HALTON CHILDREN AND YOUNG PEOPLE SAFEGUARDING PARTNERSHIP

2022-23 Annual Report

Reporting Period April 2022 – March 2023

Contents

1. FOREWORD AND EXECUTIVE SUMMARY FROM THE CHAIR

Welcome to the Halton Children and Young People Safeguarding Partnership (HCYPSP) Annual Report for 2022/23.

As well giving an overview of the Partnership's important work, the report showcases the commitment and dedication of our partner agencies as they continue to do everything they can to keep Halton's children and young people safe.

While the report gives examples of the difference being made to support children and young people across the borough, it also identifies areas where we need to continue to make improvements so that every child in the borough is safe, thriving and heard.

The Partnership has been identifying and learning lessons through Child Safeguarding Practice Reviews and Rapid Reviews and the learning from these has been shared widely through workshops and training sessions. You'll be able to find out much more about this learning in this report.

I would like to welcome new members who have joined the Partnership this year and thank those who have left for their contributions. The Partnership is in a much stronger position because of their efforts. I also want to thank all members of the Executive for their continued professionalism, commitment, and support throughout the year.

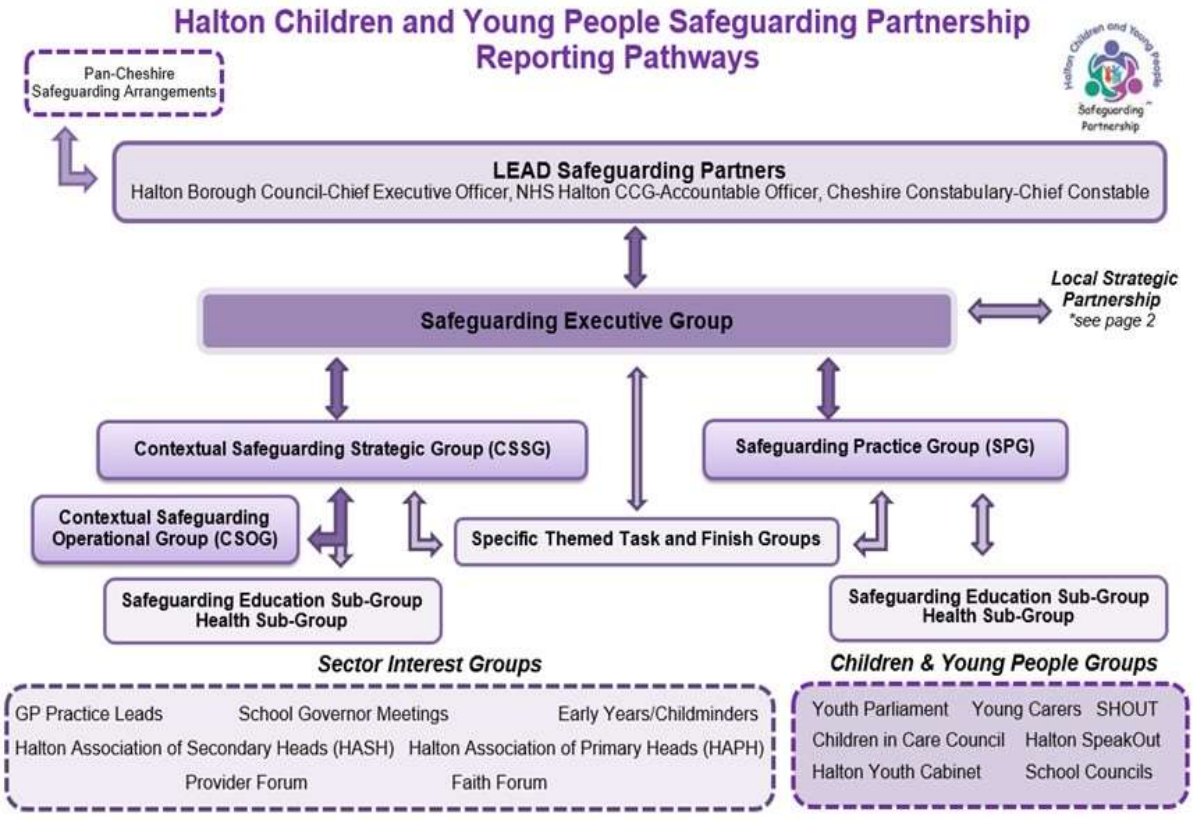
Finally, and importantly, I want to thank all agencies and frontline staff for the incredible work they do to keep children safe from abuse and neglect.

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

2. ABOUT HALTON CHILDREN AND YOUNG PEOPLE SAFEGUARDING PARTNERSHIP

The Halton Children and Young People Safeguarding Partnership (HCYPSP) is a statutory, multi-organisation partnership coordinated by a business unit, which oversees and leads children's safeguarding across the Halton Council area. The main objective of the HCYPSP is to gain assurance that local safeguarding arrangements, comprised of partner organisations, are working effectively, individually, and together, to support and safeguard children in its area who are at risk of abuse and neglect. The HCYPSP acts as a critical friend and a champion for best practice.

The HCYPSP replaced the local Children's Safeguarding Board in July 2019 and in 2022 some governance documents were reviewed and refreshed. These included the terms of reference of the Executive and subgroups to the partnership. A briefing document prepared for an accountable officers meeting in June 2022[1] includes a diagram describing the relationship between these. (See diagram below).



2.1 GOVERNANCE ARRANGEMENTS

Halton Memorandum of Understanding (MOU) states that the Accountable Officers for safeguarding partners are the Local Authority Chief Executive, the Accountable Officer of the Integrated Care Boards, and the Chief Constable of Police. To fulfil their responsibilities during 2022-3 the Accountable Officers relied heavily on their senior officers, particularly those who attend the Executive and/or chair subgroups.

The Partnership is chaired by a representative of each safeguarding partner for a year at a time. The Chair provides leadership, vision and support and is responsible for ensuring that all organisations contribute effectively to the work of the HCYPSP. Effective communication between the Business Unit and Chair ensures that there is a clear link between the subgroups and executive group, enabling risks, themes, and opportunities to be highlighted at an executive level, and challenge, direction, and opportunities to be shared into subgroups. This is supported by meetings for subgroup Chairs to provide clarity about the role of each subgroup in the priority areas and to raise any process or participation issues with the Chair.

Quality assurance remains our key driver across all the subgroups, using frameworks that will measure the impact of subgroup activities and challenge those working in the safeguarding arena. We also continued to ensure that our policies and procedures are embedded in the work we carry out, that toolkits, guidance, and procedures draw on the knowledge of subject experts locally and nationally to inform them, and that we can demonstrate the impact of learning that has taken place.

2.2 OUR VISION

To work together to enable children and young people in Halton to live a life free from fear, harm, abuse, and exploitation, and ensure that every child is safe, thriving and heard.

The HCYPSP's objectives are to:

- Co-produce with children, young people and families using their strengths and assets to develop services to meet their individual needs.
- Provide robust independent scrutiny and assurance to the partnership in relation to safeguarding and the welfare of children and young people in Halton.
- Make children's safeguarding personal and swift so they remain in families, in school.
- Build children, young people, and families' resilience.
- Drive an even stronger partnership with schools, colleges, and local agencies.
- Ensure children and young people are safeguarded in their wider community from exploitation.

The safeguarding partners have agreed to:

- Work collaboratively and creatively with children, young people and families using their strengths and assets.
- Lead on engaging with relevant agencies to ensure collective responsibility for building children's resilience and safeguarding.
- Further develop and promote the best of what already exists in Halton and think innovatively about multi-agency practice to improve outcomes relating to children's resilience and safeguarding.
- Lead on system change and work across the wider policy and partnerships landscape 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 across the safeguarding pathway.
- Continue to develop our independent scrutiny framework to provide high levels of assurance across the children's safeguarding pathway.

2.3 OUR PARTNERS

Working Together 2018 is statutory guidance that provides children's safeguarding with a legal framework, setting out the responsibilities of local authorities and their partners. From a statutory perspective the three legally required bodies are:

HALTON BOROUGH COUNCIL

NHS Cheshire and Merseyside

Cheshire Constabulary

However, we work closely with a range of other partners including:

- ✓ Cheshire & Merseyside Social Work Teaching Partnership
- ✓ Youth Justice Service
- ✓ Halton's schools, nurseries, colleges
- ✓ Change Grow Live
- ✓ Youth Justice Service
- ✓ Liverpool John Moores University
- ✓ Research in Practice (Reflective Supervision)
- ✓ Hope University
- ✓ Edge Hill University
- ✓ C & M Social Work Teaching Partnership

3.THE LOCAL CONTEXT

Halton Borough Council was created as a unitary council is 1998 with the two largest settlements of Runcorn and Widnes facing each other across the River Mersey.

The borough benefits from excellent connectivity and transport infrastructure. There are good road and rail connections to London (less than 2 hours by train) and Birmingham. Similarly, there is good proximity and access to airports at Liverpool and Manchester and to the Merseyside seaports.

Halton is also part of the Liverpool City Region Combined Authority. This is one of the few City Regions to have secured a Devolution Agreement with the Government, meaning decision making and resources around key priorities are managed locally.

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. Nationally, cuts in budgets due to austerity have adversely impacted a range of children's services making it more difficult for practitioners to secure or provide the support that children and families need.

3.1 CHILDREN AND YOUNG PEOPLE IN HALTON

5%* of pupils are recorded in the school pupil census as Black, Asian, and other Minority Ethnic.

25,954 children and young people (0-15); 4310 aged 16-18

19,130* pupils attend state funded schools in Halton

38.2%* of pupils are eligible for free

33 Children are being tracked as missing from-education.

1417 children and young people have Education, Health and Care

793 Children and young people are electively home educated.

3079 Children with Special Educational Needs (SEN) support in Halton schools

4.3%* of pupils have a first language other than English.

*Data taken from the January 2023 School Pupil Census

3.2 EDUCATION CONTEXT

There are 65 schools in Halton with 49 primary schools (8 academies and 41 maintained), 8 secondary schools (7 academies and 1 maintained), 4 special schools (1 primary academy, 1 secondary academy, 1 secondary maintained and 1 all-through maintained), 3 maintained nurseries, and 1 Pupil Referral Unit.

With 75.4% of Halton schools judged to be good or better by Ofsted, the potential for children achieving positive outcomes is good.

The number of children who are home educated is 793 (as of 30 April 2023) which, although small when compared to all children accessing school provision, is monitored, and reviewed by the Partnership annually to ensure oversight of this cohort of children and young people.

Based on the January 2023 school spring census 14.85% of the school population were SEND (Special Educational Needs and Disabilities). This figure includes those that had an Education Health Care Plan (EHCP) and those that have SEN support. The number of children with Education, Health and Care (EHC) Plans or statements of SEN in Halton is 1417.

There is a large body of evidence and research to show that children who live in poverty are more likely to face additional traumatic experiences or be exposed to a range of risks that can have a serious impact on their mental health and life chances. The University College London (UCL, July 2020) found that poverty was strongly associated with an increased odds of a child reporting ACEs (Adverse Childhood Experiences) such as being sexually abused, coping with parental separation, or their parents' experiencing issues with mental health, drug or alcohol abuse. With its high levels of deprivation and approximately 25% of children already living in poverty, the research suggests that the impact is only likely to increase, putting further pressure on families. It is therefore important for HCYPSP to be fully aware of this cohort of children and young people and ensure that these are considered within aspects of the partnership's work programme.

3.3 LISTENING TO THE VOICE OF HALTON YOUNG PEOPLE

The numerous experiences and opportunities offered to children & young people across Halton through voice & influence campaigns, participation activities & community events are specifically designed to empower, increase social capital, raise self-awareness and self-esteem, to foster resilience and support better outcomes for our vulnerable children & young people. Here are some of the things that we have been doing over the past twelve months:

In 2022, a spoken word artist worked with a group of children and young people from YJS, on the power of language and creative expression and YJS has also formed a partnership with Theatre in Prisons Project (TiPP) to put on participatory music making groups. These creative initiatives are examples of 'socially prescribed' relationship-based, psychosocial therapeutic activities for children in the justice system and exemplify the relational child-first approach YJS will be embedding over the next few years. (Youth Justice Service)

Resolve is an emotional health and wellbeing service for children, young people, and families to reduce the impact of domestic abuse on individuals, families, and the community.

The team is made up of experienced and skilled professionals who provide an opportunity for children and young people to be believed, reassured, and listened to. In all the Resolve work, the voice of the child is extremely important and central to the plan of work that takes place. In particular, Resolve provides a safe and confidential space where a young person and family feels listened to and understood.

4. SAFEGUARDING IN HALTON 2022/23

4.1. LEARNING FROM SAFEGUARDING PRACTICE REVIEWS

Local Child Safeguarding Practice Reviews (CSPR)

The overall purpose of a Local CSPR is for agencies and individuals to learn lessons and to improve the way which they work, both individually and collectively. It is also to explore how practice can be improved more generally through changes to the system as a whole, to safeguard and promote the welfare of children and young people.

Halton Borough Council has a duty to notify the National Panel Child Safeguarding Practice Review Panel if it knows or suspects a child dies or is seriously harmed, and abuse and neglect is known or suspected. There is a statutory requirement on safeguarding partners to conduct a 'Rapid Review' when serious child safeguarding cases are identified. The reviews should be completed within 15 working days and a report provided to the National Child Safeguarding Practice Review Panel (NCSPRP).

HCYPSP remains committed to gathering as much learning as possible during the rapid review process and to only progressing to a Local Child Safeguarding Practice Review (LSCPR) where necessary.

Not all incidents that are reviewed will meet the definition of a 'serious child safeguarding case' but may still raise issues of importance. This might include cases where there has been good practice, poor practice or where there has been a 'near miss'. In these circumstances the HCYPSP will decide whether to conduct a Local Reflective Review or case audit to ensure that learning is captured and shared with the workforce.

Number of notifications made to HCYPSP in 2022/23	2	Child I Child J
Number of Local Child Safeguarding Practice Reviews (independent author)	1	Child G
Number of Local Child Safeguarding Practice Reviews published in this period.	1	Child G
Number of rapid reviews conducted in 2022/23	2	Child I Child J

How a case is referred for consideration in Halton

Any organisation with statutory or official duties in relation to children must inform HCYPSP of any incident which they think should be considered for a review as soon as they become aware of the incident.

To support early identification of relevant cases, consideration of a referral for a Child Safeguarding Practice Review is an agenda item in all multi-agency strategy meetings convened following serious harm to, or death of a child.
A referral form allows a partner to outline the case and propose the process they feel is required either:

1. A Local Child Safeguarding Practice Review or
2. An alternative learning review– potentially leading to a multi or single agency learning process.

The completed referral form is submitted to the HCYPSP Business Unit who notify the Head of Safeguarding and Quality Assurance.

Child Safeguarding Practice Reviews

There was one Child Safeguarding Practice Review in 2022/23. It was agreed by the Partnership in June 2022 and published in Feb 2023.

At the age of 6 months Child G had non accidental injuries; brain injuries which were thought to have been caused by shaking, and fractured ribs caused on a separate occasion. Subsequently a Finding of Fact Exercise, undertaken by the court, made adverse findings in respect of Child G's Father.

Learning for this review was analysed under 3 themes; transfer in arrangements, meeting the health and education needs of the children; the arrangements to safeguard Child G and his siblings and promote their welfare; consideration of cultural background.

Feedback from the HCYPSP during the reporting period has been good with some key learning identified.

Summary of Learning:

•The importance of effective systems to share information between agencies and services about families who move between areas.

• The importance of written transfer summaries being written in a style which minimises scope for misinterpretation by a new practitioner

• The need for health visitors to take account of key vulnerabilities e.g., historical domestic abuse and being new in an area plus the impact of unusual circumstances when categorising the service level to be offered.

•The importance of agencies reporting or receiving reports of Acute Life-Threatening Events (ALTE) promptly identifying any siblings and considering any risks to them and their needs

• The importance of hospital staff reporting all concerning parental behaviour to their safeguarding teams

• Importance of accurate recording about the ethnic and cultural background of all members of the family

• The importance of enquiring what a parent's cultural heritage means to them, and considering the impact on parenting

• To maximise opportunities for reachable moments for providing advice and support to victims of domestic abuse.

• The importance of "respectful scepticism" when parents deny reported incidents of domestic abuse, especially if the mother has previously been subject to domestic abuse, and/or she is pregnant

• The importance of recognising the impact of domestic abuse on children including unborn babies and that this can include the risk of retriggering trauma if they have witnessed domestic abuse of their mother by a previous partner

• The importance of specifically engaging BOTH parents directly in providing information and support about crying babies. This may require creative approaches as current maternity and early years health services are not currently designed with fathers' needs in mind.

• The importance of prompt referral of all Acute Life - Threatening Events (ALTE) to police and Children's Services as some of these later turn out to be due to abuse.

Rapid Reviews & Practice Learning Reviews

Key learning points were also derived from two Rapid Reviews (Child I and Child J) conducted between 2022/23 and a Practice Learning Audit on Neglect:

Child I:

The Rapid Review Report for Child I identified that in future it would be beneficial to consider how social workers can have more contact with children in care who are very settled within their placements where agencies are advised the children do not wish to attend their meetings as part of the care planning process. For Child I there were occasions when the social worker met with the children separately to gain their wishes and feelings, but it would have been beneficial if the children attended some Care Planning meetings, PEPs and CIC reviews, rather than foster carers attending on their behalf to give the young people's views.

Hence, in future a learning point is how we sensitively manage the wishes and feelings of children not wanting to attend, with how we are satisfied that this is their view to take into meetings. We cannot enforce attendance from children within meetings as that is not child focussed but a general good practice standard should be agreed, especially for children within long term placements where they feel they are a family unit and regard social care involvement as intrusive.

A requirement was identified for the fostering service to be more robust in foster carer review forms. As the expectation is that the social worker assists the children and young person to complete these it was seen as a further opportunity to seek children's views on their placement.

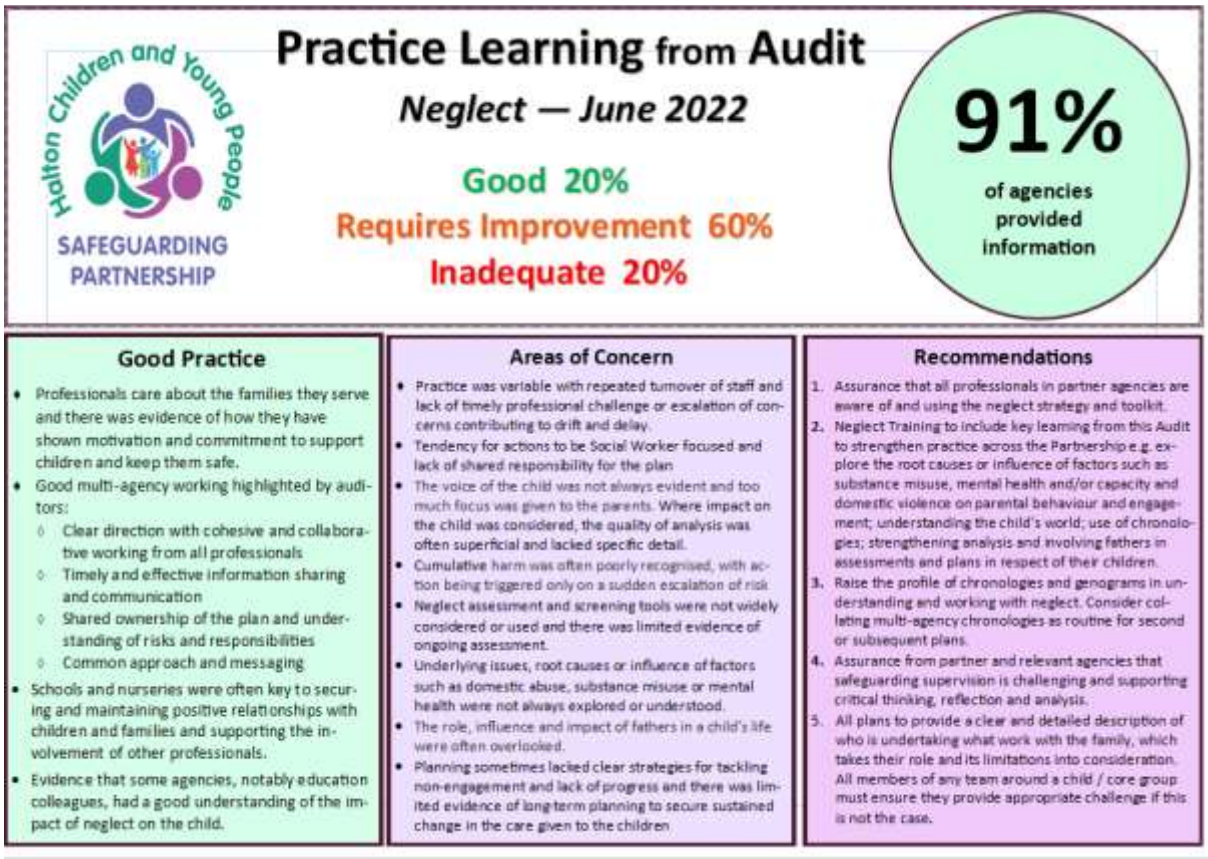
A useful training exercise was identified for foster carers to explore the impact upon children when foster carers find themselves at odds or disagreeing with children's social care. Specifically, how this discourse when demonstrated in front of the children they care for can negatively impact the child's relationship with their own social worker.

As children become older, we need to find ways to engage them in their planning and reviews even when they have previously not wanted to participate. We need to agree the frequency of when this is reviewed with the child. They need to be consulted, subject to their age and understanding about their care plan and review who they want to attend their meetings and about the venue of the meetings.

When a new IRM is being allocated the IRM must introduce themselves and complete a visit and gather and document clearly how the children want to participate in their reviews. All children need to be sent the consultation

documents consistently unless they specifically request not to receive this and this needs to be clearly documented within the review notes.

During the Covid Pandemic there was an opportunity to engage previously hard to engage young people or those that chose not to and communicate via phone calls and video call, sometimes with positive outcomes. For Child I this again was potentially a missed opportunity to talk to the children about their plans and reviews. Moving forward this needs to be reflected upon and used more in practice to engage young people i.e., text/tech platforms/calls etc as alternative options for children who do not want to engage as it perceived to be less intrusive by some children and young people.



Child J:

The Rapid review did not reveal any significant concerns about the way the local authority, partners or other relevant persons worked together to safeguard Child J that contributed to her death. There were no indicators that the death of Child J could have been predicted or prevented.

The review did identify some single agency learning opportunities identified and improvements to the wider systems around multi-agency information sharing were identified, but these did not have a significant impact in this case and would unlikely have changed the outcome.

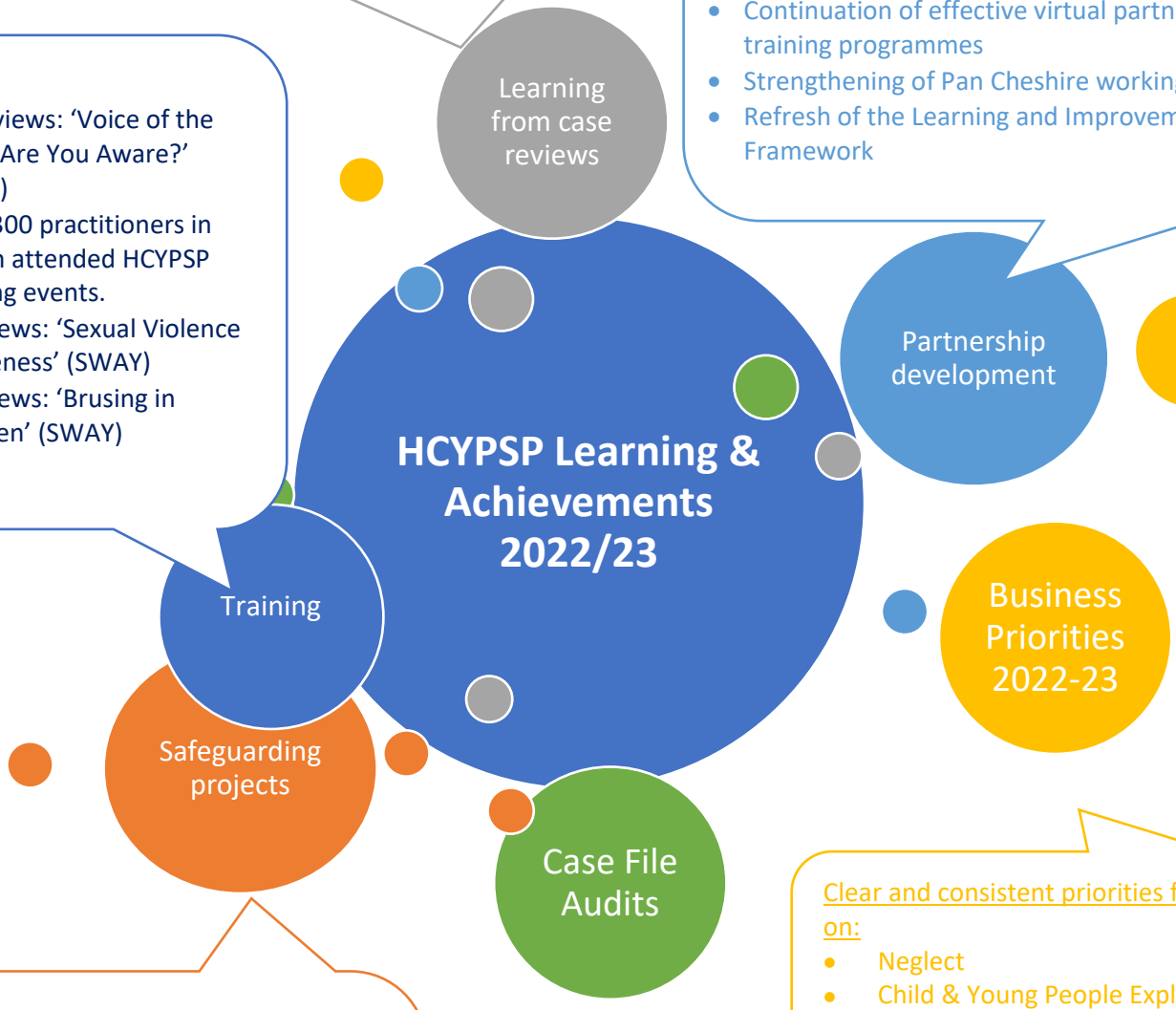
An action plan was created to address the identified areas of learning with the improvement activity overseen by Safeguarding Practice Group. This will focus on how we can more effectively implement a Think Family approach, this will include consideration of system changes as well as professional developmental support for practitioners.

4.2 KEY LEARNING & ACHIEVEMENTS FROM 2022/23

- 2 multi-agency Rapid Reviews conducted to respond to serious incidents.
- 1 LCSPRs signed off by Lead Partners and Board
- 1 LCSPR published.
- 1 Practice Learning Audit: Neglect

- New Chair recruited from statutory partners.
- HCYPSP Sub-Groups' Terms of Reference updated.
- Strengthening partnership focus on learning and impact.
- Continuation of effective virtual partnership training programmes
- Strengthening of Pan Cheshire working
- Refresh of the Learning and Improvement Framework

- 7583 views: 'Voice of the Child: Are You Aware?' (video)
- Over 300 practitioners in Halton attended HCYPSP training events.
- 785 views: 'Sexual Violence Awareness' (SWAY)
- 697 views: 'Brusing in Children' (SWAY)



- Improved outcomes for Pupil Premium Plus Funding
- PEP target setting enhanced-including 121 tuitions as part of PEP.
- IT equipment made available to young people to continue learning remotely.
- Closed the progress and attainment gap between Children in Care and Non-Care peers.
- Focus on Safeguarding under 5s.

Clear and consistent priorities focusing on:

- Neglect
- Child & Young People Exploitation
- The Quality & Effectiveness of front-line practice

- New S175 audit launched across all schools using Phew online recording system.
- Close working with Cheshire West & Chester to conduct S11 audits and produce summary document representing key findings for two Pan Cheshire local authorities.

4.3 WHAT THE SAFEGUARDING PARTNERSHIP HAS FOCUSED ON IN 2022/23

Our Priorities

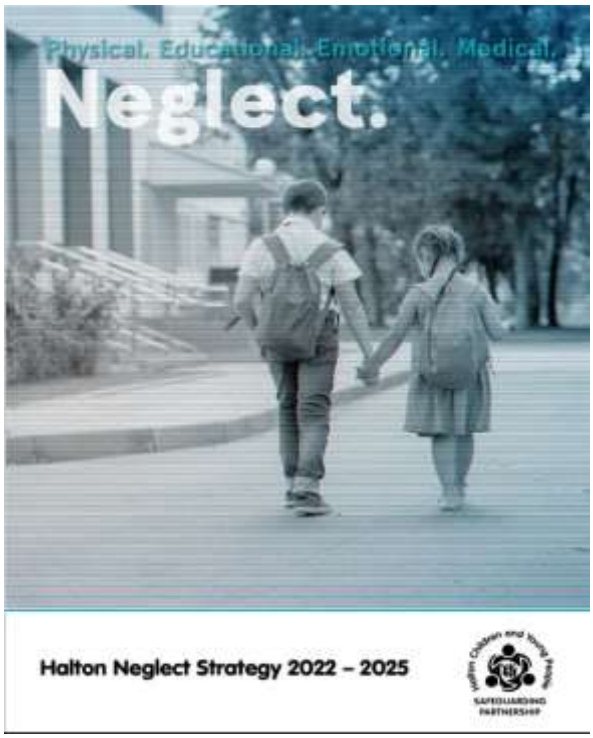
The HCYPSP Business Plan was developed collectively in January 2022 and outlines the strategic objectives that will inform the work of the Partnership in the years 2022 to 2024. The following information was considered when we met to agree these priorities:

- The HCYPSP Annual Report – 2020/21
- The Wood Report: Review of New Multi-Agency Safeguarding Arrangements – 2021
- The Child Safeguarding Practice Review Panel Annual Report – 2020
- Recommendations from inspections and other reviews
- Priorities identified from the HCYSP performance management data and local quality assurance audits. Outcomes of case reviews and audit – including national serious case reviews and local reports.

Priority 1: Halton will have a clear strategically driven, multi-agency response to children experiencing 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.

What we wanted to achieve:

- Strategic commitment across all agencies to effectively tackle neglect.
- Improved awareness understanding and recognition of neglect.
- Prevent neglect through early help.
- Improve effectiveness of interventions and reduce the impact of neglect.



What we achieved:

- A Partnership Assurance tool was completed by organisations to evidence their commitment and implementation of the Neglect Strategy and to evidence impact and inform future learning and development.
- The Neglect Partnership Performance Group continued to meet and assess how effectively agencies' response to Neglect is in Halton and to analyse scorecard indicators.

***Priority 2:** The partnership will 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.*

What we wanted to achieve:

- Ensure a consistent understanding and application of the levels of need across the partnership.
- Improve how we work together with families before and after birth to safeguard young children and babies.
- Improve the quality of multi-agency risk assessment and planning.

What we achieved:

- The revised thresholds procedures were formally launched across the Partnership with good attendance amongst agencies.
- The new information has been included on the Working Together course and disseminated via this route.
- In November 2022, Ofsted carried out a focused visit that dealt with the issue around application of threshold into early help and children social care. The overall response was robust, and the quality of information received was of a good standard.

***Priority 3:** The partnership will collaborate with Halton Adult Safeguarding Board and Halton Community Safety to develop a local all age Contextual Safeguarding Strategy and Operational Model, that will include effective responses and procedures to safeguard, protect, and prevent children and young people from exploitation.*

What we wanted to achieve:

- Identify, understand and respond to the changing and emerging profile of child exploitation in Halton.
- Deliver our multiagency operational model to ensure that it provides the support that individual children and young people need alongside a plan to reduce risk that addresses the context that is causing them harm; this includes taking action to disrupt and detain the perpetrators who exploit and abuse them.
- Support the development of an all-age approach which supports young people at transition at 18 where risks remain and includes modern slavery, forced marriage and FGM.

What we achieved:

- Collaborated with partner Local Authorities to help create the Pan Cheshire All-Age Exploitation Strategy with a focus on supporting children, young people and adults in 4 priority areas.
- Relationships established with Halton Community Safety and Halton Adult Safeguarding Board to ensure the All-Age strategy is implemented effectively across all agencies and utilising the expertise of all practitioners.
- Broader dissemination of the All-Age Strategy across voluntary organisations and faith groups in Halton and beyond.

What else did we achieve?

- We continued working at full capacity in the post pandemic period.
- We successfully completed most of the actions in the three priority areas we committed to
- We did 'bring the voice of the child or adult' more into case reviews and wrote into Terms of Reference for reviews the need to draw out the individual in questions lived experiences.
- Our Business Team, in conjunction with PAN Cheshire colleagues began to scan reviews taking place in other areas so we could draw on their learning and avoid duplication if a particular scenario had already been covered extensively elsewhere in our local area or other parts of the country.

4.6 TRAINING AND DEVELOPMENT

The Partnership delivered various online learning events and materials for professionals working with children and adults in 2022/23. Some of these were case review events to explore the learning from specific cases, and others focused on key areas of safeguarding. The events delivered and materials produced were as follows:

- Conducted two Local Learning events for dissemination from Child F and Child G reviews.
- Helped create the new online delivery format of Intra Familial Child Sex Abuse for Multi agencies (alongside CMSWTP)-for disseminating across stakeholders in 2023/24
- Created a new support guide for Harmful Sexualised Behaviours with NWAIT input for dissemination 2023/24.
- Supported the introduction of new on-line iCART referral service.
- Created a number of courses-viewable through pre-recordings or through SWAY on the HCYPSP website, including recordings for bruising in non-mobile children and the ICON message.
- Updated the Safeguarding Children Induction booklet.
- Updated the multi-agency tool kit.
- Introduced evening training sessions to ease availability for attendees.
- Raised awareness and promoted campaigns on key dates throughout the year, including White Ribbon Day, National Child Exploitation Awareness Day, and Internet Safety.
- Developed and published a series of 7-minute guides.
- Communication briefings conducted throughout the year.

Comments

Sarah and Rach were fantastic.

I thought it was really interesting and although the content was hard hitting, delivered in a sensitive, caring way.

This was one of the most informative safeguarding training I have completed in a long time.

The information about the SARC was very useful, to get a greater understanding of what some survivors have been through.

It helped me to realise the amount of domestic abuse and to realise I may have had prejudices.

Comments

This training was delivered well and kept as interactive as possible when online.

I feel updated as to recent changes and more empowered to deal with situations as they arise.

I have used today's learning to have a conversation with our head teacher about any changes we need to put in place.

In person would have been more beneficial for me.

NHS England North West Region – Safer Sleep Task & Finish Group 7 March 2023

Halton Children and Young People SAFEGUARDING PARTNERSHIP

Domestic Abuse & Working Together Course Feedback

	Number of Courses Held		Total Number Booked	Total Attendees	% Attending
Working together to safeguard children level 3	6		152	135	89%
Working together to safeguard children refresher	5		126	102	81%
Sexual Violence Awareness	2		24	21	88%
Intra familial Child Sex Abuse for Social Workers & Managers through the Cheshire & Merseyside Social Worker Teaching Partnership	2				
Level of Needs Workshop	6		197	161	82%
Managing Allegations against people that work and volunteer with children	3		56	40	72%
ICON workshop	1		10	5	50%
Bruising in non-mobile children	2		18	11	61%
Domestic Abuse Awareness	3		43	35	82%
Fabricated and/ or Induced Illness and Perplexing Presentations course	1		17	17	100%
Abuse of Position of Trust	1		18	13	72%
	32		**661**	**540**	**82%**

5.INDEPENDENT SCRUTINY

The 3 safeguarding partners are responsible for determining local arrangements including the provision of independent scrutiny. The independent scrutiny function is described on page 80 of Working Together 2018. Independent scrutiny provides the critical challenge and appraisal of Halton's multi-agency safeguarding partnership arrangements in relation to children and young people by doing the following:

- Providing assurance in judging the effectiveness of services to protect children
- Assisting when there is disagreement between the leaders responsible for protecting children in the agencies involved in multi-agency arrangements
- Supporting a culture and environment conducive to robust scrutiny and constructive challenge.

Discussions continued regarding the role of an independent scrutineer during the reporting period, in addition to the commissioning of independent authors for Child Safeguarding Practice Reviews. Whilst the latter was deployed in the CSPR for Child G, an independent scrutineer was not employed. However, a job description has now been agreed for this role which will commence in 2023/24.

6. OUR FINANCIAL ARRANGEMENTS

The HCYPSP work is funded by the following statutory partner agencies:

- Halton Council.
- Halton Clinical Commissioning Group (CCG); and
- Cheshire Police

The contributions are reviewed on an annual basis and presented to the Board for approval. Additional contributions were also received from the Youth Justice Service.

The following summary details a breakdown of the budget and spend in 2022/23.

Reserves	2022/23
Opening Reserves	
Closing Reserves	**23,836.68**

	2022/23 Actual Outturn (£)
Expenditure	
Salaried staff	154,851.80
Revenue Contribution to Reserves	23,836.68
Contracted Services	20,718.99
Training Costs	6,326.58
Mobile Phones & Pagers	168.00
Computer licenses	120.00
Telephone Charges	84.15
Total	**£206,106.20**
Income	"
Reimbursements & Other Grant Income	- 106,011.16
HBC Support Costs Income	- 79,390.04
Internal Fees Income	- 16,500.00
Transfers from Reserves	- 4,205.00
Total	**£206,106.20**

7.PAN CHESHIRE COLLABORATION

The PAN Cheshire Policy and Procedures Group continued to meet throughout 2022/23 to share best practice and to purport a consistent approach across the region. Progress was made in relation to a number of areas, and these included:

- The Erase Tool
- Pre-Birth Guidance
- The PAN Cheshire Escalation policy
- Bruising in non-mobile children
- Gender Dysphoria – PAN Cheshire and PAN Mersey collaboration
- A Task and Finish Group for Harmful Sexual Behaviour Policy
- Guidance for Maternity Special Circumstance Forms

8. HCYPSP PRIORITIES FOR 2023/24

Since its inception in 2019, the Partnership felt strongly that priorities should relate to key areas of child safeguarding: those identified as of highest risk in the county, where multi-agency working is essential and where significant change and/or commitment is necessary to reduce risk.

Despite the considerable environmental challenges, the Partnership, driven by the business unit, remains committed to its role as critical friend and champion of best practice. Our vision remains the same, but we will update our business plan to ensure that we:

- Have a data set (performance paper) which sets out activity, themes, and multi-agency risks, which is completed by all relevant partners.
- Have a Quality Assurance Framework that demonstrates how we will effectively scrutinize key safeguarding areas using what methods and how that will inform improvement.
- Have a completed and costed training plan with a date for implementation that clearly delineates how learning will be embedded and impact measured.
- Develop the pace and impact of the Training and Development team, so that we can disseminate learning quickly using a range of methods to reach those who need it.
- Drive the Neglect Strategy to optimise outcomes for young people, particularly in relation to Educational Neglect.
- Market the work of the Partnership, including key documents such as the Continuum of Need to ensure we are clear how our work can support partners.
- Demonstrate how we are sharing learning from reviews and work more closely with the PAN Cheshire partners to share best practice from such reviews.
- For any new piece of work in the subgroups, we document how we have:
    - used the voice of the child/young person to inform the work.
    - agreed that we will share the learning from it (how and who do we intend to reach).
- Agreed how we will measure the success of the work.

What's Next For 2023/24?

Refine the Partnership's data evidence bank across all agencies to ensure performance indicators are informing practice.

Carry out regular multi-agency auditing of practice, to inform the Partnership about the effectiveness of our interventions and responses against a variety of themes, including neglect.

To begin implementing the Pan Cheshire All-Age Exploitation strategy with a focus on the areas identified as most urgent.

Revamp the Partnership's online booking system & web site to ensure communication around learning reviews, training opportunities and policy/procedures is effective.

Ensure QA processes-including the role of the independent scrutineer-are firmly established and providing challenge across all agencies.

8.1 Indicative Audit timeline for 2023-24

Audits for 2023/24 will reflect the priorities and major themes arising from case reviews and other HCYPSP work. Where possible, audits will be all ages, and the approach will be multi-agency and single-agency audits again, along with softer quality assurance from the Professional Advisors. An early indication of some of the themes are:

- Children in the system we are worried about, and how well services are responding to keep them safe.

- S11 audits for the following:
  1) Local Authorities that provide children's and other types of services
  2) NHS organisations
  3) The police
  4) The National Probation Service and Community Rehabilitation Companies
  5) CAFCASS (Children and Family Court Advisory and Support Service)
  6) Early Years settings

- S175 audits-completion of the 2022/23 audit

9. Glossary

ACE	Adverse Childhood Experience
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
CRG	Case Review Subgroup
CSOG	Contextual Safeguarding Operational Group
CSP	Community Safety Partnership
CSPR	Child Safeguarding Practice Reviews
CSSG	Contextual Safeguarding Strategic Group
DfE	Department for Education
EET	Education, Employment, or Training
EHE	Electively Home Educated
ICART	Integrated Contact and Referral Team
GP	General Practitioner
HCYPSP	Halton Children and Young People Safeguarding Partnership
JTAI	Joint Targeted Area Inspection
LA	Local Authority
LAC	Looked After Children
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
MACE	Multi-Agency Child Exploitation Group
MAP	Multi-Agency Plan
MASH	Multi-Agency Safeguarding Hub
MOU	Halton Memorandum of Understanding
NCSPRP	National Child Safeguarding Practice Review Panel (NCSPRP).
NHS	National Health Service
NPS	National Probation Service
NWAIT	Northwest Trainer Group
PEP	Personal Education Plan
QA	Quality Assurance
SAB	Safeguarding Adults Board
SCARF	Single Combined Agency Report Form
SCP	Safeguarding Children Partnership
SCR	Serious Case Reviews
SPG	Safeguarding Practice Group
T+F	Task and Finish
YJS	Youth Justice Service