding respectively. See section Delivery of Priorities. There are also two other subgroups which focus on health and education issues respectively.

20) The remit of the Education subgroup is to improve the efficiency and effectiveness of safeguarding practices within education settings, including academies. During 2021-2 the group was re-launched to include nurseries. The group made sure that education settings were represented in work on neglect and informed about the work of the contextual safeguarding subgroup. They led the delivery of a 175 audit[8]of schools', colleges and nurseries' safeguarding arrangements and refreshed and digitized the model to make this easier to update in future. Operation Encompass[9] was launched in nursery settings. This has resulted in improved communication between early years settings and children's social care including more referrals. Training has been delivered to schools on escalating concerns and promoting a more consistent approach to sharing safeguarding school files across Halton and Cheshire when pupils change schools.

21) The group led the work to prepare Halton's response to Ofsted's review into sexual violence and harassment and peer on peer abuse within schools. This included consultation of pupils and resulted in training for Designated Safeguarding Leads[10] and whole staff groups being written and provided to all Halton schools. Adults were shocked by the extent to which inappropriate behaviour is normalised and recognised the need to overcome children and young people being "cold shouldered" if they report incidents.

[7] Public Law Outline (PLO) meetings with parents are called if the Local Authority is concerned about the care that a child is receiving where consideration is being given to the potential or actual necessity of starting care proceedings Unless the risks are so serious that an immediate application is required their purpose should be to explain to the parents what they need to do to avoid proceedings.

[8] Section 175 of the 2002 Education Act requires local education authorities and the governing bodies of maintained schools and FE colleges to make arrangements to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children.

[9] Operation Encompass is a system for reporting to schools, prior to the start of the next school day, when a child or young person has experienced domestic abuse.

[10] The designated safeguarding lead is the person appointed to take lead responsibility for child protection issues in school. The person fulfilling this role must be a senior member of the school's leadership team,

Further work based upon data collected on a termly basis will inform future actions. The group also did a piece of work on anxiety driven school avoidance which has become worse because of the Covid pandemic. This resulted in a service to address this.

22) The Health subgroup is a joint subgroup of children and adult health providers and commissioners which aims to provide an effective forum for the work of local partners and agencies to work collaboratively to ensure that children and vulnerable adults in Halton are safeguarded. The action plan considers the priorities of both Boards and provides a conduit to allow information exchange, contribution and feedback of all partners and agencies.

BUSINESS PLAN AND DELIVERY OF PRIORITIES

23) The previous annual partnership report acknowledged that the partnership had managed well without the development of a formal business plan but recommended that one be produced. The partnership held a development day held in August 2021. This involved senior managers from CSC, Health police and education representatives (virtual head teacher) and key partnership officers. The accountable officers for police and local authority attended, the Clinical Commissioning Group was represented by the Chief nurse. If the role of the lead representative had been formally delegated for this meeting this was not clear in the notes, as the Wood report has suggested would be helpful for the future.

24) The Business plan 2022-24 confirms the partnership's three priorities to be for the partnership to:

- Have a clear strategically driven, multi-agency response to childhood neglect, with well embedded, effective multi-agency strategy and assessment framework which supports awareness, understanding and recognition, leading to a reduction in children and young people experiencing long standing neglect.
- Improve the quality and effectiveness of front-line practice ensuring that the multi-agency workforce recognise the early and emerging signs of future risks for young people and respond with preventative interventions.
- Collaborate with Halton Adult Safeguarding Board and Halton Community Safety to develop a local all age pan Cheshire Contextual Safeguarding Strategy, that will include effective responses and procedures to safeguard, protect, and prevent children and young people from exploitation. This was not achieved in 2021-22 but a soft launch is planned for January 2023

25) The Neglect subgroup suffered from some variable attendance which delayed the production of a strategy. The development and early implementation of the Neglect strategy included practical assessment tools, multi agency practice standards and guidance to assist in recognition, training for staff, awareness raising for children and young people, a 12-month communication strategy and a performance framework to measure the impact. Presentations were delivered to the Adult Safeguarding Board and the post Ofsted inspection Improvement Board. The strategy and approach to implementation was consistently mentioned as a strength by those who were interviewed for this report. For future staff joiners the information is built into the Working Together training and single agency inductions. Assurance statements will be sought from partners to confirm this. Partners are reporting that there is widespread awareness of the strategy

and that key practitioners/managers are aware of the requirements on them. The education subgroup has had feedback that the assessment tool has clarified the threshold for referral for education settings and helped them present evidence about children's circumstances.

26) Although the Contextual Safeguarding group had designated representatives representing the local authority, health and police, attendance was variable with the only consistent attender being the chair. This prevented a shared understanding of the purpose of the group and there was insufficient join up with and challenge to the operational group to ensure agreed actions were followed up. Findings and recommendations of the inspections of the Youth Justice service and the local Police force (see paragraphs 40 and 41) suggests there is much to do locally to improve the approach to Child Criminal Exploitation and Child Sexual Exploitation. Membership of the subgroup, including a new chair, was refreshed towards the end of the financial year and by March 2022 there was agreement on a data set for performance management. However, some measures will require manual cross matching and this piece of work is a good example of the challenges for agencies who work across more than one partnership (in this case the police) receiving multiple data requests for similar, but not necessarily the same information.

27) During 2021-2 the Safeguarding Practice Group: updated its action plan in the light of the business plan; signed off a revised threshold document before presentation to the Executive; reviewed gaps in training capacity; oversaw the development of a Learning and Improvement framework agreed and oversaw task and finish groups to review Working Together training; and commissioned two Child Safeguarding Practice Reviews (CSPRs) during the year, one has been published the other will be once the criminal investigation has been concluded. For more details see section on learning.

VOICE OF THE CHILD, ACTIVITY, AND IMPACT

28) Child and young people should be consulted about decisions that affect them. Part of the role of the safeguarding partnership is to ensure that this is happening to influence assessment and plans for vulnerable children in need of care and protection. Partnership case audit tools are based on Signs of Safety[11] key questions (what worked well, what are we worried about) but dId not include anything specific to identify the child's voice and/or their lived experience.[12] For the "harm outside the home" audit comments about this were evident in only half of the cases audited (five out of ten) yet all of the children were aged 14 years or over, which should mean there should have been evidence of successful or otherwise attempts to speak to them. For the "emotional abuse audit" child and family views were again only apparent in five out of 10 cases. Although seven out of the sixteen children involved were under 5 years consideration could have been given to their "lived experience"

29) There are a few examples where feedback has been sought from young people to inform the delivery of partnership activity. For example, the partnership felt it was essential that

[11] "Signs of Safety" is a system of working which engages child and parents alongside practitioners to plan and deliver intervention after analysis about "What do you think is going well?" "What are you worried about?" "What needs to change?"

[12] The Child's Voice and their lived experience are not necessarily the same thing. Some children are too young or disabled to be able to express their views which have to be deduced from observation of their presentation behaviour and living circumstances. Some children and young people may be unwilling to share their views at all or reluctant to share them honestly.

community members and young people were able to recognise and respond to neglect as children have not been visible during the pandemic and there may be future lockdowns. To inform the neglect strategy, local children and young people were asked what neglect means to them and what they would do if they recognised a friend was being neglected. They co-produced the imagery within the strategy and supported the partnership in developing their community awareness programme. As previously mentioned, children and young people's views informed Halton's response to Ofsted's review of sexual violence and harassment in schools.

30) There will also be individual examples of consultation and involvement of children and young people conducted by single agencies, but there is currently no mechanism for identifying relevant activity and aggregating the learning from this. Whilst based on issues known to cause harm to children, nonetheless all the examples given start with adults' perspective of what needs to be explored. Children in Halton might have a different view of what makes them feel (most) unsafe. Halton's approach to voice of the child could be strengthened by the development of a simple framework for consultation and involvement which includes: how the partnership wishes to ensure that vulnerable children's views are sought and taken into account in decisions that affect them individually; how their views might inform service development and improvement on local or nationally driven priorities and what are the broader community of local children's concerns about safety. Any such framework needs to articulate clear values and principles. These should enable an honest conversation with children and young people about why their views are being sought (or are not being sought) and what will be done about them. **See Recommendation K**

VOICE OF PRACTITIONERS

31) Frontline practitioners are a good source of information about what is working well for children and what needs to be improved. They may have a different perspective to managers about this and about the systems that support good practice and any that impeded it. The partnership consulted with front line practitioners to understand the obstacles in timely and effective responses to neglect, and how best to raise awareness. A week of practitioner workshops in February 2022, introduced the assessment framework and the strategy was attended by nearly 200 frontline practitioners. Feedback from social workers about recruitment and retention identified additional travel costs associated with being located in one part of Halton and this has been addressed. Practitioners' involvement was integral to the two Child Safeguarding Practice Reviews conducted during 2021-2, both in the writing of single agency reports and in meetings with the lead reviewer to identify learning and suggestions for service improvement. Feedback via supervision activity or concerns expressed to or identified by designated professionals is also fed into the partnership. Two examples from health practitioners were concerns about the level of "Was Not Brought" for children on Child Protection plans (which led to a thematic audit) and the challenges identifying and managing cases of Fabricated Illness[13] which led to a revised policy and procedure. There may be other single agency examples which should be harvested in future to add to the collective understanding of practitioners' views across the children's workforce. **See Recommendation L**

[13] Fabricated or induced illness (FII) is a rare form of child abuse. It involves a parent or carer exaggerates or deliberately causes symptoms of illness in the child.

32) Audit participant feedback was used as quotes in reports describing the audit process and learning from individual case audits, positives, negatives, and suggestions. Feedback was also sought from schools about their experience of the 175 audit. Views about it being too onerous have been address by the development of an online system which permits updating of previous responses. Evaluations were also received from practitioners involved in the Child Safeguarding Practice Reviews (CSPRs) which suggested that they felt they had enough support and information to participate effectively and that the process had identified learning relevant to improving practice.

PERFORMANCE

33) During 2021-22 a lot of time, thought and effort has gone into creating local indicators (performance dashboards) for the partnership's key priorities, harm outside the home and neglect. Performance measures need to be reliable, (timely and consistent in their collection and recording and interpretation methods) and valid, (relevant to the real world). National KPIs have been developed, tested, and refined by performance professionals over several years. Constructing new local indicators is difficult because this often involves new collection methods or deconstruction of measures that were introduced for a different purpose. These challenges affect the local dashboards. Some of the measures reflect other common challenges in measuring performance; they are activity not outcome or trend measures and will be hard to interpret. For example, the KPI proportion of Child Criminal Exploitation cases which are high medium or low risk has limited usefulness as there is no information on total numbers (i.e. an increased in proportion of high-risk cases could be fewer children) and is no way of telling whether risk is reducing on increasing for individual children. Use of the dashboards during the next year provides an opportunity to a) make sure that disproportionate attention is not placed on producing the dashboard as opposed to focusing on addressing what the data shows and b) ensure they are used alongside qualitative data, for example the perspective of children and young people and staff. This may mean reducing the number to measures that are most meaningful.

34) Whilst the focus on partnership priorities is important, the partnership is not making use of what should be robust data about the child protection system which is used by Ofsted to make judgements about local arrangements. Despite the abnormal service conditions over the period of Covid pandemic, which has made data more difficult to interpret and comparisons with statistical neighbours less useful, such measure as rates of S47[14] enquiries, repeat children protection plans and duration of child protection plans for example would provide useful intelligence across the partnership. Whilst they are typically seen as local authority measures, they are in fact heavily influenced by multi-agency activity and therefore there are limits to what the local authority can do alone to improve performance, and in any case other partners will have a view about what good performance looks like. Prior to the multi-agency improvement board being set up because of the Ofsted report in November 2021, such data was monitored by the senior leadership team within council children's services, but not shared in any multiagency setting. Health and Police partners have told the author how seeing "local authority" data has made them

[14] S47 of the Children Act 1989; the local authority's duty to investigate where there is reasonable cause to believe a child may have suffered or be at risk of significant harm.

recognise not only should some of it be included in Partnership performance arrangements but also that there may be equivalent data in their own agencies which should also be shared regularly or when concerns become apparent. An example during 2021-22 was the work undertaken by public health on injuries to children under 5 years which led to a multi-agency group and revised training, which was well received, on non-accidental injuries to babies. **See Recommendation F**

EXTERNAL SCRUTINY AND INSPECTION REPORTS

35) There are three forms of external scrutiny that apply to partnerships: feedback from National Safeguarding Panel regarding any Rapid Reviews of serious incidents and any resultant CSPRs; that provided by Inspectorates; and independent scrutiny of partnership arrangements and functioning, which should be commissioned by the partnership as per Working Together 2018. There has been limited feedback from the national panel regarding Rapid Reviews and CSPRs during 2021-22; the decision to undertake two CSPRs was endorsed, and feedback on the published report on both reports is awaited.

36) During 2021-22 the relevant national inspectorate visited council children's services on a between Joint Targeted Area Inspection (JTAI) inspections monitoring visit (October 2021), the Youth Justice Service (December 2021) and, Cheshire Police (January 2022). Each of these inspections resulted in recommendations which are relevant to partnership activity which have been shared in meetings of the partnership so that action plans can be aligned.

37) Ofsted noted a significant deterioration in the quality of social work practice for children in need in help and protection since their last visit in 2020, when the rating was "requires improvement to be good." There were two areas for priority action: the assessment and management of risk to children, including the frequency of visits to children, in line with assessed risk and needs and; improving management oversight and supervision to provide effective support and challenge. The report described social workers as feeling overwhelmed by high caseloads. Key areas of weakness which resonate with those identified and being worked on within the partnership during 2021 was that audit judgements were inflated (single agency judgements being higher than multi-agency ones) and that these did not consider the impact for children, nor identify all necessary corrective actions. Inspectors were also concerned about high levels of repeat child protection plans. This had been discovered by audit activity within the council and the Ofsted report notes that the audit findings informed the neglect strategy. The Ofsted report mentioned three specific groups of vulnerable children were mentioned: those who are privately fostered (where assessment and checks need to be improved); those who are neglected (where the approach is inconsistent, with too many children experiencing a second child protection plan identified through an audit) and homeless 16- and 17-years olds where practice has improved since the last inspection).

38) For the Youth Justice service all but one of the twelve standards (planning for court disposals) were rated good or outstanding. Areas for development which resonate with those for the partnership or other partners include that: family members' support for children who are exploited is underdeveloped; staff rely too much on the child's and parents' ability to manage the risks: that there needs to be an effective multi-agency response to reduce the risks of exploitation, which targets and disrupts perpetrators; and that there is limited support for children who are exploited and a lack of work to proactively target perpetrators, to break the cycle of abuse.

39) Some good practice was identified during the national child protection inspection of Cheshire police. However again there were recommendations about the response to Child Sexual Exploitation and about missing children (who are vulnerable to all forms of Child Criminal Exploitation) These were; to improve understanding of child sexual exploitation, paying particular attention to improving staff awareness, knowledge and skills in this area of work; the importance of timely sharing of information with partner agencies; undertaking risk assessments that comprehensively consider a child's circumstances and risks to other children; and improving the oversight and management of cases; improving the response to missing to be consistent with the risks identified and ensuring that the response is effectively supervised; immediately engaging with its safeguarding partners to review the terms of reference and practices of its multi-agency risk management meetings in relation to missing children and children at risk of exploitation, to include how incidents are investigated and addressing the lack of progress in some investigations when children are at risk of sexual exploitation; and prioritisation of children at risk of sexual exploitation who are repeatedly missing. In addition, the inspection report also recommended that the police should make sure that officers obtain and record children's concerns and views (including noting their behaviour and demeanour) to help influence decisions made about them.

40) Working Together 2018 states that safeguarding partnerships should have formal arrangements to scrutinise the effectiveness of the partnership in safeguarding all children and young people in the area including the arrangements to review serious cases. Independent scrutiny should consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership. The Wood report concluded that independent scrutiny was not being well utilised nationally and drew a distinction between it and self-assessment or internal peer challenge. Scrutiny arrangements should be made public; those for Halton are contained in the Memorandum of Understanding (MOU) which describes a range of activities, which, apart from the authorship of Child Safeguarding Practice Reviews and the production of an annual report, are all self-assessment or internal peer challenge. Last year's annual report recommended that the partnership consider further options for independent scrutiny. This was not done during 2021-22 but the learning from approaches elsewhere described the recent report into the nature and impact of scrutiny arrangements nationally[15] will be helpful to refine an options paper drafted in 2022. Wood recommends the use of a Six Steps Model for independent scrutiny of safeguarding which this research further refined into a "Checklist for independent Scrutiny" which outlines the advantages and disadvantage of a range of options.[16] **See Recommendation G**

QUALITY ASSURANCE, LEARNING ACTIVITY WORKFORCE DEVELOPMENT AND TRAINING

41) HCYSP has had a multiagency quality assurance process since 2020. The aim was to conduct three multi-agency audits each of ten cases completed from inception to report in three-month cycles, three times a year. There was only one audit (on emotional harm in

[15] Pearce, J., Stratton, I., Parker, L., and Thorpe, A. (2022) Independent Scrutiny and Local Safeguarding Children Partnership Arrangements TASP

[16] https://theasp.org.uk/MEMBERSSITE2020/MEMBERSSITE2020/RESOURCES/Independent-Scrutiny-Research-Project.aspx

September 2021) that fell within the financial year covered by this report. Audits on harm outside the home and neglect were conducted just before and just after the financial year covered by this report. Audit themes are agreed annually by the Halton Safeguarding Executive Group and identified through local priorities, learning reviews, inspection findings, performance data and national research. Some audit process issues had been recognised, which were addressed by a new Standard Operating Procedure, agreed in October 2021.[17]

42) The annual report of the multi-agency audit programme from Sept 2020 to October 2021 was presented to the Executive in November 2021. Variable timeliness and quality of information returned agency involvement was less than 60% in two out of the three audits conducted within that time frame with some key agencies relatively absent: GPs and 0-19 Health service. The impact of Covid is a relevant context for this due to the capacity issues in the health economy. This report identified a consistent overoptimism in rating practice within single agencies as multi-agency grades were consistently lower. The main themes identified included lack of confidence with escalation, and gaps in understanding the child's lived experience, wider family context dynamic and history. Action plans from the audit did not always address all the key learning; the emotional abuse audit actions did not include tackling interchangeable use of different terminology (emotional harm, emotional abuse, and neglect), therefore not distinguishing between abuse by parents and harm to children. **See Recommendation J**

43) HCYPSP requires schools to undertake a full S175[18] audit on a biennial basis; in 2021 schools completed a full audit alongside an update on any outstanding actions from the previous year's action plan. Over 90% of nurseries schools and colleges participated with over 90% judging that they had met or exceeded the standards. The moderation panel which scrutinised 60% of returns agreed that they had met the standards but that for settings who had judged themselves to be exceeding standards, 40% did not provide sufficient information to support their judgment or had graded themselves too highly. This finding has parallels to the inconsistency of gradings for the multi-agency audits. Approximately 80% of settings reported that they had completed all actions from the previous audit. Most of the outstanding actions related to training with changes in staffing and COVID-19 identified as a contributory factor.

44) Approximately 60% of settings reported a good level of awareness of the Multi-Agency Escalation Procedure and described sharing information through their school website, staff folders and/or including it within staff meetings, training, and induction. 35% of schools (19) reported that they had used the escalation policy within the past 12 months and 5 schools identified checking or improving staff awareness of the procedure as an action.

[17] Practice discussion days are informed by single agency audits of records by first line managers with the practitioner for the last 6 months of involvement. These are collated into a summary proforma under the headings of, overall quality of audit returns, chronology, assessments, planning, supervision, good practice, and areas for improvement. A plenary group of facilitators, chaired by the partnership's Head of Safeguarding identifies conclusions which are presented to the HCYSP Executive. Child's voice is included in assessment and planning summaries. Parents including fathers and extended families are included in assessment summary.

[18] For schools and colleges, the statutory responsibility to fulfil safeguarding duties is laid down in Section 175 or 157 of the Education Act 2002.

45) There were good levels of attendance by staff at most forms of training, including safeguarding training. However, the most frequent type of training identified as necessary in action plans by 14% of settings was governor training. Given their strategic responsibilities and role in calling the school leadership team to account more detail should have been sought about the precise nature of the deficit, perhaps via the safeguarding governor, which all schools should have.

46) During 2021-22 HCYPSP has been involved in two Rapid reviews which resulted in Child Safeguarding Practice Reviews (CSPRs). Both were young babies, one who died, the other who survived with life changing injuries. Key learning included: the importance of considering parents' cultural backgrounds; whether and how they might affect their understanding and response to their child's diagnosis, their expectations of treatment and their parenting; recognising that, when a child has a disability, signs of abuse can be masked or misinterpreted due to assumptions about ongoing health conditions or impairments; the importance of recognising the potential for some Acute Life-Threatening Events (ALTEs) to later turn out to be due to abuse, the need to refer ALTE promptly to the police and children's services and to consider any siblings; that all care givers need to be able to cope with babies crying and it is not enough to rely on mothers passing on key messages to fathers and "Respectful skepticism" being important when parents deny reported incidents of domestic abuse, especially if the mother has previously been subject to domestic abuse, and/or she is pregnant. Seven-minute guides, aimed at frontline practitioners and managers in particular, have been published for both cases. The report regarding Child F has been published in full, that relating to Child G cannot be published before the conclusion of the police investigation.

47) These were the first cases that have met the criteria for a CSPR or its precursor, a Serious Case Review, for several years. This provided an opportunity to review the commissioning processes and develop a model should there be other CSPRs required.

48) As recommended bv last year's partnership annual report a draft Learning and Improvement Framework has been produced to describe all the learning activity undertaken by HCYPSP. Whilst the draft document states that sharing of learning amongst the partnership to ensure transparency, accountability and consistent improvement to practice is integral to the success of this framework, there is insufficient detail to indicate how this will happen. The only specific examples of impact of the learning (e.g. training or changes in procedures) are activities rather than outcomes for children. The document would benefit from more content on learning from children's views which could be addressed by the development of a framework for consulting children and young people as suggested above.

49) A Learning and improvement tracker has been produced to support the implementation of the Learning and Improvement Framework. It aims to monitor progress on the delivery of actions from audits and CSPRs. This is supported by assurance forms to provide evidence of the implementation and impact of actions. Whilst this will reduce reliance on meetings to check progress on activity, the forms focus in more detail on dissemination of learning and its use will need monitoring to check whether outcome evidence is provided. **See Recommendations I**

50) A Training and Development Officer was appointed in September 2020 to reinvigorate the approach to training and dissemination of leaning. The multi-agency Working Together training has been redesigned as a first course followed by a refresher course. The training

is supported by a pre-read booklet which was piloted before rollout, plus worksheets for each session and a post course booklet focusing on child protection plans. Numbers are capped at a maximum of 20 and participants receive a certificate of completion. This training has had positive feedback from participants. GPs rarely attend the multi-agency Working Together training, although they occasionally attend specialist courses. Other challenges for involving the full range of people working with children include that the online booking system rejected certain email addresses and that certain groups e.g. childminders, find it hard to attend during the day/on a weekday. Representatives from the faith sector are only occasional training attenders and there is also more to do to encourage attendance from the voluntary sector.

51) The neglect training was successfully designed to overcome these challenges to engage the maximum numbers of the widest range of practitioners. This was achieved by delivery in 1-hour slots at different times of the day, including the evening, over a week. In Specific requests to make training more convenient were accommodated, a nurse delivered the package to a group of GPs, and the package was provided to ICART staff online.

52) Topic based short courses are popular. These are delivered by subject experts and updated as necessary. Some training e.g. on non-mobile babies has also been recorded so it can be accessed independently.

53) The list of subject expert facilitators was updated, and a training needs analysis produced a programme for 2021-2 which included ongoing courses and training. The training and development officer has co-ordinated the distribution by email of several briefings related to learning locally from audits or CSPRs or nationally from CSPRs or in response to changes in service delivery, for example, change in arrangements for referrals to iCART to online. These are then added in batches to the partnership website It is positive that some of these have been supplied from outside the safeguarding business unit e.g., one from health staff on harm amongst children under 5 years. Recipients responding with comments or questions or suggestions for other topic areas and examples of improved practice (e.g. identification of someone who had been trafficked) imply these are being read. However, the mailing list is small (200 people) and arrangements for wider distribution ad hoc and the list is difficult to keep up to date. One way of addressing these challenges would be to distribute the information to each agency via holders of the main central distribution lists **See Recommendation M**

54) Attendance is monitored, and any patterns for individual agencies identified and challenged if necessary; booking by police officers has improved because of this. Unfortunately, 20% of those booked on course don't attend. There is no pattern for any particular agencies. Reasons include sickness and other more urgent priorities. A charging fee for non-attendance contributes to costs of training.

55) The only dedicated cash budget for training is generated from those who pay to attend training (practitioners from agencies which do not contribute to the partnership budget see paragraph 57). Small organisations with a turnover of less than £100k per year are exempt) and fines for non-attendance. Training is mostly resourced in kind, by agencies supplying facilitators for example. The partnership funds the Training and Development Officer who provides co-ordination, she seeks out opportunities for income generation, one example during 2021-22 would be payment for her contribution to her work in partnership with the National Centre of Expertise for Child Sexual Abuse which has resulted in a training package on intra-familial sexual abuse which will be delivered pan-Cheshire.

SUMMARY AND CONCLUSION

56) 2021-2 continued the difficult times due to the covid pandemic and its aftermath. Halton had been one of the worst and longest affected places in the country. Other organisational challenges for each partner include that Halton is a small local authority which limits capacity for engagement in development work, the police forces cover four partnerships and the ICB two. Capacity for senior officers in each of the three key agencies has also been affected by the impact of activity to address inspections (Ofsted and the Police) and the transition from CCGs to ICBs. The determination to establish partnership arrangements which were not rebadging of the previous safeguarding board may have resulted in too much streamlining which has reduced input from previously highly engaged partners from "relevant local agencies".

57) During 2021-2 progress has been made in delivery some of the recommendations from last year's annual report. The partnership delivered several achievements during 2021-2 These include: reviewing the role of subgroups; developing and launching the Neglect strategy; engaging nurseries as well as schools in the education subgroup; improved delivery of Working Together training, engagement of a wider audience in topic-based training by delivering this outside office hours; review of the audit arrangements; distributing learning, dissemination or learning briefings including those written by partners as well as business unit staff. Ongoing work is therefore better underpinned with written arrangements and more pro-active.

58) There are several opportunities for 2022-3 in particular: to establish more visible leadership from the Accountable Officers, to look out for further opportunities where pan-Cheshire working might benefit children in Halton, to make better use of feedback from children and young people and practitioners; to agree options for Independent Scrutiny; to refine the partnerships approach to monitoring performance; and to seek assurance that service improvement as a result of learning is consistently embedded.

RECOMMENDATIONS

Governance and strategic direction

A. That Accountable Officers need to meet regularly to develop a shared understanding of their role and how they will work together and lead the partnership to implement their vision for safeguarding children in Halton and address any emerging issues that threaten the safety of children. They need to ensure that arrangements to deliver the work of the partnership are collectively effective in terms of resources (cash and in kind), capacity, information, and data sharing, learning from training and serious incidents and the involvement of children and young people and practitioners. They should meet at least three times a year, meetings to be timed in line with the planning cycles for example, plus consideration should be given to adopting standard agendas to ensure key business is always covered. Provision should also be made for the calling of emergency meetings of the Accountable Officers in crisis situations.

B. The partnership should formally consider whether and which closer working arrangements within the Cheshire footprint might improve outcomes for children, enhance local capacity or reduce costs or otherwise add value. As a minimum this should include:

   I. Agreeing with other partnerships who require participation by Cheshire police or the LCB which day of the week meetings will be held to maximise attendance and continuity of attendance through avoiding clashes of dates.

   II. performance and data collection arrangements where some organisations e.g. the police received multiple requests for similar information from different partnerships.

   III. Aligning approaches to emerging safeguarding issues

   IV. Delivery of training

C. That the risk register be reviewed to ensure that

   I. Critical risks to safeguarding local children are captured.

   II. All significant risks to the functioning of the partnership are captured.

D. That financial arrangements are transparent in terms of the amount of each partner's contribution, the source and amount of any other income, the level of reserves and planned expenditure (including on staffing and scrutiny) and less predictable expenditure (e.g. commissioning CSPRs). Further opportunities to generate income should be considered.

E. That the Local Arrangements Protocol (2019) should be updated and streamlined to include the Memorandum of Understanding (2019) and ensure that the relationship between the safeguarding partnership and other partnerships, and how these work in practical terms, is clear.

Performance, independent scrutiny, and learning

F. Lead Safeguarding Partners should agree a minimum data set which includes information about the performance of the overall child protection system as well as the partnership priorities. This should include information on impact/outcomes as well as activity.

G. Lead Safeguarding Partners should agree arrangements for independent scrutiny of the local safeguarding arrangements from a person or persons who have not worked for any of the local agencies.

H. Lead Safeguarding Partners should ensure that where partners have been challenged about issues which may have a significant impact for safeguarding children or the functioning of the partnership the there is evidence of a satisfactory resolution.

I. The partnership should build on existing arrangements to seek assurance from lead officers and partners about progress on delivering agreed actions in action plans to identify the impact on children's safety and wellbeing.

J. That the partnership considers whether a more impactful approach to learning from audits might be to aim to do fewer (e.g. two per year rather than three) which would give more capacity to reflect and act on the learning and embed any changes

Involvement of and communication with key stakeholders

K. The partnership should build on existing arrangements for involving children by developing a framework for seeking and acting upon feedback from children about how they experience service delivery and what local children see as priorities to help them stay safe.

This framework should recognise that “Children’s Voice” is not the same as “Children’s lived experience”.

L. The partnership should build on existing arrangements for involving practitioners by developing a framework for seeking and acting upon single agency and multi-agency feedback from practitioners to include the quality of services they deliver, what is working and where there are challenges and areas for improvement that would benefit from a multi-agency approach and/or input from strategic leaders.

M. The partnership should review arrangements to engage relevant local agencies, for example:

   I. Consider the development of a forum or other mechanism for representatives of relevant agencies not directly represented in the subgroups of the partnership to share information, discuss issues, and seek feedback!
   II. Development of communication system which uses agencies’ own distribution lists and umbrella groups for disseminating learning and other partnership information.
   III. Working together training needs to be delivered by a pool of trainers representing different agencies.

Appendix 1 list of interviewees

Name, job role and Agency	HCYPSP roles 2021/2022	Changes for 2022-3
Michelle Creed	Chief Nurse Halton Clinical Commissioning Group Member of the Executive group	No longer in post
Andy Davies	Chief officer Halton Clinical Commissioning Group and lead representative	No longer in post
Rachael Greenwood	Partnership Learning and Development Officer	No change
Angela Houghton	Partnership performance Manager	No longer in post
Ben Holmes Council	Temp chair Education group covering for Virtual Head	Promoted to Virtual Head confirmed as chair of education subgroup
Gareth Lee	Chief superintendent Cheshire Police joined Executive group in February 2022	2022-3 Temporary promotion to Assistant Chief Constable Cheshire Police, lead representative
Susanne Leece	Head of safeguarding (Manager of HCYPSP business unit) Member of the Executive and Safeguarding practice groups, Chair of Neglect subgroup	No change
Denise Roberts	Deputy Chief Nurse Halton Clinical Commissioning Group Chair of Safeguarding Practice Group	Associate Director responsible for safeguarding 2022-23 Chair of Executive
Mil Vasic	Strategic Director of People, Halton Council Chair of Executive group	2022-3 Member of the Executive Group

Halton Children and Young People Safeguarding Partnership

Reporting Pathways

Pan-Cheshire Safeguarding Arrangements

Lead Safeguarding Partners (Accountable Officers)

Halton Borough Council – Chief Executive Officer, NHS Halton ICB Accountable Officer, Cheshire Constabulary – Chief Constable

Safeguarding Executive Group

Contextual Safeguarding Strategic Group (CSSG)

Neglect Sub-Group

Safeguarding Practice Group (SPG)

Safeguarding Education Sub-Group, Health Sub-Group

Contextual Safeguarding Operational Ground (CSOG)

Specific Themed Task and Finish Groups

Section Interest Groups

GP Practice Leads | School Governor Meetings | Early Years/Childminders

Halton Association of Secondary Heads (HASH) | Halton Association of Primary Heads (HAPH)

Provider Forum | Faith Forum

HCYPS

Children & Young People Groups

Youth Parliament | Young Carers | SHOUT

Children in Care Council | Halton Speak Out

Halton Youth Cabinet | School Councils