



Annual Review of Effectiveness Report 2021- 2022



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Foreword

Since our last report there has been work undertaken to strengthen our partnership arrangements with a particular focus on the progress made on the agreed priorities including:

1. Leadership and the work undertaken to improve the Partnership's governance
2. Work undertaken to improve the safeguarding system in relation to the Right Help Right Time document and the understanding of thresholds, and
3. Specific developments relating to protecting children from Neglect and Child Exploitation.

This report covers the period from 1st April 2021 to 31st March 2022. The last twelve months have remained challenging for all practitioners in Herefordshire due to the continued impact of the pandemic on services and on our professional and personal lives. Despite the ongoing situation, work has continued across the Partnership to protect children. Practitioners have remained committed and have worked tirelessly to ensure children have been seen and kept safe.

Working practices changed during the pandemic with less face to face working. However, the importance of maintaining in-person and virtual contacts cannot be overstated, with a move back to increasing face-to-face contacts being implemented across many services as soon as practicable and the pandemic allowed. In addition, where appropriate, telephone and on-line access has also been retained.

The Partners acknowledge that whilst much work has been undertaken to drive improvements, the pace of change has been slower than anticipated. Over the forthcoming business year we will continue to work together to improve outcomes for children, young people and families and prepare for the much anticipated OFSTED Inspection of Local Authority Children's Services (ILACS).

Herefordshire Safeguarding Children Partnership – Accountable Officers



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Chief Constable Police
West Mercia Police



Paul Walker
Chief Executive
Herefordshire Council



Simon Trickett
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Herefordshire and Worcestershire
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the local policing area
West Mercia Police



Darryl Freeman
Corporate Director for Children
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Lisa Levy
Chief Nursing Officer
Herefordshire and Worcestershire
Clinical Commissioning Group

Herefordshire Safeguarding Children Partnership – Delegated Officers

1. Introduction

The purpose of the safeguarding arrangements, as set out in Chapter 3: Working Together to Safeguard Children 2018, is to support and enable local organisation and agencies to work together in a system where:

1. Children are safeguarded and their welfare promoted,
2. Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children,
3. Organisations and agencies challenge appropriately and hold one another to account effectively,
4. There is early identification and analysis of new safeguarding issues and emerging threats,
5. Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice,
6. Information is shared effectively to facilitate more accurate and timely decision making for children and families.

This report presents the work that the Herefordshire Safeguarding Children's Partnership (and the organisations that make up the HSCP) have done, in the last year of operation, to keep children and young people safe. The report covers the period from 1st April 2021 to 31st March 2022.

2. Herefordshire Context

In Herefordshire, the population size has increased from around 183,500 in 2011 to 193,615 in 2021. As of 2021, Herefordshire is the least densely populated of the West Midlands' 30 local authority areas, with an area equivalent to around two football pitches per resident.

There are approximately 36,000 children and young people under the age of 18 years living in Herefordshire. This is 18.6 % of the total population of the area (ONS mid population estimate).

Growing up in Herefordshire – if there are 100 children the following would be a breakdown of their circumstances and lived experience

14 would be living in poverty
13.4 would be from a minority ethnic group
16.5 children would be claiming free school meals
2 children would be subject to a child protection plan
15 children would live in households with any of the so called 'toxic trio' of domestic abuse, parental mental ill-health or substance misuse; 0.8 of them with all three risks.
3.8 children would be in the care of the Local Authority
18.9 children would have special educational needs
3.8 children would have an education Care and Health Plan
2.4 Are children from the Armed Forces (service families)
10 children 5-15years are likely to have difficulties with their mental health
71.8 children would achieve a good level of development in their Early Years Foundation stage of their education
10.9 children would be classed as persistent absentees
1.9 teenagers would be pregnant



3. Our Partners

The HSCP extends beyond the contribution of the three key statutory partner agencies with commitment, on-going support, and contributions from a wide range of relevant agencies including the voluntary and community sector and education providers.

The Safeguarding Partners Board (SPB) is the meeting of executive members with delegated responsibility. The Board has met seven times over the course of the year. There is no requirement for Accountable Officers to attend the SPB meeting. The variance in attendance rates for the Council occurred as a result of Herefordshire Council’s appointment of its new Chief Executive in May 2021 and the change from an interim Director for Children’s Services to the permanent recruitment of this role in December 2021. There was a representative from each of the three Safeguarding Partners at every meeting.

In addition to the SPB meetings there have been nine Safeguarding Partners Extraordinary meetings. These were convened to provide leadership and traction to areas of the strategic plan which had stalled. These meetings were chaired by the Chief Nursing Officer, NHS Herefordshire & Worcestershire CCG.

Both SPB and Extraordinary meetings have had 100% attendance achieved by the HSCP Independent Chair and Scrutineer.

Safeguarding Partners Board Meeting Attendance Rates			Extraordinary Meeting Attendance Rates		
Agency	Accountable Officer	Delegated Officer	Deputy	Delegated Officer	Deputy
West Mercia Police	-	86%	71%	100%	100%
NHS Herefordshire & Worcestershire CCG	-	71%	100%	100%	100%
Children & Families, Herefordshire Council	43%	71%	57%	55%	66%

4. Funding and Support

The HSCP continues to be supported by the Partnership Support Team.

In June 2021, Herefordshire Council commissioned an Independent Strategic Partnerships Advisor to undertake a review of the partnerships effectiveness and its business support arrangements. The Partnership Team provides logistical support, administration and development support to the HSCP, the Herefordshire Safeguarding Adults Board and Community Safety Partnership.

The review concluded in December 2021 and the findings identified that the Partnership Team did not have sufficient staff and resource to meet demand arising from the partnership’s day to day function and that there was a need for additional contribution to reconfigure the support arrangements. In addition, the review highlighted the need for greater leadership, a change of culture and practice of HSCP and a need to promote greater engagement and accountability of members for the work of the partnership. Further work is to be undertaken through 2022-2023 to address the issues raised.

Contributions			Category	Expenditure £
Agency	21-22 Contribution £	%		
Children's Wellbeing	143,519	0.35	Salary Costs	281,110
			Transport costs	0
Adults Wellbeing	108,150	0.26	Independent chair costs	78,246
CCG	95,550	0.23	Consultancy costs	10,198
Police	65,100	0.16	Training expenses	-1,400
			Office expenses	28,573
			Training income	-75
Total	412,319	100%	Total	396,652

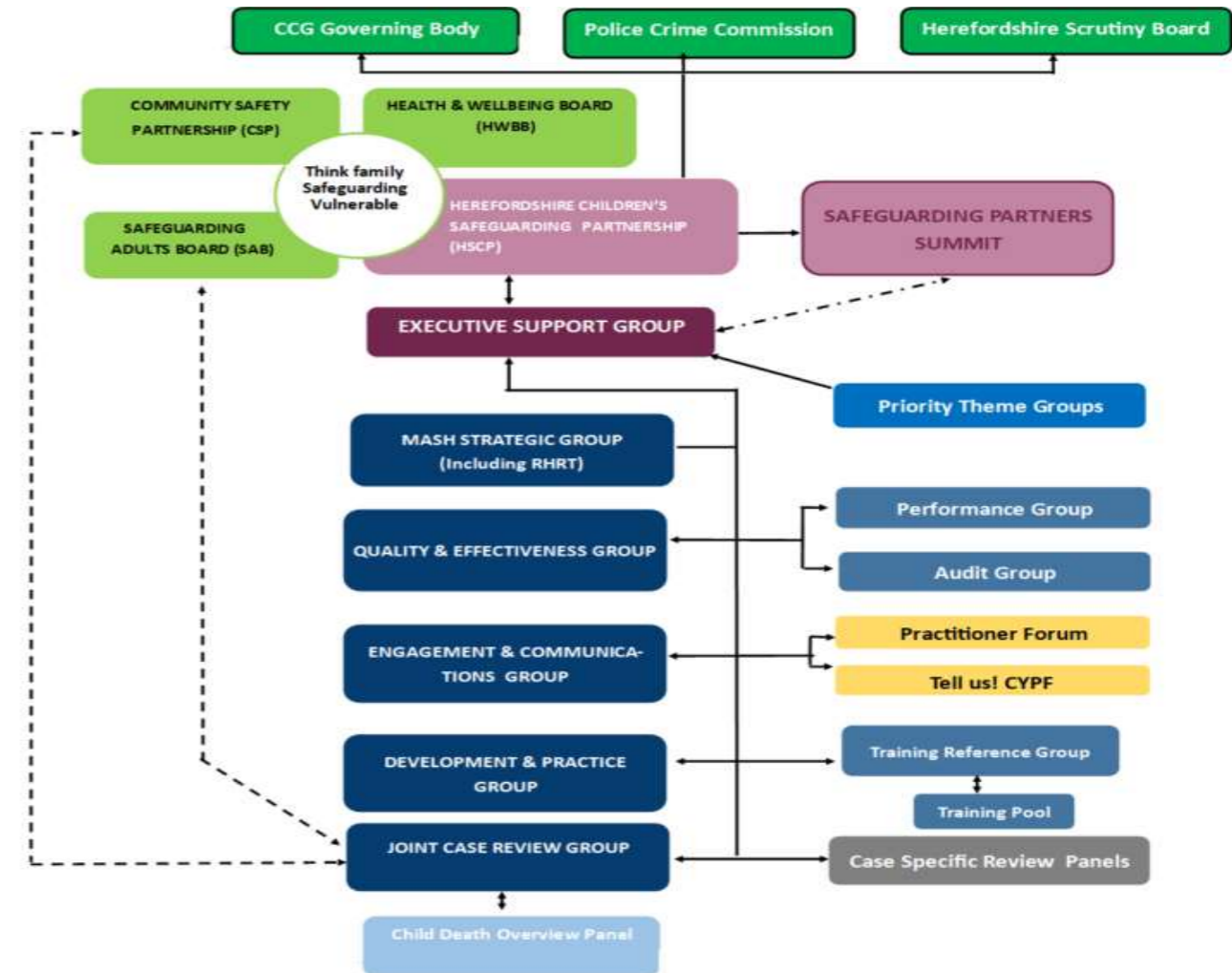
5. Governance Arrangements

The Herefordshire Partnership Vision is:

Children are safely cared for by their family because services work well together, and with families

Working Together to Safeguarding Children 2018 - This statutory guidance says we must publish a report at least once in every 12-month period. It must set out what we have done as a result of the arrangements, including on child safeguarding practice reviews. The report should also include evidence of the impact of the work of the safeguarding partners and relevant agencies.

Governance Structure - Safeguarding Children and Young People in Herefordshire (SCYPIH) 2020-2021



Structure diagram of HSCP Multi-Agency Safeguarding Arrangements

The Herefordshire Safeguarding Children Partnership is made up of the three statutory safeguarding partner organisations - West Mercia Police, Herefordshire and Worcestershire Clinical Commissioning Group and Herefordshire Council - and continue to be supported by a range of relevant agencies, which include:

- Wye Valley NHS trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Herefordshire and Worcestershire Fire and Rescue
- Herefordshire Voluntary Organisation Support Service (HVOSS)
- West Mercia Youth Justice service

The Statutory Partner members have joint and equal responsibility for the success or failure of its multi-agency safeguarding arrangements (MASA). The partnership understand the absolute dependence on each other and on relevant agencies to make a difference to the work with children young people and families in Herefordshire.

During the course of this reporting year, the HSCP underwent a review of its multiagency safeguarding arrangements. The HSCP substructure changed to reflect the new arrangements and ambition to strengthen strategic and operational activity and improve effectiveness for the children and young people of Herefordshire.

Further information with regard to the HSCP's multiagency safeguarding arrangements is available on the Herefordshire Safeguarding Children Partnership's [website](#)

6. Safeguarding Children – what have we done as a result of the safeguarding arrangements? 2021-2022 in review

Progress made against the HSCP Priorities

Priority 1 – Leadership and Partnership Effectiveness

Aim: Through the leadership of the three Statutory Partners, promote a culture of collective responsibility, accountability and professional challenge built on guiding principles of respect and openness to forge an effective Safeguarding Children Partnership with strong governance, shared work practices and meaningful engagement with children and families.

What have we done?

Under the Leadership and Partnership Effectiveness Priority, we have –

- Held two Partnership Summits in May and November 2021. This is a meeting of leaders and was attended by over 80 representatives respectively to share the progress against the HSCP Strategic Plan and provide opportunity to engage in discussions about improving partnership effectiveness and participation, and engagement with children and young people.
- Published the Strategic Plan 2021-24.
- The Executive Support Group (ESG) was established in May 2021. The group was originally Chaired by the Independent Chair and Scrutineer but agreement was reached that this function needs to remain separate and therefore the function was placed with the Safeguarding Partners Delegated Officers. From November 2021 the ESG was Chaired by the Interim Assistant Director Quality Assurance Safeguarding and Partnerships, Children and Young People and sponsored by the Director of Children's Services.
- The ESG is the engine room for the HSCP and has delegated responsibility to drive the HSCP strategic plan through the operating sub-groups. ESG has undergone further in-year development to ensure robust oversight of the sub-groups' action plan delivery and progress reports back to the SPB.
- We secured funding from the DFE for a project on improving engagement and participation of children and young people within partnership working, and completed this project.
- We secured funding to commission a Local Government Association Advisor to provide 20 days of support to the HSCP to improve the Partnership's effectiveness
- We commissioned an Independent Strategic Partnerships Advisor to undertake a review of the Partnership Team and support us to improve our effectiveness.
- We hosted two Practitioner Forums: one in September 2021, which was attended by over 80 practitioners, on the topic of Learning from Case Reviews, and another in February 2022, focusing on Peer on Peer Abuse and Voice of the Child.
- Reviewed the multiagency safeguarding arrangements (MASA) including the HSCP governance structure.

- Sub-group Terms of Reference underwent review and revision alongside the related delivery plans, to provide an outcome focussed approach and greater accountability for the progression of work.
- Reflective discussions have taken place with Safeguarding Partners and agency leads relating to the changes required to leadership values, culture and behaviour.
- We agreed an Annual Plan for Independent Scrutiny, to ensure that there is constructive and critical challenge to the effectiveness of the multi-agency safeguarding arrangements for the HSCP.

In February 2022, a partners' reflective session was held with leaders from statutory and relevant partner agencies to provide clarity about expectations and requirements of a safeguarding children partnership and their leadership accountabilities. The event also created the space to review the effectiveness of the Partnership and its strategic work programme, and collectively identify how improvements can be achieved. The meeting was well attended and there was good contribution to discussions about what makes a strong partnership, the legislative framework and time for self-evaluation. A resource pack was produced as a complete guide for leaders of the Partnership with all documents and information they would need.

What do we still need to do?

Key areas for further development includes the following:

- The Leadership event highlighted that the Partnership needed to reset itself in terms of identity and other issues discussed
- There was a need to improve leadership direction – including a revisit to how we promote our purpose and identify internally amongst the sub-groups, and externally to the partnership
- Clarity with regards to the vision for how sub-groups and work plans will work together
- Further events between the SPB and ESG to embed leadership principles and to support a change in behaviour and cultural practice
- Members to know the purpose of their role in HSCP - Induction for new and existing members
- A need to improve engagement and accountability of HSCP members
- Embed evidence-based approach to partnership practice to understand impact
- Improve the communication and engagement networks within the partnership and other partnerships
- Create formal space for information share and receipt between the SPB and the Improvement Board

Priority 2 – Neglect

Aim: We aim to recognise, prevent and reduce neglect to improve the safety and wellbeing of children and young people in Herefordshire.

Neglect is the most common form of childhood maltreatment and can recur multiple times. Neglect may be difficult to identify and respond to, and it commonly occurs alongside other forms of abuse. The harm resulting from neglect can be wide-ranging, apparent in many areas of a child's life. The impacts of all types of neglect can be serious, enduring and can potentially continue across the life course.

Focused inspections by Ofsted in 2019 reported, "issues of neglect are not always recognised quickly enough, and the graded care profile to help identify neglect and poor parenting is not being used consistently to help measure progress" and in 2021, "Graded care profiles are not completed within the child's timescales and actions identified through the graded care profile tool are not acted upon quickly enough. This means that children's needs are not fully understood, and they remain too long in neglectful situations."

The HSCP Neglect Strategic Group was implemented to develop a Neglect Strategy to support the HSCP Safeguarding Partners to tackle child neglect in Herefordshire, and to ensure that:

- Multi-agency strategic leadership prioritises and drives tackling childhood neglect in Herefordshire
- Partners and our workforce are well informed, competent, and work well together to prevent, identify and tackle neglect

- Risk factors and children who may not be thriving are identified and responded to at the earliest stage so that neglect is prevented
- Less children are harmed, as a result of childhood neglect or have repeat interventions

The HSCP Neglect Strategic Group is responsible for:

- understanding the level of child neglect in Herefordshire, including trends and dynamics of neglect.
- Being aware of strengths, weaknesses, opportunities, and threats in service/ support provision for children and families suffering neglect.
- Setting the strategic direction for multiple agencies to work in partnership to address child neglect in Herefordshire.
- Preparing and upskilling the Herefordshire workforce* (*including volunteers) to competently identify and address child neglect in Herefordshire
- Developing and delivering a work plan to support the reduction of child neglect cases in Herefordshire

What have we done?

Under the Child Neglect priority, we have –

The Interim Neglect Strategy was approved by HSCP in August 2021, pending better understanding of neglect in Herefordshire. The revised strategy, planned for 2022, will include a stronger focus on prevention and community resilience and helping families to thrive, before neglect happens.

The initial priority in the Neglect Delivery Plan is to undertake a needs analysis to identify, quantify and qualify the needs of children and young people in Herefordshire, to help us understand what we need to do. This piece of work is being led by Healthwatch and aims to:

- Gather a current picture of the issues surrounding neglect in Herefordshire from professionals and community leaders who work with children & families
- Explore what the barriers are to families and children accessing earlier support to prevent the circumstances of neglect
- Gather x number of anonymized neglect case studies and utilise these case studies to explore current issues and experience of neglect in Herefordshire

The Neglect Strategic Group will develop a ‘dashboard’ of performance indicators identifying child neglect in Herefordshire to identify trends and availability of service provision support and resources needed. In addition, the group will review current tools, e.g. GCP2 and develop a suite of tools to identify risks of and actual neglect across the spectrum of neglect across all agencies.

Moving forward, the group will examine relevant neglect training packages/resources and work in collaboration with partners to develop a robust multiagency training offer.

Priority 3 – Right Help Right Time

Aim: We will seek to provide children and families with the right help and support at the right time through a coordinated multi-agency safeguarding approach.

What have we done?

Under the Right Help Right Time Priority, we have

- Launched a new Working Together to Safeguarding Children training, to offer an overview of child safeguarding for any professionals who interact with children
- Launched a training on the Right Help Right Time thresholds. Although this was briefly paused in October, the training has resumed
- Completed a review of the front door and subsequently established a new Strategic Group, to oversee the MASH Operational Group
- Worked with SafeLives to complete a review of our MARAC (Multi-Agency Risk Assessment Conference) arrangements for domestic abuse cases, which highlighted the strengths in our approach, and also some work-on points that we will address

The MASH is a single point of entry and essentially the ‘front door’ for access to early help and children’s services. Any concern or query that comes into the local authority for a child will be screened by a Manager within the MASH team, in order to make a timely decision on what needs to be done to ensure that child is safe and receives the most appropriate support/ intervention if required.

The effectiveness of the MASH relies on the collaborative work with partner agencies to ensure timely information sharing to aid multi-agency decision making.

- Agreement reached for plans of co-location of the multi-disciplinary team
- Application of threshold is being applied appropriately to manage risk this has been evidenced in audit activity undertaken across the year
- In March 2022, 93% of the threshold decisions were appropriate this is a significant progress to outcome of audit activity undertaken 6 months earlier. This evidences that threshold application is proportionate and the right decisions are being made for children and families at the front door

Priority 4 – Child Exploitation

Aim: We aim to prevent and reduce child exploitation and improve the safety and wellbeing of children and young people in Herefordshire.

What have we done?

- Held a joint Child Exploitation Conference with Worcestershire in May 2021
- Developed and published a Peer on Peer Abuse Guidance
- Offered training on Child Exploitation and Contextual Safeguarding
- Completed a review of peer on peer abuse cases in Herefordshire

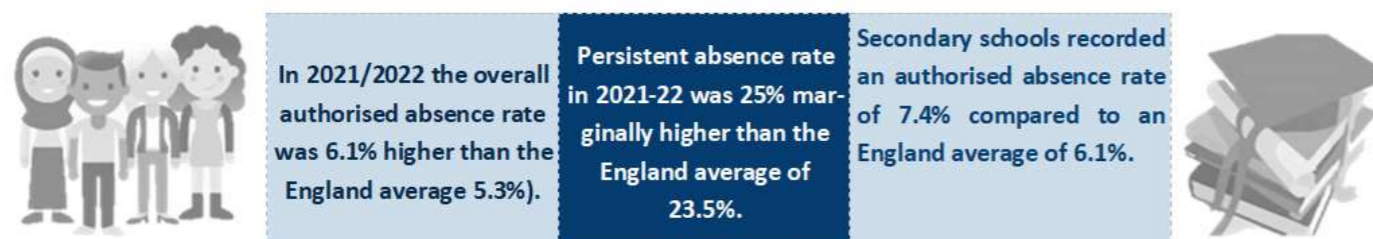
In addition,

- 120 Return Home interviews completed in last 12 months
- 123 Child Exploitation Risk Assessments completed in last 12 month
- 74 initial Risk Management Meetings (RMM) held in last 12 months
- 164 Review RMM held in last 12 months
- 87 children/Young people identified vulnerable to CE in last 12 months: Emerging: 33 Moderate: 33 Significant: 21
- 117 children/young people identified vulnerable to CSE in last 12 months: Emerging: 36 Moderate: 29 Significant: 26 Actual: 26

7. What do the Safeguarding Partners know about the effectiveness of the safeguarding arrangements in 2021/22 and how do they know it?

Children’s Education

The Government have recently published their White Paper on education and a further document called ‘Working Together To Improve School Attendance’. School attendance is a priority in Herefordshire. Overtime, Herefordshire have reported particularly low rates of unauthorised absence whilst rates of authorised absence have been particularly high (largely composed of sickness absence). The safest place for children is in school and schools are working hard to improve overall attendance rates. Below is a snapshot of Herefordshire’s latest absence data:



Education and Children’s Mental Health

39 schools/colleges took part in the Children and Young People’s Quality of Life Survey 2021. This gave us some insight into wellbeing and mental health in our schools and colleges. See link below.

[Children and Young People’s Quality of Life Survey 2021 - Understanding Herefordshire](#)

The survey found that:

20% of primary pupils, 34% of secondary pupils and 44% of FE students were worried about their mental health.
76% of primary pupils, 58% of secondary pupils and 55% of FE students are quite or very happy.
24% of primary pupils, 13% of secondary pupils and 13% of FE students had a high resilience score.
SEND pupils were less likely to feel they belonged to their school, were less happy with life and were less likely to keep trying if at first they don’t succeed.
38% of primary pupils, 17% of secondary and FE students were worried quite a lot about coronavirus.
79% of primary pupils, 72% of secondary pupils and 74% of FE students said if they were worried they had a trusted adult to talk to.
Soft intelligence from schools/colleges in Herefordshire also suggests more pupils have anxiety post Covid and this is also affecting school attendance rates. In 2020-2021 the second most popular reason in Herefordshire for choosing EHE (elective home education) was cited as Covid.

Mental wellbeing has been addressed in Herefordshire’s schools and colleges through the council funded Covid catch up project which has funded grants for secondary schools to support non-attenders and grants that all schools could apply for to support mental wellbeing through outdoor spaces and staff CPD (Thrive programme). A nationally funded programme run through CAHMs/NHS called WEST is also available in all secondary schools and will be rolled out to primary schools later this year.

Section 175/157

The section 175/157 audit was sent out to schools and colleges in November 2021. This was completed by all bar 5 educational establishments and showed that overall safeguarding in our schools and colleges is effective.



All published OFSTED reports on Herefordshire schools in this last academic year have found safeguarding to be effective

All safeguarding concerns regarding Herefordshire Schools are followed up by a safeguarding audit – where audits have been undertaken they have largely demonstrated that safeguarding is effective.




The School Improvement Lead ensures that safeguarding always forms part of their visit to educational establishments and a section on safeguarding is included in each note of visit produced.

There is a robust system in place to address concerns through action plans monitored and overseen the Education Safeguarding Lead.

The Education Safeguarding Lead and Head of Learning and Achievement attend partnership meetings, sub groups and ensure key issues are communicated effectively to schools and settings.

Further effective communication and liaison between the Education MASH, The Education Safeguarding Lead, the LADO and schools/colleges evidences effective safeguarding arrangements within settings.

Children in the Safeguarding System 1st April 2021 to 31st March 2022

Child Protection	Children in Need	Children Looked After
No. of children subject to child protection plan at 31/03/22 was 286	Children with an open episode at 31 March (rate per 10,000 children) rate is 622, total number is 2240 this is an increase from the previous year. SN and England rates not released at time of reporting.	Herefordshire looked after a total of 378 children, 204 (54%) were boys and 174 (46%) were girls. There were 158 new children brought into care over the course of the year almost double the previous year.
Child Protection Plans reviewed in time: 101 (66%) . Performance has decrease from the previous year (81%) and is much lower than the statistical neighbour 97% and national averages 93%	Total number of referrals into Herefordshire MASH was 3329 (up from 1,080 the previous year	Children between the age of 10 and 15 were the highest category of children entering care 87 (53%) boys and 78 (47%) girls. This is in line with regional and national averages. A total of 76 young people were looked age 16-17years. 59% (45) boys and 41% (31) girls.
No of children subject to child protection plan for a second or subsequent time has increase from 32 the previous year to 87 (23%) , this is in line with statistical neighbours and slightly higher than the national average of 22%	 Number of males 1669 Number of females 1588	Good performance on Children Looked After at period end with three or more placements during the year 5.6% (21 out of 378 children) which is lower than the 202/21 England and Statistical neighbours at 9% and 8% respectively.
Missing Children	Referrals that became section 47s: 1025 to 410 initial child protection case conference (ICPC) (up from 388 and 176 respectively in the previous year) 	Good performance on Children Looked After in care at least 2.5 years at period end living in their current placement for at least 2 years was 86.7% (104 out of 120 children) this is higher than the 202/21 England and Statistical neighbours at 70% and 72% respectively
There was a total of 182 missing episodes recorded through the year.	The majority of referrals continue to be made by Schools: 286	Good performance on the percentage of Children Looked After at 31 March placed outside LA boundary and more than 20 miles from where they used to live.
More girls than boys went missing last year 26 girls and 18 boys respectively.	Number of assessments completed in 45 w/days: 1720 (77%) an increase from 1104 the previous year and performing much lower than the statistical neighbours (87%) and England average of (88%)	Inadequate performance - Initial Health Assessment (IHA's) completed in Statutory Timescale for children living in Herefordshire is 16.35%
Children aged between 10-15years 2- 0 children went missing on 70 episodes		Adoption Good performance - 22 (24.4%) children were placed for adoption this is significantly higher than England 10% and Statistical Neighbours 12%
The highest number of missing episodes occurred in children aged 16-17 years . This involved 18 children and 84 missing episodes .		Leaving Care 21 young people reached 18 and stayed with their carers 25 children ceased to be looked after 23 children returned to parents or relatives 10 children were made subject to special guardianship orders 3 Residence or Child Arrangement Orders 30 children's care ceased for other reasons

8. Activities that have supported safeguarding priorities 2021/2022

The Multi-agency Early Help Service

Why is this service important to us?

The Early Help approach in Herefordshire is the Right Help at the Right Time using the strength based model Signs of Safety. The Early Help Service in the council is made up of:

- The Early Help Hub (part of the Multiagency Safeguarding Hub) which manages contacts screened by MASH at level 2 or 3 on the Herefordshire Levels of Need threshold document
- The Early Help family Support Team – work with complex level 3 cases; the Early Help Coordinator team – administrate the early help assessed cases;
- Children Centre Services – support families with children 0-5 years; the Supporting Families administrative team
- Early Help Co-ordinator team – facilitates and administers the Early Help Assessments and Early Help Multiagency meetings
- Supporting Families Team – administers and tracks cases for the Supporting Families Programme

Families with emerging or more complex needs below the threshold of requiring statutory intervention are identified and assessed using the Early Help assessment (EHA). The assessment is holistic and supports the family to identify their strengths and their individual and collective unmet needs. This informs an outcomes focused support plan, drawn up with the family, to bring about sustainable change and leave the family stronger for the future. Each family has a 'Lead Practitioner,' this role is usually fulfilled by a professional from a partner agency e.g. a primary or secondary school, health visitor or early year's provider. The lead practitioner is the link for the family and co-ordinates all professionals required to bring about sustainable change in the family.

There are on average at least 1000 active EHA's in the county at any one time. The service has developed an Early Help Practice Framework to bring together all information and practice standards for early help into one document. It also highlights the requirement for high quality EHA's and has put timescales in for allocating cases and regular reviews to monitor the impact of the work being completed and prevent drift.

The impact of the work of early help is evidenced in the number of Payment by Results (Supporting Families sustainable outcomes payments) which have been achieved. This is mainly work completed with families at high end level 3 on the Right Help Right Time Herefordshire's levels of Need document. In 2020/21 Herefordshire achieved 183 PbR's meeting the target set by central government. In 2021/22 Herefordshire is on track to achieve the target of 190 set by Ministry of Levelling Up, Housing and Communities having already got 181 (February 2022).

What is working well?

- Up to 80% of Early Help Assessments are completed by a range of partner agencies mainly schools both primary and secondary, health visitors and early year's providers.
- First Steps is a programme developed by Children Centre Services in partnership with midwifery, health visitors, Nationwide Community Learning Partnership and the Rotary. It supports all young parents 21 years and under with a mentor and additional support including a Moses basket full of essential items provided by the Rotary.
- Herefordshire is on target to meet its Supporting Families target set by the Department for Levelling Up, Housing and Communities (DLUHC) for the second year running. Herefordshire is third in the West Midlands for the percentage of PR's completed at the end of Qtr 2 2021/22 against the target set by DLUHC.
- Early Help Hub has met its target of completing 95% of all contacts within 72 hours since its inception in September 2020.
- Supervisions continue to be 100% for all early help staff and their cases.
- A significant increase in NEF take up during the autumn term 2021 of 92.5%, well above the national average of 75%.
- Children Centre Services have a very buoyant Facebook page with 11,334 people having seen the page in January 2022.
- Feedback is collected from families at the end of the intervention is collated and analysed.

An example of feedback is

“The support I’ve had as a mother have had from the EHA has been vital for the healing and growth of the whole family. The regular meetings gave me a safe space to feel heard and supported. The different leaders involved gave me excellent advice which was key in helping me move forward. I was often signposted to other areas where I could receive more support. I was also given some basic targets in order to help me progress in confidence and re-teach me how to take control and act on things which need to be done. I am forever grateful for this support. Thank you.”

What have we been doing?

- Following the audit of a large amount of early help cases an audit action plan was completed and the actions are being carried out including improving recording particularly the child’s lived experience and the impact of work being carried out on the child’s lived experience.
- Incorporating the Early Help Hub into a single front door.
- A new Early Help Practice Framework has been drafted and the framework is now out for consultation with partner agencies. This has been developed to include the required standards for the quality assurance of EHA’s and work completed, time frames for assessment; cases to be allocated; frequency of visits and regular Team around the Family (TAF) reviews.
- Working on workflows in Mosaic for early help - initially at the front door moving onto workflows for the day to day work of the teams. This will enable data to be extracted from Mosaic using PowerBI which will improve analysis and be used to better inform future need and commissioning.
- High quality training has been commissioned for frontline managers which has been well received and the learning is being put into practice. Core skills training for early help frontline staff has also been commissioned to address the areas for improvement identified by the audits. This is in the process of being delivered.
- Developed EH team guidance and protocols to enhance consistency of practice

What do we still need to do?

- Launch the Early Help Practice Framework in April 2022 following completion of the consultation process and reviewing the framework.
- Development of an Early Help dashboard. A lot of the early help data is collated from excel spreadsheets.
- Review and revise the Early Help Strategy into an Early Help & Prevention Strategy following the work being completed under the DfE funded project in the Right Help Right Time work stream of the Children & Families Improvement Plan. This work includes consultation with children, young people and their families and community groups. Mapping the child’s journey from conception to adulthood, mapping community assets and analysing data and information held by the council and partner agencies.
- Development of the Early Years & Sufficiency Strategy together with Early Years Partnership.
- Development of the proposals for the implementation of Family Hubs across Herefordshire.

Multi Agency Safeguarding Hub (MASH)

Why is this service important to us?

The MASH is a single point of entry and essentially the ‘front door’ for access to children’s services. The MASH team comprises of onsite Social Workers and their Team Managers, Women’s Aid practitioner, Education, Police and Health colleagues. There is also virtual access to Probation Officer, GPs and maternity services colleagues.

The MASH process involves liaising with the key agencies, speaking with parents and importantly, speaking with the children themselves when appropriate to do so, in order to explore and obtain appropriate information to inform decision making.

The MASH team have 24 hours to process any contacts that come into the local authority and a decision will be made about action to be taken within this timeframe. This could involve making a decision that no further actions is required, that Early Help support is appropriate or it may be that the child(ren) require statutory involvement with one of our Social Work teams.

What is working well?

There is a Strategic MASH and Operations group which sit within the HSCP substructure, Oversight and reports on progress made against the strategic plan is presented to the ESG meetings and directly to SPB as a key focus for the MASH is to ensure that there is effective application of the partnerships Right Help Right Time thresholds guidance.

- Application of threshold is being applied appropriately to manage risk – further evidenced in recent audit activity. A recent multi agency audit showed that there was an agreement with 93% of the threshold decisions which had been made, which is a significant progress to outcome of audit activity undertaken 6 months ago. This evidences that threshold application is proportionate and the right decisions are being made for children and families at the front door.
- The team continue to forge and adopt positive relationships amongst each other and with other relevant partner agencies.
- Recent training held with the MASH team to look at outcome of audits and what the next steps are that we are working towards. This has helped the team to see the journey that we are on and to have time together to reflect on practice.
- A team training session has taken place on Signs of Safety, looking at how the service can apply this model in a bespoke manner for the MASH. This has helped to streamline the practice and ensure consistency of assessment across the team.

What do we still need to do?

- Complete co-location of partner agencies within the MASH
- Continue to work with partner agencies to ensure consistent understanding and application of thresholds
- Ensure robust and timely response to referrals and the embedment of the ‘Right Help right time’ guidance (and Right Quality)
- Improve the quorate, timeliness and decision making of strategy meetings and its impact on the outcomes of CYP
- Improve the communication of the key decisions made about children, within strategy meetings, to relevant partner agencies

Conference and Review Service

Why is this service important to us?

The Conference and Review Services is the team of child protection chairs and independent reviewing officers (IRO), Herefordshire’s most vulnerable children are children subject to a child protection plan or children looked after by the local authority and will be subject to regular reviews of their child protection plan or care plan.

What did we do?

The priority of the service over the last year has been for both the CP and IRO service they were to:

- Improve the footprint of IRO through visits, monitoring and oversights on child’s records including escalations
- For CP service they were also about improving the visible foot print of conference chairs; reviewing implementation of Signs of safety, increasing staffing assignment and subsequently recruiting interim staff
- Embedding standards and expectations re process of conference and parent/ child focused practice, looking at how child’s voice can be better heard / reflected in conferences
- Fostering IRO (FIRO) role to be introduced and developed

“Sarah is a tremendous asset to the Hereford IRO team, after taking over from another IRO she had big boots to fill which she certainly did. I’m very thankful to have someone as supportive as Sarah.”

What did we know?

- Evidence behind these activities was that conference chair resource was inadequate for the increasing number of children subject to a plan and to undertake an effective quality assurance role including oversights and escalations.
- Signs of safety had not been reviewed since introduction and there was a lack of inclusion of young people in the conference process and for older young people lack of engagement in their own safety plan.
- For IROs there was inadequate evidence of their role as a significant person in a child's life and their planning – their footprint was not being clearly seen.
- There needed to be oversight and independence in terms of fostering reviews being undertaken.

Where there has been little progress or things have not gone well, what lessons have been learnt?

There has been progress across all areas and this will continue in some areas particularly including voice of the child in the conference as whilst some children are being seen at or contributing to their conferences it is still not a proportionate number to the age of children who could contribute to their meetings.

With regards to the role of the IRO, the year average for initial Child Looked After Reviews completed within the 20 working day timescale is 78% which requires improvement. There have been systems issues that have impacted on the timeliness of the IRO Service receiving notification. Manual reporting has been used for the last 4 months to ensure that we capture all children coming into care and allocate an IRO within 5 working days.

There have been 18 formal disputes raised by IRO's between April 2021 and March 2022. The main themes coming from disputes demonstrate delays in assessment and care planning which directly impact children's right to permanency and right to family life in a timely manner. This demonstrates that the LA is not progressing permanency for children at pace. Although challenged by IRO's through the Dispute Resolution Process (DRP) this has been hampered by changes of Social Workers in Children in Care (CIC) teams and adequate management oversight and monitoring to ensure timely progression. Given pressures on CIC teams IRO's have not used the DRP process robustly. Improvements are needed in this area with robust challenge from the IRO service, followed through and escalated further at the necessary intervals to ensure children's care plans are progressing effectively and in within the right timeframe for them. To this end DRP process has been reviewed. Weekly DRP meetings have been rescheduled with a plan to involve Team Managers and IRO's within discussion to monitor, progress and resolve disputes within the 20 working day timescales. More recently DRP process has been used more effectively and a large portion of the disputes that have not been concluded in a timely manner have now been resolved.

IROs are moving back to more face to face meetings with children when they want them rather than Teams meetings. There needs to be more improvement on better understanding of the threshold for a child protection plan.

How has learning from activities (including from rapid reviews and local or national child safeguarding practice reviews) been shared with key partners?

IROs, FIRO and conference chairs are all part of all staff briefings and groups that are relevant to their roles which provide opportunities for learning from others and sharing knowledge. Staff all receive briefings from Chief executive and director that disseminate information and links that are used as part of team meetings and CPD. Information from the Partnership board is disseminated in both teams for team meetings and reviewed in terms what can we learn from this and how can we change practice for the better. In terms of learning both service managers attend a range of panels where individual children are discussed /considered which enables best practice decisions to be made. There is an awareness of national issues like child deaths that will impact on professional practice.

Service manager for IROs are part of National Association of Independent Review Officers (Nairo) forum that considers regional and national issues relating to safeguarding children any information and learning is also shared within the service.

All IROs attended a bespoke training to enhance their skills in challenging delay in children's care plans. IROs have monthly development sessions where they share knowledge and learning from training and discuss practice issues.

Conference chairs are now having more regular team meeting / practice discussion sessions and have had a refresh with signs of safety lead as part of the ongoing development of signs of safety. The conference chairs have also participated in joint sessions with team managers to look at improving joint understanding of the model. Both CP chairs and IRO undertake individual training as it arises through opportunities offered through the academy. IROs have a link to a service area across children's services where they can discuss issues and look to develop better links with the team. They have regular joint meetings with Cafcass to promote better understanding of each other's roles and improve working together.

Impact is being measured by how the information and learning is being used –i.e. helped IROs develop mid-point template they now use. Feedback from parents led to current development of information sheet for parents. Team members have been actively involved in staff reference group to contribute to service improvement.

What difference did we make?

Performance has been consistently high with regards to IRO oversights with the year average being 100% of all children having an IRO oversight in 12 months and 98% with two or more IRO oversights of their care planning.

The IRO service has also performed highly in terms of consulting with children as part of their care planning and review process with the year average being 99.7% of children being consulted by their IRO's.

The year average for subsequent Child Looked After Reviews being held within timescales is 92%. This has dipped as a result of changes in Social Workers and reports and care plans not being completed in time for children's Reviews. To this end IRO's recently completed an expectations and bottom lines guidance for all service areas which they are promoting as part of their link work. The IRO Service Manager has also raised these issues with other Service Managers. The informal and formal escalation process has also been used where necessary.

IROs are now evidencing their communication with children and other relevant parties, children are encouraged to participate in their reviews.

Midpoint check template is now live.

Escalations are being completed and chased by IROs and the service manager.

CIC service manager meeting with IRO service manager weekly to discuss open disputes and closing them down as promptly as possible.

Performance for the conference chairs has fluctuated across the last year – initially due to increase in volume of conferences and insufficient chairs but since December 2021 Increased Conference chairs has meant more conferences can be chaired and offered in timescale. Delays have therefore been about social worker and managers cancelling meetings, not returning convening lists so invitations cannot be sent out. The average timeliness of ICPC across the year has been 52% which is inadequate but generally improving. Current reasons for delay are changing social workers, social worker leaves no one to immediately take over, no time to complete work.

A number of strategies have been put in place to chase / remind people. Business support remind a worker x 3 of need for Request To Convene and on a Thursday the following week's conference list is sent to workers and managers to remind them.

Conference chairs can now escalate concerns and data can be produced going forward about this. This Started at the end of March 22. Oversights are placed on mosaic and specific timescales have been given for when this is undertaken to ensure adequate monitoring of the plan.

A consistent group of conference chairs has meant standards can start to be reinforced and practice improved for children.

The FIRO is able to demonstrate effectiveness of independent reviews for carers that also provide a QA service in terms of work done with carers and for children's, if all relevant checks are in place.

Feedback from Children and Families

For IROs, questionnaires go to children and ask their views in the CP service parents were called after every meeting to see how it was for them this has reduced currently because of lack of business support to complete all tasks. All parents are met with before conference to discuss process and expectations in these discussion some parents raise issues that are relevant to service improvement. We are currently drafting a 1-page document to go out with invitations that shows threshold and scaling – parents have expressed that if they have this and then have questions they can discuss when they meet the conference chair

No Wrong Door (NWD)

Why is this service important to us?

Herefordshire Children Safeguarding Partnership worked with No Wrong Door (NWD) on a 6-month Children and Young People's Participation Project funded by the DfE, to improve the ways that we engage with, listen to, and act on the voices of children, young people and families in Herefordshire as a multi-agency partnership. NWD is an established voluntary organisation that has strong connections to children and young people across Herefordshire including some of the harder to reach communities, this includes an established network of children within education and health provisions.

What is No Wrong Door?

No Wrong Door was established to be an infrastructure organisation, creating a partnership of services for young people with a single 'front door' for young people to access whatever support they need. Open to support young people between the ages of 11 to 25, it works to enable young people to access the most appropriate support services for information, help and guidance to meet their full potential.

Who we help and how?

Any young person can walk in to one of our Drop-ins for advice, guidance, or support and be able to talk about anything. No Wrong Door responds to the needs of all young people offering low level early intervention. Work targets vulnerable young people in need of additional support to enable them to regain purpose and direction, build their resilience, develop coping strategies and help them progress positively in life.

We provide a process of support to Young People including Triage – Assessment; Action Plan and a Referral process to enable Young People to access the most appropriate support services from our partner agencies

We provide a cross-sector partnership of now 51 youth agencies and services in Herefordshire who have signed up to a protocol of data sharing and working together to enable support to all young people but targeted at those most in need. Our youth offer is:

- **A Safe Space to Talk:** having someone to talk with who is non-judgemental and who then can open up to and be honest with, who supports their goals in life
- **Find Help:** where young people not always having the confidence in themselves, find appropriate advice and guidance on navigating to the adult world
- **Make a Difference:** to access a platform where they get support not only to be able to make a difference to their own lives but to others as well

"I work representing the views, wishes and feelings, as instructed by the young person. I have found Carole to be incredibly supportive of the role. She actively encourages and accommodates the voice of the child throughout the review, both when a young person is in attendance and when I am there as a representative of their voice. In my experience, Carole conducts meetings in both a professional and an appropriate manner – ensuring that everyone, whether in attendance in person or via the submission of a report, has an opportunity to share their views whilst being respectful and appropriate to all. I have known Carole to challenge professionals and young people alike, during a review. These challenges have been carried out appropriately whilst treating people with respect and understanding. I have, on numerous occasions, had communication with Carole, outside of reviews, to ensure clarification for a young person. She has always been very responsive and pertinent."

What needs are we addressing?

The past 18 months have been disjointed, traumatic and seemingly never ending for so many of us. Young people have seen their lives put on hold and lacking stability, and many have experienced lockdown as a 'pressure cooker' and are experiencing increased mental health issues. On top of this Young People face many more challenges as they make the transition into adulthood. Challenges like developing strong relationships, building resilience, finding a job, reaching their potential and playing an active role in their community. As we adapt post-pandemic, there is also a need to focus on academic catch-up alongside young people's mental health and wellbeing, and employability. Through consultation with young people and our partner agencies we have asked how best to support the growing needs of young people experiencing anxiety. Feedback has identified the preference for access to a safe space where they know they can talk to someone who will listen to them, who will not judge them, and who they trust to help the young person make sense of their life and find positive ways forward.

We believe that Youth Work has a key role to play in helping promote young people's personal and social development. We know this makes a difference to their formal education. Research also shows that good youth work can help improve attendance and behaviour, promote achievement and improve home and community links.

Funding however continues to be a significant concern!

Key achievements (the period covered is 1st April 2021 - 31st March 2022)

Through consultation No Wrong Door asked Young People how best to support those most affected. The result was young people forming a "Herefordshire Youth Reps" group, coming together they made a short film capturing **Lockdown Stories**. The views and issues of young people together with their suggested solutions were also put together and presented to the Local Authorities then head of Children's Service.

Following the success of this work, young people have helped design our **new flyer** with one young person drawing the characters.

Our work to value young people, enabling them to take a leading role to express their views, developing a service and now impacting on Herefordshire's strategy and practice was nominated by Jo Hilditch DL and High Sheriff of Herefordshire for the National High Sheriffs Crimebeat Award where a group of young people attended the awards ceremony in London where we gained 2nd prize. It is hoped that this practice will continue and be embedded in the future.

NWD was commissioned to survey and capture the "Voice of the Child" where a **new Young Person's Advisory Group** has emerged from our Youth Reps group to help inform strategy and policy for the Herefordshire Community Safeguarding Board.

All children and young people in Herefordshire were invited to take part in the **Take-Over Challenge**. In collaboration with No Wrong Door, the HSCP have developed a series of Missions that children and young people can complete as part of their school lessons, to help shape the work of the Partnership. The Missions are age-appropriate for primary and secondary school students and based on the work of the Safeguarding Partnership. Work will be fed-back to the HSCP Leadership team and will influence the priorities of the safeguarding partnership. [HSCP Voice of the Child Participation Toolkit - Herefordshire Safeguarding Boards and Partnerships](#)

Numbers assisted (including groups and individuals)

Since January 2021, over 700 young people have accessed the No Wrong Door services and with the support of Multi Agency team. Commissioned work enabled us to provide outreach work in the city and create a New Youth Space working in collaboration with St Nicholas Church based at the Church house. The No wrong door partnership has steadily grown to 51 partners, and we are now working in collaboration with 7 high schools across the county.



Some quotes from young people highlighting the difference made

There has been a notable increased feeling of safety within local communities and schools with the visual presence of NWD. This initiative has proved so successful, Quotations from young people supported by No Wrong Door include:

“If I hadn’t walked through No Wrong Door doors, I would never have imagined I would have felt so confident and now have a full-time job”

“I’ve been pretty bad at home but because I’ve been here, I’ve been good at home”

“I’ve learnt to be kind”

“Since I have been coming to No Wrong Door, I have had some good days and bad days, but I feel good now. I am no longer bullied, I have had my storey published, I am studying full time and just moved into my own home.”

“Playing with older kids helped build my confidence”

“I would like to express our gratitude for the work that NWD has completed here at EMC this term on Monday afternoons. The sessions have been very well received.

Development areas/priorities for the year ahead

We recognise the importance of work with high schools and to be able to provide early intervention support to targeted, vulnerable young people who are suffering from anxiety, whose wellbeing is at risk, or those that are not flourishing suffering or becoming involved in exploitation. To enable youth services to reach as many young people as possible we would like to see the development of a **larger multi-agency base** to service **hub and spoke model**, which will enable us to reach out across the county.

We have just negotiated a new project funded by the CRF to work with schools and communities, 5 senior youth workers recruited from different disciplines of JNC qualified youth workers, teachers, Social Workers, Counsellors started 1st April. We hope to pilot this new way of working to **evidence proof of concept** and demonstrate our Theory of Change Model and measure impact of the work. The final report will inform further ways of supporting young people based on all learning captured during the engagement and enable us to extend and expand this of this new way of working.

A big thank you to all our funders including the Eveson Charity, Herefordshire Community Foundation, Herefordshire Community Safety Partnership, they all who have believed in us.

No Wrong Door and its partnership have demonstrated ways to improve the quality of young people’s lives and make a positive difference. By demonstrating safe practice and with the movement back to face-to-face work, including work with schools we hoped that new initiatives this coming year will build on what we have shown so far.

West Mercia Police

Why is this service important to us?

The Police have a central role in protecting children, this includes the duty to safeguard and protect children and to investigate crime. The Police may hold important information about children who may be at risk of harm as well as those who cause such harm and it is important that this information and other intelligence is shared with other organisations when necessary to protect children.

What did we do well?

Covid brought about a curve ball which led us to change our ways of working to ensure children were safe. This highlighted the need for a multi-agency Domestic Abuse hub which would triaged cases daily. We also agreed a cohort of children at risk and arranged for local officers to conduct safe and well visits.

RHRT was established to pull together what the framework looked like. It required tweaking and training. The inconsistencies of thresholds brought about the need for training as there was too much work coming through the front door which led to people being risk adverse. Also issues with the step down from child protection to child in need without partners being informed led to confusion on cases.

Signs of safety was introduced with limited initial training. This is now firmly embedded across Police staff.

We saw the implementation of the MASH strategic board. The Neglect sub group was introduced to promote the use of early help assessments and now a busy group that mirrors regional best practice.

The child exploitation and missing sub group has ongoing work around transitions which was an issue that hadn't been addressed. There was no focus on transitions but there is now a focus to capture data which informs us on who the perpetrators are and where it is prevalent. Positively, the Prevent and Disrupt operational group is well attended and enhances the understanding of contextual safeguarding.

What difference did we make to the lives of CYPF?

Over the past year we have moved to a vulnerability model whereby we have specially trained child protection officers with dedicated supervisors. These officers work closely with partner agencies, building stronger working relationships. The engagement that vulnerable children and young people receive from these Officers ensures their voice is heard.

Our child exploitation team works closely with partner agencies and meet regularly to ensure we are all sighted on the cohort of children at risk or being exploited. Through multi-agency risk management meetings, we have examples of where young persons at risk of exploitation and on the edge of being criminalised, have been referred to the 'Climb Project' – a support worker identified and suitable hobbies which has successfully diverted them away from being exploited and potentially criminalised. Police lead and chair a monthly multi-agency prevention and disruption meeting focussing on hotspots, themes and places related to exploitation. This group is attended by more than 30 representatives from across both statutory and non-statutory organisations.

The introduction of an early intervention and prevention officer within our harm assessment unit has identified individual families that require support. This officer works closely with the early help team and has forged links to improve outcomes for families.

Youth engagement Officers work alongside schools and colleges and other local groups to identify any safeguarding issues and promote good practice.

**An analysis of any areas where there has been little or no evidence of progress on agreed priorities*

COVID prevented co-location, with most agencies working from home. Although this did hinder some lines of communication the harm assessment unit and child protection team have worked hard to continue improve communication with partner agencies and respectfully challenge partners, this needs to continue with agreed outcomes being reached.

The imminent move to a co-located MASH will improve communication and build stronger relationships between partners.

Criminal Exploitation has made little progression on transitions pathways for young people requiring adult services post 18 years. This is an area of work which will be given particular focus for development in the next business year.

Were there opportunities to learn and improve?

Our dedicated harm assessment unit reviews all Police incidents involving children and young people. All officers within that unit have now attended training on the right help, right time thresholds. This now provides consistency around the use of thresholds. A recent internal audit on the application of thresholds revealed that there is assurance in this area.

Learning from safeguarding-related reviews is promulgated across the organisation by the Strategic Vulnerability Safeguarding Team, and governance is provided by the Strategic Governance & Oversight Board, which reports into the Service Improvement Board. The Learning & Development Department ensure that practice is developed and continuous improvement continues.

West Mercia's Statutory Major crime review team have responsibility for all statutory reviews. Any learning identified from such reviews are all recorded, by the Detective Inspector who will then disseminate to the correct person for outward dissemination to frontline staff.

There are various ways this can be done:

- Reflective Practice to the individual officer/team via their supervisors.
- 60 second learning documents completed for all staff.
- Regular meeting with Vulnerability and Exploitation trainers to disseminate learning to frontline staff and partner agencies.
- Regular contact with the Strategic leads for relevant areas to assist with inputs during Continual Personal Development (CPD) days.
- Through the Vulnerability and Safeguarding DCI to Chief Officers through Strategic Improvement board.

- Regular contact with learning and development and CPD trainers to ensure learning is passed to frontline staff.
- Recently a Domestic Abuse Audit was completed within two policing areas of West Mercia which highlighted a number of learning opportunities this was driven through the organisation by the Domestic abuse delivery group. These types of audits are seen as the way forward and other areas of business are currently being considered.
- WMP have recently developed reality testing (seen as promising practice by VKPP) that now takes place via a schedule on different topics. Centrally we have the ability to ensure that any learning points are included as part of this reality testing.
- Learning from serious case reviews in regard to multiagency public protection arrangements (MAPPA) offenders is the responsibility of the MAPPA Performance and Standards Sub-Group with oversight from the Strategic Management Board. Again this learning is disseminated through the channels listed below and is included in the programme of audits to ensure learning has been embedded.

This is a continual cycle and the actions/recommendations are reviewed on a regular basis with Senior Managers to ensure the recommendation has been embedded.

What are the remaining challenges?

Police staff experienced to complete internal and multi-agency audits is limited however the importance of these is recognised and therefore this area of work does need to continue.

The continuous change in management roles makes it difficult to maintain consistency with processes, this can make third party sector frustrated as they are not always included in the communication of changes.

There is an uphill struggle with press attention from all agencies, which can prevent people from reporting child abuse matters.

Issues with the single agency decision to step up or down with partnership consultation.

With the current improvement plan in place as a service we need to be included in this.

Violence Against Women and Girls (VAWG) cross cutting themes – Domestic Abuse children come under definition DA bill.

Child Exploitation & VAWG- We need to map and ensure all data is pulled together.

Training – need to make sure all staff are trained making use of the multi-agency training that is available. Links in with all sub groups to ensure we cover the cross cutting themes and reduce the number of sub groups wherever possible.

Make use of 'Walk the Floor' activities. Police have started this with Health colleagues.

NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG)

Why is this service important to us?

The CCG ensures that keeping children safe whilst they are receiving services commissioned through the CCG is central to what they do. The CCG work together with all provider organisations to achieve this it means that all commissioned organisations have robust systems that safeguard children in line with section 11 of the Children Act (2014), and clearly understand their role in safeguarding children and young people, this includes: clear accessible policy and procedure, safer recruitment, training and governance systems.

What did we do well?

Herefordshire and Worcestershire Clinical Commissioning Group (HWCCG) as one of the 3 Safeguarding Children Partners has supported driving the safeguarding agenda and improving the effectiveness of the Partnership. The CCG Executive Leads, along with Executive leads from the other two Partners, recognised that the effectiveness of the Partnership was not where we wanted it to be. Therefore, over the last 12 months, the Partners convened monthly Extra-ordinary meetings Chaired by the CCG Chief Nursing Officer. These continued until March 2022. The purpose is to improve traction, pace and completion of outstanding work within the Multi-Agency Safeguarding Arrangements (MASA). For example, traction on development and publication of several key documents: the Herefordshire Safeguarding Children Partnership Strategic Plan 2021 – 2024, HSCP Annual Plan for Independent Scrutiny 2021-2024, HSCP Strategic Plan- Performance Outcomes Framework 2021 – 2024. The Extra-ordinary meetings are in addition to the 6 weekly Safeguarding Partnership Group (SPG) meetings. The funding provided by the CCG equates to a 22% increase over the last 3 years.

The position regarding the Herefordshire Safeguarding Children Partnership Multi-Agency Safeguarding Arrangements (MASA) is showing early improvement. However, progress remains slow in achieving consistent traction/pace, despite the measures in place.

In addition, the CCG has supported the HSCP through appropriate representation and contribution at the: Executive Safeguarding Partners Group, Executive Support Group, Quality & Effectiveness Group, Development & Practice Group, Child Exploitation & Missing Group, Joint Case Review Group, Neglect Strategic Group and MASH Strategic and Operational groups. As well as the many Task and Finish or other Groups established to support the work of the Partnership such as the Performance Data Group and Audit group. The CCG have provided leadership across the partnership and supported driving the safeguarding agenda forward including roles of chair and vice chair for some groups.

The Safeguarding Health Leads from Herefordshire and Worcestershire meet at a quarterly forum. The group shares 'Integrated Care System' wide learning and works together to drive system improvements from all multi-agency safeguarding across the health economy.

What difference did we make to the lives of CYPF?

Herefordshire and Worcestershire CCG are a commissioning organisation therefore we do not have direct contact with children and young people. However, the providers of the services we commission do have feedback from people who use their services. Compliments and complaints and the actions taken are shared as part of the reporting processes from Providers to the CCG. In addition, any serious incidents are shared with the CCG, who provide scrutiny and oversight to ensure actions taken address the issues raised. When services are visited, as part of the CCG assurance process, feedback is obtained from staff and services users when appropriate. When issues emerge, information is sought from the providers. For example, the CCG sought assurance from the Trust regarding the children's workforce to confirm that public health nurses and midwives were not redeployed in the lockdowns during this reporting period. Information is triangulated to evidence that the services are safe and are of a high quality. Where there are areas for improvement the CCG has oversight to ensure these are addressed.

HWCCG commission health services for the population of Herefordshire and Worcestershire. We work with Provider organisations, such as Herefordshire and Worcestershire Health and Care NHS Trust, (HWHCT) and Wye Valley NHS Trust (WVT), to seek assurance regarding the effectiveness of safeguarding across the partnership. This includes evidence that action has been taken to address single and multi-agency learning from local case reviews. To support the assurance processes, the Trusts invite the CCG Safeguarding Leads to their internal safeguarding committees. In addition, within the Quality Schedule, there is a Safeguarding template, to ensure NHS contractual requirements in respect of safeguarding are met and reported upon which includes learning from reviews. As a health system, we are working within the partnership to improve how we evidence impact; or i.e. the 'so what', what difference have we made to the lives of children and young people.

HWCCG have supported awareness raising of the Early Help process and Right Help Right time Guidance; to GPs and other clinicians in primary care to demonstrate how they can support the early help offer through discussion with families, other practitioners such as Health Visitors and understand how to refer into targeted Early Help services when required.

The partnership response to learning from the National Panel, in respect of 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm, Final report July 2020'; the Fieldwork report: National Review of Non-Accidental Injury in under 1s September 2021, "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers September 2021; is being led by the CCG in collaboration with the Board Managers from HSCP and WSCP, and leads from the Child Death Overview Panel (CDOP). The learning also links with learning from local reviews, as well as findings from CDOP. The 'Keep Me safe...' strategy has been developed to support these work streams.

Its purpose is to provide consistent and co-ordinated messages to practitioners across the Herefordshire and Worcestershire Integrated Care System (ICS) to help reduce the number of children who are seriously injured or die. 2022-2023 will see the strategy disseminated to all multi-agency partners alongside key information that focus on particular themes. For example, guidance relating to 'Keep me safe...when I am sleeping' and 'Keep me safe...when I am crying'. To support the focus on 'Under ones', the full ICON programme has been purchased by HWCCG via NHSE/I funding streams. ICON is an evidenced based programme designed to help people who care for babies to cope with crying. ICON stands for Infant crying is normal, Comforting methods can help, it's Okay to walk away, Never, ever shake a baby. It aims to reduce the number of babies suffering from Abusive Head Trauma due to shaking.

The purchased ICON programme will support the free resources which have already been disseminated across the system over the last 12 months. ICON links in with work that the Local Maternity and Neonatal System (LMNS) are leading on, including the 'DadPad'. DadPad is an information pack developed by dads for dads is helping fathers in Herefordshire and Worcestershire prepare for family life and tackles the mental health issues which can affect new parents.

It covers a range of issues, such as the support dads can give while mums are breastfeeding, being aware of perinatal mental illness and the anxiety and frustrations that come with parenthood, as well as hands-on advice on issues like nappy changing. Its aim is to provide new fathers across Herefordshire and Worcestershire with guidance on how to develop the mind-set, confidence and practical skills needed to meet their baby's physical and emotional needs.

Representatives supporting the development of the 'Keep Me Safe When I'm Crying' and 'Keep Me Safe When I'm Sleeping,' strands of the strategy, are from across the multi-agency system.

HWCCG has fully supported the Children Looked After (CLA) agenda, working closely alongside both health and Children's Social Care to drive forward improvement in the quality and timeliness of information shared between agencies to ensure the best health outcomes are sought for this cohort of children. The Deputy Designated Safeguarding Nurse for CLA attends the Corporate Parenting Board.

Were there opportunities to learn and improve?

GP Practices are offered support visits, reflective sessions, as well as learning and development sessions which incorporate learning from reviews, locally and nationally. Discussion/reflective sessions regarding learning from Rapid Reviews or CSPRs are also provided to the GP Practice involved to help improve safeguarding practice across the partnership.

HWCCG have continued to commission bespoke learning and development sessions for Primary care and have widened this to invite multi-agency partners – these have included Fabricated and Induced Illness training, Domestic Abuse Training and the White Ribbon Conference. Supervision Training is commissioned, to increase the number of health professionals who can provide safeguarding supervision. High quality supervision is important in supporting staff to ensure they are able to safeguard children; or adults (with care and support needs) by providing appropriate advice and challenge in safeguarding matters. Safeguarding Supervision is mandatory for all Health Professionals working with

children and families. Safeguarding supervision has been demonstrated, to be fundamental in supporting frontline practitioners in delivering high quality care, providing risk analysis and individual action plans (NSPCC, 2015).

Learning from across the Integrated Care System-The Safeguarding Health Leads quarterly forum provides the opportunity to share learning from across the system. An example includes sharing how the HWHCT have oversight and monitoring of their Single and Multi-Agency Recommendations and actions taken to address, through the trust's Integrated Safeguarding Committee. This has been shared with WVT who have attended the HWHCT internal safeguarding meeting, in order to improve their oversight and monitoring processes. Other examples are where joint work can be undertaken across the system, such as for policies and procedures. This is an opportunity to work jointly across the multi-agency system, not just across health.

What are the remaining challenges?

These remain an area for development across the system:

- Strengthen oversight of implementation of recommendations and that those findings have been used to change/improve the safeguarding system. Particularly, improving evidencing impact as a result of changes.
- Drive the changes identified through the Leadership development sessions and improve traction and pace across the partnership.
- As a partnership we need to work smarter and consider what information is already available to us via CSC systems recording as well as utilising individual agency data if there is a gap. However, we need to ensure we focus on relevant key and succinct themes to support ongoing priorities, rather than trying to have too much data without the narrative.

Herefordshire and Worcestershire Health and Care NHS Trust

Why is this service important to us?

The Health and Care NHS Trust are the main provider of community nursing, therapy and mental health services. They provide services for people of all ages, across a range of settings, experiencing both physical and/or mental health conditions.

The child and mental health services (CAMHS) provides assessment and support services for children with emotional behavioural and mental health difficulties. It is important to Herefordshire due to the increased rates of mental health reported on following the national lockdown measures as a result of Covid 19.

What did we know?

Audit of referrals showed that CAMHS staff are risk averse and are completing MARF even when the actions they have taken had already reduced the risk. Short focused training package has been developed for a named nurse to deliver to the various multi-disciplinary meetings to empower staff to be comfortable holding the risk.

List of all children subject to child protection plans and looked after are now provided to HWHCT so that mental health staff working with those families in Herefordshire are aware of the additional challenges facing the family. Where children are placed in Worcestershire that information is shared with the public health nursing service to ensure they provide an appropriate response to the child. This has improved the speed at which services can become involved in the support for these children and their families.

What difference did we make to the lives of CYPF?

91.5% of the workforce in Herefordshire has completed or refreshed the appropriate level of safeguarding children during the last 3 years in line with the NHS Intercollegiate training guidance.

Were there opportunities to learn and improve?

As the Trust provides services across two Counties learning from DHRs and CSPRs in one County are shared across both. Particularly some of the learning for health visitors from Herefordshire have been shared with Worcestershire where the Trust does provide a public health nursing service.

A paper was provided to Child Exploitation strategic group to look at the support CAMHS provide generally and specifically to this group of children. There were no queries as a result of this paper.

What are the remaining challenges?

Referral rates into the service have appeared to be relatively stable over time (with a dip in early 2020 due to the pandemic despite the service remaining 'open'); however CYP are presenting with, a higher rate of referrals that meet thresholds and are accepted into the service; in 2019/20, this was 54%, 2020/21 was 58%, and 2021/22 (to date) 71% of referrals are accepted.

Highest Number of Referral Types

Largest increase in referral type (from 2016/17-2021)

1. Eating Issues
2. Self-Harm
3. Low Mood/Depression
4. Separation Anxiety
5. Generalised Anxiety Disorder



Wye Valley NHS Trust

Priority 1 Leadership and Impact

Safeguarding children is a multi-agency process and the Trust works closely with colleagues across Herefordshire to support the work of the Herefordshire Safeguarding Children Partnership (HSCP) ensuring that the Trust is represented at its groups and contributes consistently to the work streams for the partnership's priorities. WVT NHS Trust Safeguarding Children provides appropriate representation and contribution to: Executive Support Group, Quality & Effectiveness Group, Development & Practice Group, Child Exploitation & Missing Group, MASH Strategic Group and Joint Case Review Group. Additionally the trust has supported the partnership at various task and finish and other groups such as: the Performance Data Group, Neglect Strategy Group, Prevent and Deter Parts 1 and 11 and the Training Reference Group and the Training Reference Group and the more recently formed CPSR review of Multi-Agency Action Plans group.

The Named Nurses - manage the safeguarding children (SC) and children looked after teams (CLA). The SC team have all received safeguarding supervision training, the senior members completing training in leadership in safeguarding and 3 members of the team so far have completed the Mary Seacole Leadership Programme. The Chief and Associate Nursing Officers have also attended Safeguarding Leadership training during this last year.

WVT Children Looked After Team

All children continued to have statutory health reviews throughout Covid Lockdowns via Video call

- Use of virtual contacts has enabled more contact with young people and carers outside of the statutory health reviews.
- CLA Nurses are able to provide consistency of professional for CLA allowing trusting relationships to be built with children and young people and their carers.
- Where there are health concerns and children have been reunified CLA Nurses have undertaken direct work with the parents and children after they have moved back home to support health needs. This has enabled children to raise concerns they have.
- The positive impact of this has been to afford greater variety of opportunities and platforms with which to engage with Children and Young People and their carers. This has allowed carers to be spoken to and raise concerns away from the child and face to face contacts with the children and young people are more focused.

Development and Practice Sub-group – Includes Neglect Priority 2 and Training and Policy Task and Finish Groups)

The Trust safeguarding team have attended all meetings of the Development and Practice sub group and associated work streams / task and finish groups. Ways WVT have contributed include:

- Delivery of GCP2 a training both internally to Trust staff as a single agency and also to the multi-agency training courses offered by the partnership.
- Signs of Safety- One of our safeguarding advisors has completed the 5 day full course, all team members and key Level 3 staff (e.g. Public Health Nursing) have attended the 2 day training.
- The development of and adoption of the Injuries to Babies and Children under 2 year's policy



Internal Governance

Safeguarding is central to quality of care and patient safety. The Trust has a clear governance structure in place.



Right Help/Right Time - Priority 3

The WVT SC team developed and delivered a training package to develop practitioner understanding of thresholds and the Right Help Right Time document

The Named Midwife delivered a presentation to a Partnership Practitioner Forum which highlighted an example of good practice and beneficial impact on outcomes using the Multi – Agency Resolution of Professional Disagreements policy

WVT authored an NHS audit (G.P., WVT and HWHCT) to explore child safeguarding referrals made by these providers to children's social care.

Child Exploitation Sub Group – Priority 4

WVT prioritise attendance at all sub-group meetings but liaise with other NHS health representatives to attend otherwise.

Main outputs include:

- Development of a social media platform locally for children and young people
- Promoted CE awareness week in March
- Completed multiagency audits and attended multi-agency task and finish regarding Peer on Peer Abuse guidance
- The outcome of the multi-agency Peer on Peer audit provides a baseline for the published guidance
- Additional focus on peer on peer and harmful sexual behaviour
- Prevent and Disrupt group continues to feed through themes and trends to inform the safety plan and provide an updated overview
- Children's' views are sought by the CE team via RMM and RHI and those are shared with WVT professionals who are involved if the child agrees

The work of the Named Midwife - since the establishment of this post the following outputs have been achieved:

- Orientation programme for newly qualified midwives to ensure they feel confident and knowledgeable with safeguarding process
- Wider implementation of the ICON initiative, which includes education and training on the ICON message
- Routine enquiry for Domestic Abuse in pregnancy/postnatal has improved and is now at 92%
- Policies and procedures are up to date with the most recent updates being to the routine enquiry and domestic abuse in pregnancy, substance misuse in pregnancy and FGM
- Monthly case alerts are communicated with the midwifery and health visiting team to ensure staff are aware of cases due each month and are confident on the safeguarding planning for each individual case
- Regular child abduction drills have been taking place with positive learning identified, the policy/guideline has been updated with multi-disciplinary input

Other Areas of Development / Impact WVT have led/ contributed to

- The development of the Domestic Abuse Hub in MASH
- A quarterly newsletter for all staff trust wide and a specific maternity safeguarding newsletter
- Fabricated and Induced Illness (FII) training to WVT staff has been developed and delivered
- Developed an escalation process for delayed discharges for young people due to lack of suitable placements for those with children's social care or CAMHS requirements
- Developed a more suitable child friendly/ young people friendly environment within our Emergency department
- ICON messages being implemented and development with additional training planned for Midwifery staff and then extended to all staff working with babies and young children.

9. Ask Listen Act – Learning from the Voice of Children and the Experiences of Frontline Practitioners

The Voice of Children (VoC)

The Voice of Children and Young People have continued to influence the work we have done over the last 12 months and in particular over the further lockdown periods across 2021-2022, children's voices has been a priority and very much at the heart of what we do.

HSCP Participation Project

In June 2021 the HSCP received funding from the Department of Education 'Multi-agency Safeguarding: Implementing the Reform' programme, to deliver the children's engagement and participation project.

The aim of the project is to inform the development of a 'system-wide approach to understanding what the issues are for children from their perspectives with support to schools, education providers and other agencies, to operate in a preventative manner by informing practice based on the 'Voice of the Child.'

The project sought to:

- Identify how to gain the views of children
- Identify the concerns around being safe are for children in Herefordshire
- Identify how front line staff can use new methodologies of working with children and to better understand and inform how they work with them – eg use of peer counselling, young inspectors
- Identify improved opportunities for children to disclose any concerns they have for themselves, their peers or their siblings
- To improve and build upon the use of the multiagency self-assessment on child and family participation
- Children would be actively encouraged to share their views on matters that affect them and are therefore more likely to disclose any issues or concerns when they arise

The DFE-funded phase of the project started in September 2021 and concluded on March 31, 2022. The HSCP partnered with local charity No Wrong Door to help deliver the project.

Key Outputs included the following:

- Your Voice Matters survey ran from October 2021 to February 2022, with 300 responses received from young people
- No Wrong Door held 3 focus groups held with young people (11-13, 16-25, NEET)
- Take-over Challenge for young people was run through schools in November 2021
- Presentation of survey findings was made to professionals at Voice of the Child Briefing in March 2022
- Survey and mapping findings were built into the Participation Toolkit to be launched in June 2022-2023
- Engagement & Communications sub-group created and as acted as professional focus group which will continue to embed this work
- Redevelopment of HSCP web design
- Bespoke training course to further promote and embed the practice of the VoC

Project Impact

While much of the impact of the project will be seen in subsequent years, when the Toolkit is embedded, there is evidence of the project having had an impact in fostering a culture-shift through in renewing the value of listening to and acting on the Voice of the Child. Evidence of impact can be seen through:

- The HSCP has established a new Engagement & Communications sub-group, to champion participation and engagement activity for the HSCP.
- The Herefordshire Children's Services Improvement Plan includes ambitions to create opportunities for children and families to feedback and influence service design.
- Herefordshire Council is developing an Engagement and Participation Framework.
- The Feedback loop that was proposed as part of this project (Ask – Listen – Act – Feedback) has been widely accepted and endorsed, with the addition of the "feedback" element showing a change in culture in how we value and communicate the impact of participative activities.

Further, during the course of the project, No Wrong Door (community partner for the delivery of the project), were recognised with a 2nd place award at the National Crimebeat Awards, for their work in enabling the voice and opinions of young people to have an impact on the design and delivery of youth services post-Covid.

Next Steps

The following areas of work are to be progressed in the business year 2022-23. The launch of the:

- ✓ Toolkit
- ✓ Children's micro-site
- ✓ Further training, and resources
- ✓ The Voice of the Child Conference on June 10th 2022

Point of View Podcasts

P.O.V. is a youth voice programme, funded by Esmee Fairbairn Foundation that is making space for rural young people to tell their stories and share their experiences in ways that will create change.

Series overview - The Point of View podcast, or P.O.V. podcast for short, is a series of conversations and interviews featuring incredible young people living in rural England. Each episode features a different host exploring a theme important to the children's lives.

There are 12 episodes in total, recorded over a few months in 2021, listed below are a few of the podcast summaries.

Jeremy Oseman (Participation Ambassador for **young people with care experience in Herefordshire**, shares his hopes and ideas for service improvements and has talked to us about what it's been like to have social workers in his life since he was three years old. He was joined by Debbie, who has been supporting him for more than 10 years.

Finding hope Living with Chronic pain - Chantelle and 18-year-old Elles are talking about their **experiences of living with chronic pain conditions**. As well as discussing the discrimination they've both faced and the realities of navigating the health system, they're sharing their positivity in the face of challenge, their resilience and their hopes for the future.

17-year-old Lola interviews Sarah Melia, who works with West Mercia Rape and Sexual Abuse Support Centre, **about safety on our streets** and protecting young people, particularly people who identify as women, from sexual violence.

Talking truth about drugs and alcohol. Harvey is talking to Charlie from Turning Point about **drug and alcohol use among rural young people**. They discuss their own experiences as well as County Lines, which is the movement of illegal drugs often across county borders. Harvey and Charlie are also poets and catch up about what it's like to be young creatives when you live in a rural county.

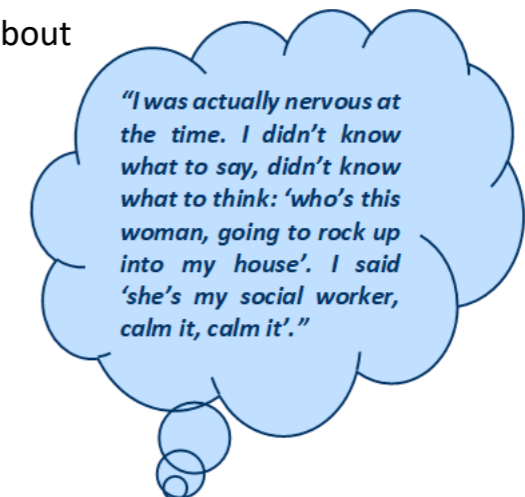
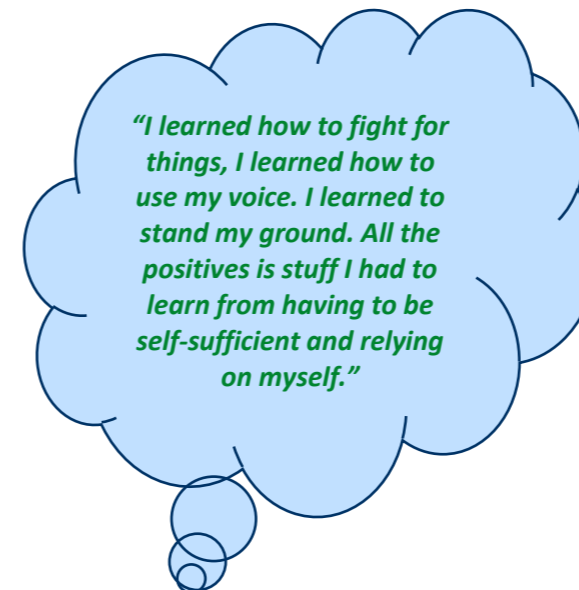
The EPIC value of volunteering. 18-year-old Charlie talks about how volunteering has changed her life. She interviews youth worker Tammy about the EPIC volunteering programme based at Close House, a drop-in youth centre in Hereford.

Where to listen to the podcast

Apple: <https://podcasts.apple.com/us/podcast/point-of-view/id1607318366>

Spotify: <https://open.spotify.com/show/0KvFKZs7eLyXTnjWqAvMti>

P.O.V. website: <https://pointofviewrural.com/pov-podcasts>



10. The Experience of Frontline Practitioners

As a Partnership, we have worked really hard to ensure that there has been regular senior leadership engagement with front line staff across all agencies and services throughout the year, during lockdown and COVID 19. We additionally have used creative approaches to remain in touch with the workforce including virtually held meetings, surveys, and Partnership bulletins, as well as the:

Multi-agency Practitioner Forums

The Practitioner Forum gives an opportunity for practitioners to reflect and learn together, provide networking opportunity for practitioners and provides an opportunity for the Partnership to assess how well things are working on the front line.

The Forum have successfully influenced a range of service and practice developments through 2021-2022 this includes the following:

- Developments regarding the MASH and the colocation of key agencies
- The review of the Right Help Right Time thresholds guidance
- The review of the multiagency referral form
- Developed innovative systems and processes for information sharing between agencies virtually during the challenges of lockdown and Covid 19

The Practitioner Forum was established to promote the voice of the practitioner in influencing strategic developments and to ensure that there was a degree of effective challenge from those working on the front line. The forum meets twice a year and is attended by the key strategic leads from across the partnership. This allows for a direct feedback link between multiagency strategic senior management and front line practice. The Forum is also attended by the Independent Chair of the HSCP.

The two Forums convened focused on the following areas of practice

Sept 2021

- Learning from Case Reviews
- Findings from the national Child Safeguarding Practice Review Panel
- Self-neglect and hoarding
- Recent trends in domestic violence and homicides
- The impact of rurality, elder abuse and child to parent domestic abuse in Herefordshire
- Keep me Safe ...strategy
- Resources to support learning

The practitioner forum is well attended by practitioners, they have additionally raised issues relating to their needs and interest in learning and development topics. Multiple practitioners have expressed an interest in the following development areas:

- Domestic abuse – impact on and supporting children and survivors
- Mental health issues and support for young people
- Drug/alcohol awareness / county lines and exploitation
- Supporting children with disabilities and additional needs
- Updates on new publications, policies, guidance, learning from reviews

February 2022

- Project BRAVE: Supporting rough sleepers
- Introducing the new Peer on Peer Abuse multi-agency guidance
- Serious Case Review for Matthew – overview and learning
- Your Voice Matters HSCP Survey – Brief Update
- Substance Use Interventions with Adults and Young People
- Voice of the Child: An Appreciative Enquiry Using Signs of Safety to Listen to Children

11. Learning from Performance Information, Assurance Activity and Case Reviews

The Quality and Effectiveness Group (Q&E)

The terms of reference (TOR) set out the purpose of the group as:

“To monitor outcomes for children, and evaluate the performance and effectiveness of the partnership safeguarding arrangements, and work to ensure findings from the audit and performance monitoring activity translate into actions within individual agencies to improve practice and outcomes for children.”

The group originally reported to SPG and had a wider remit than performance and quality assurance e.g. approve CSPRs and oversee the work of sub groups. The review of the partnership arrangements completed in 2020 recognised that the remit of Q&E sub group was too broad and that Q&E needed to solely focus on performance and quality assurance activity; the creation of Executive Support Group (ESG) facilitated this change. Much of the partnership work has been very ambitious and has been overly complex leading to a lack of focus and progression. The Partnership commissioned the support of the Local Government Association (LGA)

Performance Data

Reviewing some of the partner agency data at the start of 2022 started to identify areas where it was not known what the multi-agency contribution was. Unfortunately the development of the Partnerships performance information has not progressed well. The following information has been gleaned from partner agency data

Issues identified through performance data and which was reported to SPB.

What is working well?

- Impact of plan to increase supervision to health visitors (now 85% was 55%) and school nurses (was 0% now 100%) – Wye Valley NHS Trust
- Routine enquiry (domestic abuse) by midwives – 90% Q4
- Increase in referrals to National Referral Mechanism (9 in total quarter 1-3, and 12 in quarter 4)
- Timeliness for decision making from Early Help, Domestic Abuse hub and MASH have been met

Areas of concern

- Right Help, Right time - what is the story:
 - Increase in demand EH/waiting list for EH support
 - Completion Early Help Assessment by partners - 73% completed by education
 - Rate of re-referrals to MASH (rate not provided – but higher than stat neighbours and WM’s LAs)
 - Rate of children subject to a child protection plan (CPP) is lower than statutory neighbours and other west midlands local authority areas
- Decrease in Persons who Pose a Risk to Children (PPRC) referrals and conversion rate PPRC and peer on peer abuse contacts
- Discrepancy Police and CSC missing data in quarter 1; not resolved by quarter 2 and repeat missing episodes (21% missing again within 72 hours) and return home interviews children placed in county
- Timeliness of health checks for Looked after children - 15% of Initial Health Assessments completed in timeframe
- Significant decrease in Child Exploitation assessments (75, quarter 1 compared to 16, quarter 2)

The challenges

- The lack of technical expertise to support the work of the group

- Quality of multi-agency dataset – gaps in commentary/benchmarking and analysis has impeded the group’s ability to deliver its core purpose
- Lack of substantive chair of audit group meant there was not the required level of direction or accountability; this has been addressed in year and a substantive chair has been appointed
- Delay in regional S11 audit tool being devised; a decision was made to explore opportunities to collaborate on a West Mercia wide footprint. A streamlined s11 audit will take place in 2022-23 to mitigate against the ongoing delay in launching the regional s11 audit tool
- December 21 meeting cancelled as only 2 papers available - not an effective or efficient use of people’s time to meet
- Lack of response from all partners (apart from Hereford and Worcester NHS Trust) to request to provide single agency audit programme
- Up to March 22, there had been little progress made on the ‘walk the floor’ activity
- The arrangements to evaluate the impact of training on practice have not gone live

In summary there is not a robust multi-agency dataset to support the HSCP and limited performance information to plan, review and make decisions about commissioning or decommissioning multi-agency service provision for children in Herefordshire and there is limited line of sight on quality and strength of multi-agency front line practice.

In year, and with effect from January 2022, there was a change of chairperson from Independent Scrutineer to Safeguarding Services Manager, Herefordshire & Worcestershire Health and Care NHS. The subgroup meets quarterly and is now supported by a standing audit group.

In addition in year, a performance group was established through the Business Unit and its purpose was to review and analyse multi-agency data and prepare the performance report that was presented to Q&E, a decision was made to disband the group following a failure to make any real traction on this improvement area.

Audits

Findings from Multiagency Audit into Strategy Meetings

The decision was taken to move from the deep dive audits of a few cases as so many of these had been undertaken as part of the improvement plan and to do a focussed audit of a large number of cases to look at partner involvement in strategy meetings. This has allowed all agencies to consider how they support crucial decision making at this juncture of the safeguarding process and identify where improvements can be made to ensure key information informs decisions.

Findings from multi-agency audit in regard to Peer on Peer Abuse:

In March 2021, an audit of current practice in respect of Peer-on-Peer Abuse was undertaken. The audit findings, presented in September 2021, noted some strengths as well as identifying areas of concern:

- This audit evidenced that the majority of the referrals into MASH in respect of peer-on-peer abuse had been referred at the correct level in accordance with Right Help, Right Time (RHRT) guidance.
- Strategy meetings are not consistently convened for all children, whether victim or alleged perpetrator. This is being followed up through the work of the Child Exploitation group.
- Audit shows schools create safety plans for children when there are concerns about the safety of pupils.

Findings from multi-agency audit in regard to Neglect/under 1’s audit findings:

- There is a lack of engagement by CSC with GPs including invites to Child Protection Conferences (CPCs) and Child in Need (CIN) threshold meetings.

It is acknowledge that as a system, audits demonstrate that the use of the escalation process is not as effective as it should be, and work continues to drive improvements across the partnership:

- For example, in health organisations, escalation is discussed in Supervision.

- In HWHCT, work has been undertaken to understand the difficulties with escalating concerns demonstrated that staff get stuck at the lower level of escalation and keep going at the same level causing all parties to get frustrated. A survey identified this was due to lack confidence with their concern to raise higher.
- In health, safeguarding leads signpost professionals to the Resolution and Professional Disagreement policy and support them with the escalation.
- Through health single agency training and supervision, Practitioners are encouraged to raise any challenges with their line managers who in turn will escalate following the policy.
- Police have raised awareness of the Resolution and Professional Disagreement policy amongst key professionals, including those in MASH, who utilise it.
- Awareness raising by agencies through training, supervision, various work streams, webpages and Safeguarding Partnership Newsletter, of the use of the escalation process using the Resolution of Professional Disagreement policy.

Wye Valley NHS Trust (WVT)

- Promoting use of the levels of need guidance and professional disagreement policy.
- All midwives are advised to seek supervision where a Multi-Agency Referral Form (MARF) is submitted at level 4 and screened at a lower level.
- Work with all midwives to empower them to make professional decisions, judgements and challenge appropriately in the best interest of the child with support from Named Midwife and Trust Safeguarding Team.

HSCP Response

- Peer on peer practice guidance produced, with associated training
- Assurance report from children social care (CSC) on invites and engagement with GPs - NB focused on CPCs.
- Clarity provided and Right Help Right Time (RHRT) training reviewed to reinforce that CIN is included at Level 4 (level of need)

Next Steps

- The new focus of Q&E sub-group has been on small discrete areas so that improvements can be made quickly and impact measured.
- Development session for the Partnership auditors to enhance knowledge, confidence and experience in conducting multi-agency audits
- Strengthen the audit process and the oversight and monitoring arrangements of the actions arising from audits
- HSCP to urgently consider the merit of additional technical support and Q&E members development session to impact on this improvement area

12. The Joint Case Review Group (JCR)

Many agencies work across more than one local authority area and work with different safeguarding adult boards, community safety partnerships and safeguarding children partnerships. Partner Agencies represented at JCR, have responsibilities in respect of Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and Child Safeguarding Practice Reviews (CSPRs). It is important that the Partnerships and Boards were cited on the overall themes from all reviews and any cross-cutting learning or issues within the system in Herefordshire. Therefore, the JCR Chair, with agreement of the Herefordshire Safeguarding Adult Board (HSAB), Herefordshire Safeguarding Children Partnership (HSCP) and Herefordshire Community Safety Partnerships (CSP), provides one report per quarter on behalf of the JCR Subgroup.

Safeguarding Children

During the reporting period 1st April 2021-to 31st March 2022, the Joint Case Review Group (JCR) has conducted one Rapid Review (Rapid Review 1).

There have not been any child safeguarding practice reviews commissioned during this reporting period.

Herefordshire Safeguarding Children Partnership (HSCP) published a serious case review and a child safeguarding practice review on February 7th and February 21st respectively. Their publication had been delayed due to on-going criminal proceedings.

Learning and Impact

Rapid Review 1

Following the death of a baby in March 21, a rapid review was completed in April 21 and a decision was made that a CSPR was not required; this decision was supported by the National Panel.

The early single agency learning identified, from the rapid review has been disseminated within agencies so that improvements can be made to the safeguarding system.

- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) have shared the learning from the review, particularly that which related to the Public Health Nurses in Herefordshire, with Worcestershire Public Health Nurses and asked them to use the learning in their practice reflections. A wider discussion was held in the internal Integrated Safeguarding Committee about what needs to trigger a discussion around Positions of Trust – extended to consider those working with adults. Specific training delivered to new associate nurses and named nurses who may take advice calls from staff.
- Following the Rapid Review, Police identified a gap in how intelligence was being managed across the different force areas and as a result the process was changed: ‘Crimestoppers’ are received into the processing unit and assessed. If the Risk appears immediate this will be shared with the Force Control room for the appropriate risk assessment and deployment where required. If the risk is deemed not immediate this will be shared via Police internal crime system (Athena) to the relevant vulnerability team. The team assess and deem appropriate action, such as recording Child/Adult Incident and sharing it to the relevant department and the Harm Assessment Unit for onward sharing to partner agencies for referrals- to ensure no safeguarding concerns are missed.
- Wye Valley NHS Trust- Developed a home visiting trigger list which is a supportive tool to encourage a more thorough assessment of the home environment. This was sent to midwives and health visitors. In addition, at least one visit is completed antenatally for any vulnerable families and ideally with midwife and health visitor.

Further learning related to the Rapid Review process and a JCR leadership reflective session was undertaken to explore how to strengthen how statutory and relevant partners analyse their individual and multi-agency practice in serious child safeguarding cases (See below- Challenges for the JCR Group).

There was additional learning in respect of the multi-agency system. The Scrutineer was asked to chair a multi-agency audit to provide assurance relating to subsequent decision making in relation to other children in the household and improve future multi-agency working in Herefordshire. A series of events were held to seek to understand what had happened and why. A series of recommendations were made to address the findings.

Key learning themes arising from the review are:

1. The value of collaborative working e.g. Joint s47 visits, joint Police and health visit as part of Joint Agency Response (JAR) and strategy discussions to make plans to assess and safeguard children.
2. An agreed approach to assessing and safeguarding children exposed to living in neglectful home conditions - What is agreed best practice?
3. Proportionate and evidence-based practice, decision making and management oversight that delivers a balanced as well as effective safeguarding response to the assessed needs of child/ren.

NB. Due to the delay in undertaking this audit, the learning has only been shared with Partners at year end, therefore, we are unable to evidence improvements or impact at the time of reporting.

CSPR Peer-on-Peer Abuse

Peer on Peer abuse was already an area of focus in Herefordshire prior to the Review. The response at the time was predominantly driven through Education. However, there has since been a shift to a focus on the multi-agency response to Peer-on-Peer Abuse and a Peer-on-Peer Abuse Task and Finish Group was established in 2020.

Recommendation 1

The safeguarding partnership seeks assurance that learning points identified by this review are addressed by the implementation of action plans in response to: (i) learning from previous safeguarding reviews and (ii) to improve the multi-agency response to peer-on-peer abuse. There should be a specific focus on the areas listed below, and further actions agreed should gaps be identified.

- Recording and processing of referrals to the Multi Agency Safeguarding Hub (MASH).
- Development of a culture within the MASH to foster collaborative decision making and effective partnership working
- Multi-agency response to peer-on-peer abuse
- Promotion of working practice where professional challenge is fostered and welcomed.
- Effective use of professional escalation and disagreement policy
- Clarity among partners about process to convene a strategy meeting
- Development of critical reflection and managerial oversight when working with young people who have alleged peer-on-peer abuse
- Provision of support to all young people involved in peer-on-peer abuse including alleged perpetrators
- Professionals work creatively to communicate directly with young people rather than through a parent or carer
- All professionals provide an opportunity to see young people alone without parent and carers and ask clear and direct questions when exploring sexual activity
- Education- Revised Peer on Peer guidance published and disseminated to education establishments.

Recommendation 2

The safeguarding partnership seeks assurance that the views and experience of young people involved in peer-on-peer abuse and their parents/carers inform practice improvements.

In the year since these reviews were completed there has been a focus on improvement in areas of work which were highlighted in the reviews:

- Family Front Door (FFD)-Review of Decision making. All Multi-Agency Referral Forms (MARFs) now overseen by a Social Work Manager-Comment from a WVT Team Leader-‘...whilst there has been an increase in Strategy meetings, these do seem to be about the right children.’
- Multi-agency Safeguarding Hub (MASH)/Decision Making-A MASH Strategic Group has been established. Plans in place to co-locate MASH- building identified and Partners have agreed to fund move.
- Challenge and Escalation-Raised awareness and collate data on use of resolving professional differences policy
- Right Help Right Time (RHRT)-Training has been delivered across the multi-agency workforce. A rolling programme of training continues.
- Culture-professional development work across the system with a focus on Leadership

These areas of improvement are part of the development work which is being undertaken through the various priority work streams of the Partnership. In addition, Neglect is a priority for the Partnership.

SCR Matthew

Matthew was 19 months old when he ingested medication while he was at home in the care of his parents. Whilst Matthew survived the incident, a Serious Case Review (Working Together, 2015) was commissioned due to the serious harm that occurred to Matthew when he ingested the medication.

Recommendations were made respect of:

1. The Framework of need and pathways- understanding and agreement in the application of thresholds of all levels of need and that referral pathways are clear and understood. That both Child in Need and Child Protection Plans and processes are robust, outcome focused and clearly understood and owned by all agencies.
2. Multi-Agency Safeguarding Hub – to develop one access point, that there is robust and consistent management oversight. That the functions are collaborative and there is a clear and understood collective responsibility. To ensure that information is shared to make effective and safe decisions including in domestic abuse cases. (See CSPR Peer-on-Peer).
3. Neglect – The multi-agency responsibility to identify and respond to all aspects of neglect. To include educational and emotional neglect and the effect on children of non-dependent alcohol use in the parents; domestic abuse; and understanding the role of fathers/males in the household.

How do we know we have made a difference?

Development Work in respect of the recommendations and learning points from SCR Matthew and CSPR Peer-on-Peer Abuse has included the following actions to improve practice and improve outcomes for children:

- Awareness of specialised agencies relating to harmful sexual behaviour and peer on peer abuse is raised amongst external professionals, via the Herefordshire Safeguarding Newsletter and webpages; and dissemination via agencies:
 - West Mercia Women’s Aid Crush Programme is commissioned to support children and young people in developing healthy relationships The group’s purpose is to expand young people’s understanding of unhealthy relationships, the impact of abuse and gender-based bullying. WVT have implemented CRUSH training for the Public Health Nursing Team.
 - Safer Streets 3 Home office funding has been awarded to Herefordshire of £515k. Over £105k is dedicated to a full-time Purple Leaf West Mercia Rape and Sexual Abuse Support Centre (WMRASASC) worker and a full time Women’s Aid worker to provide inputs to university, sixth form colleges, high schools and some primary year groups. These will feed into the Child Exploitation/Contextual Safeguarding group to shape and influence any learning.
 - Purple Leaf is a resource designed for children and young people aged from 8 to 18 years. The Purple Leaf Education Programme (funded by West Mercia Police and Crime Commissioner) increases young people’s awareness of sexual abuse and exploitation, both on and offline. It equips them with the skills, knowledge, and tools to be able to identify healthy and unhealthy relationships and behaviours, including Peer on Peer abuse; and to know where to go for help and support. Training is offered to professionals to enable them to support young people as part of the programme.
- Seeing young people alone:
 - Within education it is standard practice when dealing with disclosures to see the child alone.
 - Health professionals, such as GPs, have been sent the learning regarding creating opportunities to see young people alone and to ask clear and direct questions when exploring sexual activity. Also, to consider pregnancy testing if possibly indicated from questions, and if clinically indicated in relation to abdominal pain/discomfort, urinary issues etc. GP Practices have given examples where this learning is shared in the practices vulnerability meetings and where it has been used to change practice.
 - HWHCT developed protocols around virtual consultations to minimise risk and maximise opportunities for disclosure.
 - WVT have implemented a new Standard Operating Procedure (SOP) related to pregnancy testing and questioning of young people who present as pregnant.
 - A Herefordshire and Worcestershire wide conference looking at Exploitation was held in May 2021. Feedback from the event was overwhelmingly positive, with attendees making commitments to how they will use in their practice and how they will share the learning.

Domestic Abuse and Domestic Homicide Reviews

- Building on previous learning regarding Domestic Abuse, presentations have been made at the Practitioner Forums held during the last year.
- During the White Ribbon Campaign a multi-agency domestic abuse conference was held using HWCCG funding to commission nationally renowned speakers.
- Piggybacking onto the work HWHCT have done around asking about Domestic Abuse asking if children feel safe at home and looking at interactions within the home for anything that will raise alarm bells. So far has led to an increase in DASH (domestic abuse, stalking and 'honour'-based violence) risk assessments being completed.
- Multiagency Domestic Abuse Training has been commissioned.
- Learning briefings, and presentations have been shared at the Practitioner Forums to raise awareness of the learning from SCR Matthew and learning from Domestic Homicide Reviews (DHRs).

Case Reviews and the Voice of the Child

The voice and views of the child and family feature strongly within the Child Safeguarding Practice Review (CSPR) process. Where children are not able to express their voice themselves, then their lived experience and 'voice' are threaded throughout the report. The JCR Group ensure that engagement with children and families is central to the review and that their voice and views are sought and properly reflected within the final report and conclusions.

As aforementioned the HSCP was successful in its application to the DfE in July 2020 for a grant to enable the partnership to have a dedicated resource to seek the views and experience of young people to inform its work. This project used a range of online platforms increasing the number of perspectives heard-over 300 children completed the survey. It is too early to evidence impact from this project at the time of writing.

Children and young people along with HSCP Leads took part in a Takeover Challenge Day on December 3rd. Its purpose was to seek the views of children and young people and involve them in the work of the partnership.

National Learning

The influence of the work of the JCR Group on the development of our services to children and young people, and the systems for keeping them safe, is evident in the collective approach to the wider 'Keep Me Safe' strategy:

In September 2021 the National Review Panel published a report titled, *'The myth of invisible men: safeguarding children under 1 from non-accidental injury caused by male carers'*. The review set out the findings from its thematic review on safeguarding children under one from non-accidental injury caused by male carers.

This will be incorporated into our multi-agency approach to safer sleeping and the on-going work related to a *National Panel report: Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm'*, published in July 2020.

This will form part of a wider '**Keep Me Safe**' strategy. It is important to note the development of which is joint work with Herefordshire and Worcestershire Child Death Overview Panel and Worcestershire Safeguarding Children Partnership. Colleagues from across both counties have been meeting to develop the strategy and themed work but have ensured key information and free resources have been disseminated to parents and practitioners whilst the funding and additional resources were being sourced. The **ICON Programme - 'Babies Cry, You Can Cope'** - will be purchased by 31st March 2022 and implemented in the following months-free resources are already in use. ICON is a recognised programme with training and resources for multi-agency practitioners to support parents of babies under one with brief interventions.

What do we need to do now?

- Ensure MASH is co-located-Joint work is ongoing with Police, HWCCG and Local authority regarding the IT infrastructure is in place.
- The Partnership acknowledges we need to embed a model of early help across partnership.
- Continue to address peer on peer abuse through multiagency contextual safeguarding (existing work stream of the HSB Group).

- The revised local multi-agency guidance for peer-on-peer abuse was published in December 2021. An implementation plan for awareness raising commenced in January 2022.
- The findings from the Audit, have been taken forward as part of the Improvement work within the Family Front Door (FFD) and Multi-Agency Safeguarding Hub (MASH). A follow-up Audit later in 2022 will review whether Strategy meetings are consistently being convened for all children, whether victim or alleged perpetrator.
- Further work will be undertaken through the Quality and Effectiveness subgroup to ascertain whether the learning shared at the Practitioner Forum in February 2022, the updated multi-agency peer-on-peer guidance and other improvement work have led to the desired practice change and to provide evidence of impact.
- Improve engagement with Father's and Men (Linked to the work streams in respect of the Keep Me Safe when I'm Crying Strategy, including ICON; and Dad's Pad and work within the Local Maternity Neonatal System-LMNS).

Challenges for the JCR Group

Throughout the year, the partnership has implemented the recommendations and taken action to address the learning from these reviews, as well as continuing to monitor progress of actions relating to recommendations from earlier reviews. However, implementation, progress, traction and pace has not been where we would have wanted.

The JCR Group, as part of the wider partnership, has faced challenges and difficulties:

Application and interpretation of Working Together 2018 Guidance:

The application and interpretation of the Working Together 2018 guidance around conducting Rapid Reviews and Child Safeguarding Practice Reviews, led to challenge from the Independent Scrutineer. The JCR members contributed to a reflective learning and development session, led by the Independent Scrutineer, JCR Chair and Interim Safeguarding Partnership Policy & QA Lead. The session was undertaken to explore how to strengthen how statutory and relevant partners analyse their individual and multi-agency practice in serious child safeguarding cases; to provide clear guidance on roles and responsibilities and improve how all members contributed to the Rapid Review and CSPR processes, in meetings and outside of formal meetings; including contributing to the Rapid Review Report sent to the National Panel.

Action taken to address:

- Governance processes have been strengthened, including updating the Terms of Reference,
- Review and revision of the rapid review and CSPR processes,
- Revision of the media and communications protocol; strengthening the planning for publication of reviews.

Evidencing the effectiveness of learning:

Evidencing the effectiveness of learning from reviews has remained a significant challenge for the partnership. The Partners asked the Scrutineer to focus on this area of work as one of the actions in the Annual Scrutiny Plan. As a result, the Independent Scrutineer reported to Safeguarding Partners, that where the safeguarding partnership has implemented multi-agency recommendations, the evidence to demonstrate progress and impact of changes made due to the learning, was not always evidenced. There was a lack of evidence demonstrating the effectiveness of learning from previously published reviews and there was a challenge to the closure of some actions. In addition, many recommendations relate to process, rather than meaningful change to practice that will lead to improvements that have a positive impact for children, young people and families.

The Safeguarding Partners recognised that learning from case reviews, as well as performance data, audit activity, scrutiny activity and feedback from children, young people and families; was not robust. For example, planned audits were overdue, or did not reflect accurately the effectiveness of the safeguarding system, the annual plan of scrutiny had not been developed until mid-2021; and performance data was either of poor quality or not routinely shared by relevant agencies. Therefore, the information could not be triangulated to provide an overall view of the effectiveness of the multi-agency safeguarding system and we were unable to consistently provide evidence of the effectiveness of the learning and improvement cycle, particularly following learning from reviews.

Action taken to address:

- The Quality and Effectiveness Group, has assumed responsibility for oversight and monitoring of the multi-agency recommendations and the action plans from the reviews.
- Developing a meaningful data set has continued to have challenges.
- A new approach is being taken to seek data to establish the level of assurance in the priority areas and using audit to triangulate data and address gaps in data.
- This area of work also has one of the 3 Partners as a 'sponsor', to provide leadership, support and oversight.
- The JCR Chair and Quality and Effectiveness Chair have met and reviewed the multi-agency action plans to ensure there are clear work streams and ownership of actions from reviews. There is one 'Master' copy with all reviews in one place.
- Single-agency recommendations and actions taken are threaded throughout the JCR section of the Annual report. However, the group is working to better evidence partnership effectiveness through improvements made and evidence of impact.
- Improved timeliness of producing and disseminating learning briefings following completion of reviews. These are published on the Safeguarding Partnership webpages and in the Partnership Bulletin.
- Single Agency and Multi-Agency Learning is disseminated by JCR members within their individual agencies/organisations.
- Bite size learning presentations produced (to add depth to the learning briefings) along with presentations at the Practitioner Forum.
- The Section 11 Audit will capture internal governance of individual agencies for dissemination of learning.

Some of these issues were compounded due to the impact of the Covid-19 pandemic and the impact of the High Court Judgement on the system (including several changes to Leadership of children's services, interim consultants, difficulties recruiting to the general workforce and resultant changes to the long-standing membership of the JCR group). Whilst these impacted across the partnership, and the work required to support learning from reviews; the Partnership recognises that we need to improve in these areas.

Learning from Child Death Reviews

In line with the new guidance Herefordshire and Worcestershire CDR Partners made arrangements for all deaths of children normally resident in both counties to be reviewed by a single CDOP. From September 2019 the Herefordshire & Worcestershire (H&W) CDOP began operating as a combined CDOP and provided the structural framework for the independent review of all child deaths.

In the counties of Herefordshire and Worcestershire the current child death review partners are:

- Herefordshire Council (Public Health)
- Worcestershire County Council (Public Health)
- NHS Herefordshire and Worcestershire Clinical Commissioning Group

Child Death Notifications in Herefordshire 2019-2021

- Between 1st April 2019 and 31st March 2021, a total of 27 child death notifications were received for Herefordshire resident children.
- 48% of notifications were male and 52% were female.
- 56% of the deaths were expected and 44% were unexpected.

The modifiable factors identified are as follows:

- Smoking (parent/carer) or in household.
- Unsafe sleeping arrangements (such as not adhering to safe sleep guidance, smoking and substance misuse).
- Substance/alcohol misuse (parent/carer).
- Maternal obesity during pregnancy.
- Poor communication and information sharing.

- Quality of service delivery.
- Domestic abuse.

13. Learning and Development

Between April 2021 and end of March 2022, there were over **630 training spaces attended** on HSCP multi-agency safeguarding courses. When events and additional multi-agency courses (Early Help Assessment, Solihull Approach, and Domestic Abuse) were added, there were **1400 training spaces attended**.

In 2021/22, four new courses were added to the HSCP training programme, these were:

- Working Together to Safeguard Children (Level 2)
- Working Together to Safeguard Children (Level 3)
- Delivering substance use brief interventions with young people
- Signs of Safety

The HSCP currently offers the following courses to multi-agency professionals, which professionals can book through the online Learning Management System.

HSCP training programme 2021/22

	Course Name	About	Trainers
1	Contextual Safeguarding*	Contextual safeguarding is an approach to understanding and responding to, young people’s experiences of significant harm beyond their families.	Multi-agency trainer pool, led by Early Help & Child Exploitation team
2	Exploitation and Vulnerability	Understanding child exploitation and modern slavery, how to respond, record and report, and the use of non-victim-blaming language	Funded trainers from West Mercia police
3	Graded Care Profile 2	To understand, recognise and address child neglect, and to instruct delegates on the use of the Graded Care Profile 2 (GCP2) tool.	Multi-agency trainer pool, accredited for GCP2
4	Meet the Local Authority Designated Officer (LADO)	Herefordshire's LADO will explain his role, and the policies and procedures involved when an allegation has been made against an adult who is in contact with children while in a position of trust.	LADO
5	Right Help, Right Time	Introducing Herefordshire's Right Help, Right Time procedure and the thresholds need – 4 levels of need that services and professionals will use to ensure the right help is provided at the right time to the right children, young people and families.	Multi-agency trainer pool

6	Signs of Safety 2-day multi-agency course	To get to know the Signs of Safety approach in children's social care	SofS consultant
7	Signs of Safety refresher courses	For multi-agency practitioners who have attended Signs of Safety training, to have a refresher on the basics of the approach and opportunity to discuss and reflect on where they have used the approach with children & families	SofS consultant
8	Delivering Substance Use Brief Interventions for Young People	A discussion-based course learning specific skills to engage young people around their substance use and work with ambivalence.	Turning Point
9	Working Together to Safeguard Children (Level 2)	An introduction to the different types of neglect and abuse, the legislative framework for child safeguarding, making a referral, challenge, curiosity, information-sharing, and much more!	Funded trainers from West Mercia police
10	Working Together to Safeguard Children (Level 3 DSL / Named Person)	A more advanced training on child safeguarding for Designated Safeguarding leads and Named Persons	Funded trainers from West Mercia police

*Contextual Safeguarding courses were cancelled in 2021/22 due to a lack of trainers. A trainer pool has now been identified and the course materials are being reviewed, with an expectation that the course will resume from June 2022. The courses below are also available to multi-agency professionals via the Learning Management System, although they are not HSCP-led.

Additional courses offered by single agencies to multi-agency professionals

	Course Name	Content	Lead
11	Early Help Assessment Support and Guidance	A chance for practitioners to receive support to write an early help assessment via the Early Help Portal.	Early Help
12	Early Help Assessment - Assessment Skills and Guidance	Additional training, following EHA - Support and Guidance, to support practitioners to write good quality Early Help Assessments	Early Help
13	Fabricated and Induced Illness	Full interactive multi agency study day covering all aspects of fabricated and induced illness in practice. Includes current guidance, international practice, legal cases, child practice reviews and case studies.	H&W NHS CCG
14	Solihull Approach 2-day foundation course	For any practitioner working with babies, young children and school-aged children, young people and their families	Public Health
15	Domestic Abuse Multi-agency Training "Curiosity Saves Lives"	For practitioners, professionals and those that wish to learn more about the impact of domestic abuse and how to initially support a victim/ survivor.	Community Safety Partnership

The HSCP, Herefordshire Safeguarding Adults Board, and Community Safety Partnership, also run **learning events** during the year:

- **Practitioner Forums:** 3-4 times per year, ½ day virtual event covering different safeguarding topics to help multi-agency professionals stay informed of new development and reinforce safeguarding messages. Typically attended by 70-100 professionals.
- **White Ribbon Domestic Abuse Conference:** November 2022 Once per year, 1 day virtual event, joint with Worcestershire, about new developments, services and supporting victims of domestic abuse. Typically attended by 150-200 professionals. In 2021, this event will expand its scope to include Violence against Women and Girls (not only domestic abuse).
- **Child Exploitation Conference:** May 20221 Has run once per year for the past 2 years, 1 day virtual event, covering contextual safeguarding topics, new developments, prevention, services and support for victims of child exploitation. Typically attended by 200-250 professionals.
- **Serious Organised Crime Professional Development Day:** July 2021 Led by the Community Safety Partnership, this event highlights the threat serious organised crime poses to vulnerable people, young and old, and how everyone has a responsibility to identify, report and jointly combat serious organised crime. In 2021, 72 professionals attended this event.

The HSCP also publishes learning resources (7-minute learning, learning briefings, etc.) on its website and via the fortnightly Partnership Bulletin, with a mailing list to over 700 contacts. In 2021/22, the HSCP published thematic learning resources about:

- Peer on Peer Abuse
- Routine domestic abuse enquiries
- New partners in a caring role
- Safeguarding children from non-accidental injury caused by male carers
- Abusive Head Trauma in children

Attendance at multi-agency courses and events 2021-22

Events (01-04-2021 to 31-03-2022)	Number of courses run	Attended	Offered Places
Contextual Safeguarding	1	11	20
“Curiosity Saves Lives” – Domestic Abuse Multi-agency Training	4	93	116
Delivering substance use brief interventions: Working with Adults & Young People	3	17	27
Early Help Assessment Support & Guidance	11	59	220
Early Help Assessments - Assessment Skills and Guidance	3	47	120
Exploitation & Vulnerability	8	63	370
Graded Care Profile 2 (GCP2) Training	6	52	88

Joint Herefordshire and Worcestershire Child Exploitation Conference	1	226	300
LADO Training	6	45	120
Learning Briefing - Voice of the Child	1	37	100
Practitioner Forum - September 2021	1	80	200
Practitioner Forum - February 2022	1	80	200
Right Help Right Time	7	96	140
Signs of Safety Refresher Workshops - For Multi-Agency Professionals	2	4	40
Signs of Safety training for multi-agency professionals	12	186	300
Solihull Approach 2-day Foundation training	4	26	58
White Ribbon Domestic Abuse Conference 2021	1	153	400
Working Together to Safeguard Children – Herefordshire (Level 2)	6	114	180
Working Together to Safeguard Children - Level 3 for Designated Safeguarding Leads / Named Professionals	1	19	23
TOTAL	79	1408	3022

The focus of work through 2022-2023 is to strengthen processes to be able to ascertain the impact of training on improving practice and outcomes for children.

14. HSCP Strategic Priorities and HSCP Business Plan 2022-2023 Year 2

Use the link to see more details in relation to the 3 year [HSCP Strategic Plan 2021-2024](#). The HSCP priorities for the second year of the strategic plan remain the same. A separate business delivery plan has been agreed and will be implemented by the HSCP sub-groups. The following plan on a page summarises the agreed business plan.



15. Evaluation of effectiveness of the HSCP



Kevin Crompton
Independent Scrutineer
From September 2022

As the new Independent Scrutineer my comments below are based on the content of this Annual Review rather than any observation of the partnership at work over the period of this annual review. I have where possible though included views based on evidence from other written documents and regulators reports on the work of the HSCP.

‘The role of the Independent Scrutineer is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area ...’ (Working Together 2018). The exercise of this function sits alongside the wider system of inspection and regulation of such services. The arrangements for independent scrutiny are made locally by the Safeguarding Partners and in Herefordshire this is through the appointment of an individual. One of the functions of the Independent Scrutineer is to provide scrutiny of the annual report to ensure that it:

- Sets out what partners have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice,
- Evidences the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers,
- Provides an analysis of any areas where there has been little or no evidence of progress on agreed priorities,
- Details the decisions and actions taken by the partners in the report’s period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements,
- Sets out the ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

Comments on the Effectiveness of the Multi-Agency Safeguarding Arrangements

The partners acknowledge the hard work of all those involved in the work of the partnership particularly in the post covid period which has left some challenges in terms of children’s needs and working patterns.

Overall, the report recognises that there is a need to 're-set' this partnership in order to improve its effectiveness in meeting statutory responsibilities and the overall requirement that local arrangements are effective in safeguarding children. To this end the partnership made changes during the year to governance by revising its sub-group structure and introducing an Executive Support Group – chaired by a senior officer from the partners to be the 'engine room' of the partnership and ensure that the priorities of the safeguarding plan are delivered. The report accepts that the impact of these arrangements has yet to deliver the expectation that the pace of change will accelerate.

There is little analysis of the effectiveness of the partners' arrangements in safeguarding children. There is, for example, no data on attendance at key meetings e.g., Strategy meetings. This makes it difficult to formulate a judgement on effectiveness of the arrangements as described in this report.

Section 8 is however more open and honest about key challenges facing the partnership and provides much more insight into the work in parts of the system. The section on early help and the Conference and Review Service report (including Independent Reviewing Officers) both illustrate some reflection on what is working well; what needs to be improved; and set a useful benchmark for work in 2022/23.

Similarly, the partnership has yet to resolve the issues identified in the review of the Partnership Team concluded in December 2021, indicating that this will be addressed during 2022/23.

Progress against Priorities

This pattern of the outcomes of work done in the 2021/22 year having impact in 2022/23 is repeated in respect of the neglect priority. Whilst the focus provided by a neglect subgroup is an improvement, Partners acknowledge it has yet to make an impact on practice and the lived experience of children, young people, families and carers.

More progress is identified in respect of 'Right help – right time' and that 93% of MASH decisions meet threshold is indicative of improvement during the year. Even so there are further changes identified as being needed to improve the workings of the MASH e.g., co-location of key agencies.

A range of activity is identified against Priority 4 – Child Exploitation, but little is said about the impact of this activity in keeping children and young people safe from exploitation.

Partners' assessment of the effectiveness of arrangements is set out in the report and the picture provided of safeguarding in schools is positive. The use of audits in schools where safeguarding concerns are reported is good practice.

The No Wrong Door project is a really encouraging part of this report as it illustrates that partners recognise the necessity to respond to children and young people's needs particularly during this post Covid period which has seen for example the mental health concerns of young people rise to an all-time high. It is unfortunate to note that the project has now concluded as funding for an extension could not be found.

Individual sections about the safeguarding partners evidence some thinking about what is working well and what needs to change. It is not clear though how many of the activities mentioned in these sections are single rather than multi agency actions deriving from the Working Together 2018 governance arrangements.

The report outlines the work undertaken to listen to and understand the voice of children and young people, includes links to podcasts, and provides other examples of direct feedback from them.

Conclusion

Overall, the report meets the requirement as set out in Working Together 2018 but the key conclusion that I draw is that there is much work either in progress or about to start that is trying to address the challenges to the partnership, some of which are identified in this report. I think the report indicates that partners understand that there is a need to improve the effectiveness of the partnership and whilst some work has commenced this is the beginning of a journey.

The introduction to the report makes mention of the ‘much anticipated Ofsted inspection of children’s services.’ This took place in July 2022 and is outside the timescale for this annual report. Nevertheless, it is relevant to this annual report in that Ofsted’s findings reflect the period covered in this report. Ofsted have judged children’s services to be inadequate in all four areas and make a number of findings that challenge the effectiveness of the safeguarding arrangements and practices of partners. In brief:

- Partnerships are underdeveloped and ineffective
- Multi agency arrangements governance is ‘weak’
- Multi agency arrangements within the Multi Agency Safeguarding Hub (MASH) are not effective
- Partner participation in key processes is not good enough
- Data, including that on the effectiveness of partnership working, is poor
- Collective responsibility for the effectiveness of arrangements needs to be improved

Taken together, these two reports confirm that the Herefordshire Safeguarding Children’s Partnership is not as effective as it should be in safeguarding and promoting the welfare of all children. The partnership will, in 2022-23, need to reflect on whether the priorities identified in this report remain appropriate in the light of the Ofsted report and whether the partnership has the right governance, capacity and capability to effect meaningful and rapid change that will improve the lived experience of children in the County especially those who are most vulnerable.

Kevin Crompton
Independent Scrutineer
From September 2022