



Herefordshire Safeguarding
Children Partnership

Annual Review of Effectiveness Report 2022 -2023



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1. About the Annual Report

Working Together 2018 requires each Local Authority Area to establish local arrangements for safeguarding children and young people.

The purpose of these local arrangements is to safeguard and promote the welfare of children, and to work together to identify and respond to the needs of children in the area.

The statutory guidance states that the responsibility for these arrangements is between the Herefordshire Council, West Mercia Police and NHS Integrated Care Board (Herefordshire and Worcestershire). Other 'relevant' agencies also have a duty to safeguard children and young people under Working Together 2018.

The Herefordshire safeguarding arrangements are reviewed annually and can be found within Multiagency Safeguarding Arrangement (MASA) published on the Herefordshire Safeguarding Children Partnership (HSCP) website.

HSCP is responsible for Local Child Safeguarding Practice Reviews (CSPR's). This includes arrangements to identify serious child safeguarding cases, which raise issues of importance in relation to the area, and for those cases to be reviewed under the supervision of the safeguarding partners. CSPR's are published on the HSCP website unless to do so will pose a risk to an individual.

At least once in every 12 month period, the safeguarding partners must prepare and publish a report on what the safeguarding partners and relevant agencies for the local authority area have done as a result of the arrangements, and outline how effective the arrangements have been in practice.

This Annual Report covers and reports on activity between 1st April 2022 and 31st March 2023

The Annual Report provides information about the structures in place that support the HSCP to undertake its functions effectively.

2. Foreword – By SPB Partners

This is the annual report from the Herefordshire Safeguarding Children Partnership. The report covers the period from 1st April 2022 to 31st March 2023. The report provides information about the work and effectiveness of our local safeguarding children arrangements during this period.

Safeguarding is everyone's responsibility and for services to be effective each citizen, practitioner and organisation should play their part. In Herefordshire, all our partners are committed to working together so that every child and young person in Herefordshire is safe, well and able to reach their full potential.

This annual report highlights the collective endeavour that takes place across our partnership, to keep our most vulnerable children safe, and to make sure that they can be as healthy as possible.

In 2022/23 Partners recognised the need to make changes to improve the effectiveness of the HSCP given the outcome of the Ofsted Inspection of children's services. This report recognises the progress that the Herefordshire Safeguarding Children Partnership has made throughout the year.

As the HSCP Safeguarding Partners Board (SPB), we reviewed the arrangements of our Partnership to ensure they are right, taking opportunities to review processes and structures where appropriate. We have considered our model of independent scrutiny, case review process, Section 11-audit, and priorities, with a view to ensuring a positive impact for children and families in Herefordshire

We have also listened to feedback from our partners and the strong desire that exists to contribute to the direction of the Partnership. As we move forward, we are clear that we want to be assured that our role as the Partnership makes a difference to outcomes for children and young people. To do this we are increasingly focused on understanding the impact of the Partnership and our work. Where possible this is reflected in this report, but we are building our approach to data and reporting to enhance this.

We are also absolutely committed to learning from Local Child Safeguarding Practice Reviews, ensuring that learning is acted upon, with better oversight of implementation and impact. As a board, we are able to lend our strategic leadership to ensure that reoccurring and difficult issues are addressed.

We as a partnership accepted the Ofsted judgment of our Children Services as Inadequate in July 2022. In order to address some areas highlighted in the Ofsted Inspection Report and of the other pressures linked to increased levels of referrals, we recognised the need to review the front door arrangements in the Multi Agency Safeguarding Hub (MASH). This work reflected on the capacity and capability within the MASH, the commitment and resource input from partners and resulted in recommendations regarding call screening, better pathways, training, resourcing, systems, and an enhanced analytical capability such as the MASH dashboard.

The action plan to implement these recommendations is now well underway, for example:

- Partners have worked together to ensure there are no barriers to safeguarding children and young people in a timely and informed way.
- Effective systems have been established to gather information to decide the right level of support to offer children and young people.
- Parental consent is routinely obtained for undertaking agency checks.
- Multi-agency Information Sharing Protocols and issues of consent have been reviewed to establish shared ways of working to strengthen decision making and management oversight in response to children and young people at risk of harm and/ or requiring support as Children in Need .

We are disappointed that we have not yet been able to produce a performance dashboard, which remains an ambition. Despite the best efforts of the Partnership Business Team and the Quality and Effectiveness subgroup, the right data has not yet been provided by partners to enable the development of a dashboard. However, there is optimism that this can be delivered in 2023/24 following renewed support from the statutory partners.

While the Partnership has developed positively over the past year, it is still struggling to evidence the impact of the considerable amount of activity it undertakes. In the coming year, we aim to place a greater emphasis on demonstrating outcomes and impact from our work. Early signs of improvements were noted by Ofsted in the first monitoring visit (March 2023), which focused on the effectiveness of the MASH.

It is clear that the Partnership has made significant steps forward in the twelve months since the previous annual report, and we continue to build on our achievements to learn and to seek to improve the safeguarding children system where needed.

3. Herefordshire Context

According to the 2021 Census there are 33,846 children and young people aged 0-17 in Herefordshire. The total population of the county is 187,000, growing by 1.9% in the past 10 years. The population is ageing and the proportion of people aged 19 and under in the county has fallen in the past decade from 21.8% to 19.8%. Herefordshire is less diverse than the country as a whole – 96.9% report their ethnicity as 'white'. 84.5% of the local population were born in England – the next most common country of birth was Wales (5.3%) and Poland (1.8%).

As of 2021, Herefordshire is the least densely populated of the West Midlands' 30 local authority areas, and the fourth least densely populated amongst English Upper Tier Authorities.

Early Help

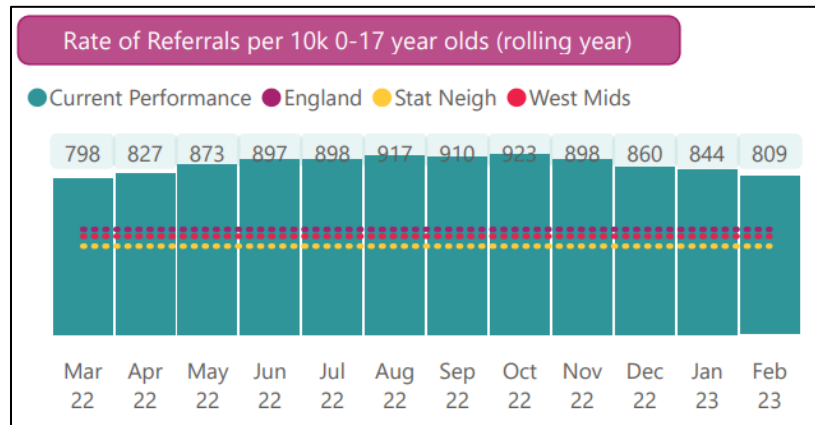
Early Help received between 205 and 368 contacts each month in the year 2022-23. The majority (over 80%) were screened within 72 hours, which allowed timely sign posting and support to children and families.

There is good engagement from partners with Early Help Assessment Plans, with a large proportion of Early Help Assessments being completed by partner agencies.

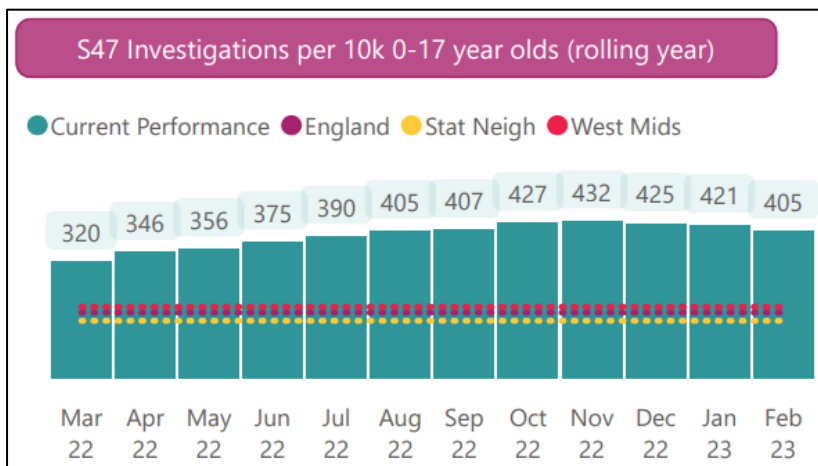
MASH Contacts and Referrals

The Rate of Referrals to the MASH has ranged somewhat between 798 per 10K 0-17 year olds, and 923.

The rate of referrals remains high when compared with our statistical neighbours.



Section 47 Investigations

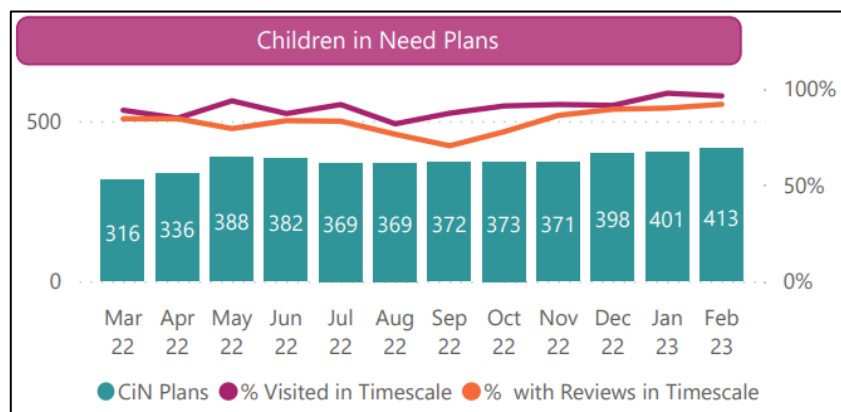


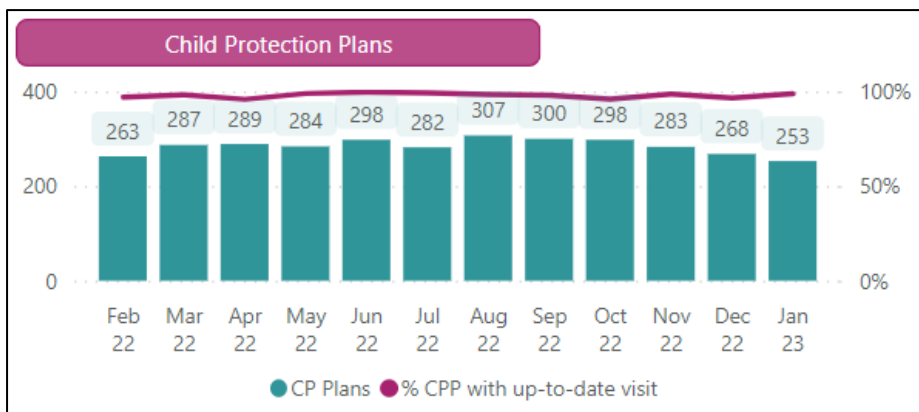
The number of s47 investigations peaked in November 2022, but has stabilised later in the year. The rate of s47 investigations is much higher than that of statistical neighbours.

Although only one in five (20.4%) of S47 Enquiries in February ended in an Initial Child Protection Conference; the year-to-date figure for this is 29.4%. This is not dissimilar that that of our statistical neighbours (31.9%).

Children in Need and Child Protection

The number of children in need increased during the year, and this is mainly driven by an increased number of children and young people being stepped down from Child Protection.

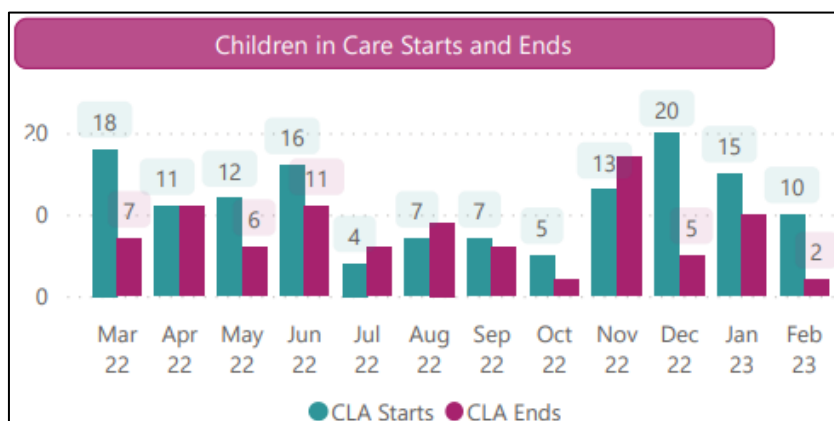




The number of children in on Child Protection Plans was at its highest in August 2022, and has since steadily decreased in the following months.

Children in Care and Leaving Care

The number of children coming into care increased slightly during the year due to the numbers of Unaccompanied Asylum Seeking Children (UASC) who arrived through the national transfer scheme, and a number of sibling groups being accommodated. Children in care reviews remained in the 90% – which is positive. We need to do more to ensure children and young people attend their reviews as their voice needs to be heard.



4. Herefordshire Safeguarding Children Partnership

The Herefordshire Safeguarding Children Partnership (HSCP) was put in place in response to the Children and Social Work Act 2017 and Working Together 2018 and replaced Local Safeguarding Children Boards (LSCBs). The safeguarding partnership is held to account by the Safeguarding Partners’ Board, which is formed of the three statutory safeguarding partners: the Police; the Local Authority; and the Integrated Care Board (ICB).

The HSCP is a statutory, multi-organisation partnership coordinated by the Partnership Team, which oversees and leads children’s safeguarding across Herefordshire. The main objective of

the HSCP is to gain assurance that local safeguarding arrangements, comprised of partner organisations, are working effectively, individually and together, to support and safeguard children in its area who are at risk of abuse and neglect and promote their welfare.

The partnership governance arrangements are detailed in the [Multi-Agency Safeguarding Arrangements](#) for the HSCP. The Safeguarding Partners are committed to the HSCP Pledge:

Our role is to keep children safe and give them a voice

Our commitment is to make sure everything we do works for children

We will make sure that children are at the heart of what we do

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

In 2022/23, the issues affecting children the most and, therefore, our priority areas remained:

- Right Help, Right Time
- Child exploitation
- Neglect
- Leadership & Accountability - Commitment to a high-level improvement plan.

The Board was supported by seven subgroups that carry out the day-to-day work in order to help deliver the Board's objectives and Strategic Plan.

Key Roles and Relationships

The Independent Scrutineer

Liz Murphy was the Independent Scrutineer and Independent Chair of the HSCP until June 2022 when she left the role. The then Superintendent of West Mercia Police, Edward Williams, took up the Chair function for the board after Liz's departure.

Kevin Crompton was appointed as the new Partnership's Independent Scrutineer and commenced in October 2022. The role of the HSCP Independent Scrutineer is set out in our Multi-Agency Arrangements to Safeguard Children.

The Independent Scrutineer provides a rigorous and transparent assessment of the extent to which appropriate and effective systems and processes are in place in all partner agencies so as to fulfil their statutory duties and ensure that children are protected and that appropriate safeguarding strategies are developed and embedded.

Key to this is the facilitation of a working culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements. The Scrutineer is accountable to the Chief Executive of the Herefordshire Council. He has retained a 'right to roam', challenging the statutory safeguarding partners and all relevant partners and agencies listed in our multi-agency arrangements.

HSCP Partnership Team

The HSCP is supported by the Partnership Team made up of Partnership Manager, a Deputy Manager, 2 Partnership Officers and 1.5 Business Support Officers. They ensure the smooth running of the Partnership's day-to-day business. The Partnership Team also supports the Herefordshire Safeguarding Adults Board (HSAB) and Herefordshire Community Safety Partnership.

Designated Professionals

The Designated Doctor and Designated Nurse for Safeguarding take a strategic and professional lead on all aspects of the health service contribution to safeguarding children. Designated professionals are a vital source of professional expertise. The Designated Doctor and Nurse have continued to demonstrate their value by offering challenge and support to partners.

Partner Agencies

All partner agencies across Herefordshire are committed to ensuring the effective operation of the HSCP. This is supported by the MASA that defines the fundamental principles through which the HSCP is governed. Members of the Partnership hold a strategic role within their organisations and are able to speak with authority, commit to matters of policy and hold their organisation to account.

Whilst being unable to direct organisations, the HSCP does have the power to influence and hold agencies to account for their role in safeguarding. This influence can touch on matters relating to both local and national arrangements.

5. Relationship with Other Strategic Boards

The HSCP does not operate in isolation, and there are a range of other multi agency partnership arrangements, which contribute significantly to the children's and adults safeguarding agenda and their respective priorities in order to influence the effective development and commissioning of services for the benefit of children, young people families and vulnerable adults. The HSCP recognises that it needs to strengthen its links with the other local boards and partnerships as we share many common themes, such as serious violence, domestic abuse and exploitation. There are clear benefits to children young people, families and vulnerable adults coordinating specific areas of business cross partnership. The Partnership's new independent scrutineer recognised this and in his preliminary findings to the board in January 23, whilst providing "some assurance" flagged up areas where there is a strong need to strengthen governance arrangements by enhancing the understanding of the partnership's roles and inter dependencies with other boards across the system. To further this ambition, the Safeguarding Partnership in 2023 will develop close structural relationships with the Health and Well-being Board, HSAB and Herefordshire Community Safety Partnership.

6. Governance and Membership

Governance

The HSCP, with the three statutory safeguarding partners, are 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
- Early Years and Education providers

The Statutory Partner members have joint and equal responsibility for the success 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, resulting in some revisions of the subgroups structure and remits. The HSCP new structural arrangement will come into being from 1st April 2023. The multiagency safeguarding arrangement (MASA) will be updated to reflect the new arrangements and the board's ambition to strengthen strategic and operational activity and improve effectiveness for the children and young people of Herefordshire.

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

HSCP Board

The children's safeguarding partnership is held accountable by the Safeguarding Partners Board. The Board meetings are chaired by the Independent Scrutineer who also undertakes the Independent Chair function. The Board is attended by the three statutory safeguarding partners as defined in Working Together 2018, and their deputies. Locally the three board members with delegated responsibility are:

- West Mercia Police – represented by the Superintendent Local Policing Commander for Herefordshire.
- Herefordshire and Worcestershire Integrated Care Board (ICB) – represented by the Chief Nurse
- Herefordshire Council (Children's Services) – represented by the Corporate Director Children and Young People and Statutory DCS. Director of Children's Social Care.

The Board's purpose is to:

- hold the Partnership to account for the performance in ensuring vulnerable children and young people are safe.

- allow discussion of priorities and commitment of resource amongst partners to promote safeguarding.
- identify any major concerns or areas for further investigation by the Partnership.
- agree funding arrangements and budgets for the HSCP.

The Board has met seven times over the course of the year:

21/04/2022	16/06/2022	08/09/2022	15/11/2022	16/12/2022	19/01/2023	15/03/2023
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In addition to the scheduled board meetings, there have been three Safeguarding Partners Extraordinary meetings:

Extraordinary Meeting 05/10/2022	Safeguarding Partners Board /Executive Support Group Development Session 16/06/2022	Leadership Development Day 03/02/2023
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These were convened to address emerging concerns and to provide leadership and traction to areas of the strategic plan, which had stalled.

Impact

The Board have made a number of key decisions during 2022 -23 including:

- Approving the HSCP Annual Report 2021-22;
- Approving the HSCP Training Programme 2022 – 23;
- Approving Child Safeguarding Review Reports for CSPR Peer on Peer, training slides and briefing notes;
- Approving the HSCP Strategic Business Plan 2021-2023;
- Approving Herefordshire Child Safeguarding Practice Review Practice Guidance and templates
- Appointing the Independent Scrutineer to Chair the HSCP Safeguarding Partners Board in October 2022

Executive Support Group (ESG)

The Executive support group is the partnership's engine room. It is held accountable by the HSCP and has a membership made up of representatives from all statutory partners as well as a range of key health, probation, education and community representatives. The group oversees the work of the subgroups which meet between the quarterly board meetings and scrutinises agency reports from across the Partnership. The agenda offers opportunities for information sharing and discussion, but also encourages questioning and challenge. The HSCP captures all challenges raised by the Independent Scrutineer/Chair and partners inside and outside of group meetings in a Risk Log. ESG regularly reviews performance through reference to its risk register, self-assessment process and partner agency updates submitted to each meeting.

There has been fluctuations around attendance, sometimes associated with changes of staff within agencies, which severely impacted on the group's quoracy and effectiveness for the greater part of the year. This led to a lack of momentum in the group being able to meet its objectives. In September 2022, following the inadequate grading outcome of Children Service's Ofsted Inspection, the Safeguarding Partner's Board decided to pause the Executive Support Group and to temporarily absorb the group's remit and function, in particular for subgroup chairs to report directly to the Board. This ensured clearer lines of accountability for the work of the subgroups. The new arrangement has had a positive impact on strengthening the links between the subgroups and the board.

7. HSCP Sub-Group Reports

Herefordshire Safeguarding Children Partnership is structured to provide collaboration, scrutiny and assurance, and to drive and enable coordination of safeguarding activity. Each sub-group has clear terms of reference and an annual work plan, which aligns with the strategic priorities for the partnership. Each work plan demonstrates golden threads to priority areas and impact on the lives of children and young people. Agendas and facilitative discussions at all meetings focus on safeguarding practice, impact and improvement. The Partnership Business Support Unit undertake the management and support function of the partnership. Task and Finish Groups are established as necessary.

Below is an outline of each subgroup, its priorities, and its achievements over the last year.

Joint Case Review Group

Heather Manning - Chair

Terms of reference - The Joint Case Review Sub Group (JCR) is accountable to the Herefordshire Safeguarding Partners, Herefordshire Safeguarding Adults Board and Herefordshire Community Safety Partnership.

HSCP have a legal duty to undertake reviews of serious child safeguarding cases (Local Child Safeguarding Practice Reviews LCSPR's) where children have died or suffered serious harm, the criteria for such reviews is set out in Working Together 2018.

Herefordshire Safeguarding Adults Board. The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult with needs for care and support in its area dies as a result of abuse or neglect, whether known or suspected, or is still alive but has experienced serious abuse or neglect, and there is reasonable cause for concern about how agencies worked together to safeguarding the adult. The criteria for such reviews is set out in the Care Act 2014 (See Care Act Guidance 2016). The Chair of HSAB has the responsibility for final decision making about whether to conduct a review in individual cases.

Overall responsibility for establishing Domestic Homicide Reviews (DHR) rests with the local Community Safety Partnership (CSP), under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)

Some 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 reporting period 1st April 2022-to 31st March 2023, the Joint Case Review Group (JCR) received two referrals for Rapid Review scoping, however the meetings were both held in Q1 2023-2024.

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

One statutory review was published during this period however this was a Serious Case Review and not a Child Safeguarding Practice Review as it was originally commissioned under Working Together 2015 guidance. There was some delay in completion and publication of this SCR due to parallel processes. Due to the timeframe involved in publishing the report and to reduce the risk of re-traumatising the family, the Herefordshire Safeguarding Partners are publishing an Executive Summary of the report only

SCR Louise – published November 2022

Serious injuries, which were sustained by Louise in June 2019, who was 18 months old at the time. The injuries caused had a life changing impact on Louise. When the injuries occurred, Louise was being cared for by her mother's partner at the mother's address. Prior to the incident, there were concerns about domestic abuse and child neglect.

Identified Learning Opportunities –

- Framework of need and pathways – To ensure that there is a joint 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.
- 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

effectively shared to make effective and safe decisions including in domestic abuse cases.

- Neglect – The multi-agency responsibility to identify and respond to all aspects of neglect. To include educational and emotional neglect and the effects of nondependent alcohol use by parents and the impact of these on children.

Key areas of partnership activity that HSCP should seek assurance on –

- Application of thresholds, to be undertaken by multi-agency audit.
- Escalation and professional disagreement policy.
- Neglect.
- Safeguarding of children in mental health services.

Further considerations –

- Training on the cycle of change and motivational interviewing.
- Escalation and professional disagreement.
- Recognition and prevention of abusive head injury in infants.

Positives and further implementation –

- The engagement of agencies in this review has been very positive; there has been a real demonstration of agency reflection to enable learning.
- The GP practice have held two internal learning events as a result of this case and their engagement in the discussion events for this process was excellent. As a result of internal discussion, they have introduced a template of safeguarding prompt questions, which are asked when any adult presents with low mood, depression or is prescribed anti-depressant medication. This was recognised as good practice and should be communicated to other GP practices.

Domestic Homicide Reviews (DHR)

During reporting period 1st April 2022-to 31st March 2023, JCR has received one referral for a DHR, which is currently undergoing a scoping exercise, work has concluded or continued for five open reviews.

Two DHR's completed in the previous year have now been approved by the Home Office. All recommendations have been completed. Two DHR's have been completed and sent to the Home Office following sign off at the Community Safety Partnership (CSP). Recommendations have been approved and action plans are in place to address these. The remaining review is awaiting the outcome of the court proceedings prior to completion and presentation to the CSP.

Safeguarding Adults Reviews (SARs)

During reporting period 1st April 2022-to 31st March 2023, the Joint Case Review Group (JCR) has received 7 referrals for Rapid Review scoping. Whilst none have met the Care Act 2014 criteria for a full Safeguarding Adult Review (SAR), learning and recommendations have been drawn from the scoping returns and rapid review meetings.

Examples of learning identified are -

- consideration for professionals recognising carers' and offering carer's assessments
- professional curiosity continue to be lacking in many practitioner/professional interactions with adults who do, or may have, care and support needs
- recognition of domestic abuse in relation to older people and their families and a lack of community awareness
- ensuring that the right people are invited to multi-agency meetings

SAR Dorothy was a Worcestershire review published in March 2023. 'Dorothy' had previously been a Herefordshire resident so Herefordshire services were part of this review.

Dorothy was 77 years old when she sadly died following a fall that occurred in the care home where she lived in Worcestershire. The fall was as a result of an altercation with another resident.

The admission to a care home and the incident took place during the Covid-19 pandemic and it was recognised that the impact of the pandemic was significant in finding a care home for Dorothy.

Points for strengthening practice, and recommendations were made and included agencies across both Herefordshire and Worcestershire, particularly in relation to commissioning out of area care and support services.

Oversight and follow on from last year

Extensive multi-agency work has been undertaken to ensure all the learning, both single, and multi-agency, from Rapid Reviews and case reviews, has been brought together to ensure recommendations have clear SMART actions assigned, and that all agencies are clear on the learning required within their own agency.

Learning briefings, and presentations have been shared at the Practitioner Forums to raise awareness of the learning recognised at all Rapid Reviews and full case reviews.

Evidence for the effectiveness of learning from reviews remains a challenge. Performance data, audit activity and scrutiny from the Independent Scrutineer is now more robust. The Quality and Effectiveness sub-group (HSCP) and the Performance and Quality Assurance sub-group (HSAB) are working towards a resolution regarding the data and audit activity in 2023-2024.

(Please note that all names used in this report are pseudonyms and not the true names of the individual)

Child Exploitation and Missing Subgroup

Rachael Gillott - Chair

To oversee and be assured that there is an effective response to child exploitation (CE) and other associated risks by partner agencies responsible for the management and delivery of services in Herefordshire. Other areas of risk and exploitation that this group will oversee will

be children missing from home or care, trafficking for the purposes of criminal exploitation, County Lines, modern day slavery, e-safety, and effective transitions between children's services to adult services

What has been achieved in the year?

For the year April 2022 to the end of March 2023 the Child Exploitation and Missing priority, sub group has seen a strengthening of commitment and engagement with renewed focus on ensuring Herefordshire's response to children and young people is effective.

Following the Ofsted Inspection in July there has been a review of the Multi Agency Child Exploitation (MACE) arrangements, the response to missing and identification of a contextual safeguarding model. After discussions with neighbouring authorities, it was agreed that HCC would move towards an adaptation of the Get Safe Model successfully used in Worcestershire. It was agreed this model would be adapted to include young people who were subject to a child protection plan due to being exploited, being offered a different plan termed a 'Get Safe plus'. This model would ensure a more tailored specific, young person focused plan, which would not stigmatise parents.

During the year, the Strategic Group met on 5 occasions, with a good level of attendance and engagement from Partners. This was initially led by the Service Director in Children's Services but after good engagement in September 2022, the group saw a change of Chair and Vice Chair. Key roles are filled with permanent staff and this means the agenda can be given focus by the right staff at the right level, for progress to be sustained.

Get Safe

The Get Safe programme commenced implementation in late 2022 with project management resource and a task and finish group meeting fortnightly with a clear implementation plan. This is mostly on track to fully launch the initiative in January 2024 following training in 2023.

A multi-agency exploitation conference will be launched in early November. Prior to the launch, multi-agency training will be delivered by the Local Authority and Partners to professionals around the completion of the Get Safe risk assessment and the process. The opportunity will also be taken to raise awareness around the Prevent agenda.

Get Safe will be a multi-agency approach to triage, assess and reduce the risk to young people from being exploited. Get Safe has been running effectively in Worcestershire and Herefordshire sub group members wanted to implement this initiative in Herefordshire. Get Safe is a contextual method of working, assessing the risk factors outside the family home that influence and impact on young people. The contextual approach enables practitioners to understand the full holistic picture of risk. A contextual approach will be demonstrated in Get Safe+ (once implemented) for young people that are assessed at Level 4 and would normally follow a standard child protection pathway. Get Safe+ will mirror child protection arrangements but will appreciate the contextual picture and will utilise a more proportionate, relational and restorative approach when the young person is being targeted and groomed by external factors due to matters beyond the control of the family. The family may have relentlessly been trying to keep their child safe. Get Safe and Get Safe+, when

implemented, will provide a complete pathway of support along the Right Help Right Time, Level of Need continuum.

The Herefordshire weekly exploitation meeting and our monthly Prevent and Disrupt group continued to meet during 2022/23. These meetings were reviewed earlier in the year and was initially found to work but over the year, the terms were found to be confusing and not used nationally. This has now been resolved.

MACE 1 is our weekly multi-agency exploitation meeting chaired by the Social Care Team Manager for the Safe Team. We have reviewed the terms of reference with the main focus being on the needs of children/young people, recognising they have a right to be safeguarded from exploitation and to discuss children/young people who are frequently missing.

MACE 2, previously Prevent and Disrupt is our monthly multi-agency exploitation meeting chaired by the police. The terms of reference have also been updated. This meeting identifies hotspots, perpetrators and groups of vulnerable children/young people.

The governance arrangements in place is Mace reporting into our CE and Missing sub group.

Task and finish group meetings took place in Quarter 4 of 22/23 to review the procedures and provision to ensure that young adults are kept safe when they transition from statutory child protection and early help support at 18 years, to no support/or support from statutory adult services only. Our current response is not yet fully coordinated or supported by partners. The next steps require wider strategic review of this as there is still much to do to keep young adults safe.

On a wider Partnership perspective, members of the Child Exploitation and Missing Group have contributed to the Herefordshire Community Safety Partnership (HCSP) Safer Streets campaign, which allocated grant funding in 22/23 to raise the awareness of child exploitation, inappropriate behaviour and vulnerability. During 2022/23 additional CCTV and street lighting was installed in CE hotspot areas and night time economy staff have been trained to support people that are at risk in Hereford at night.

In Quarter 4, the HCSP drafted the Herefordshire Sexual Violence Strategy (agreed in April 2023) incorporating reducing the exploitation risk to young people. Members of the CE and Missing sub group sat on the task and finish subgroup to inform and develop the 2023/27 Sexual Violence Strategy. The impact of this Strategy will be evaluated at a later date.

What are the challenges?

The challenges facing Herefordshire include establishing effective transitioning arrangements and support for young adults leaving children's social care support aged 18 to prevent them from being exploited.

The implementation of the new process has faced challenges due to capacity of staff and multi-agency partners, challenges around recording of data while trying to mirror Worcestershire practises. The implementation of Get Safe and Get Safe+ and establishing a new way of working with contextual safeguarding will be challenging over the next 12 months. It will need commitment to training and implementing the more restorative way of

working with young people and their families. This will need to be embedded across all partners and their response to this form of child protection. However, the Child Exploitation and Missing Sub group are confident the new approach will be effectively implemented.

A fast paced, strong and effective child safeguarding improvement plan for Herefordshire places demands on resources and personnel. Effective intelligence and information sharing, and case conference arrangements have been developed for 2023/24.

The data is currently primarily coming from within Children's Services and there is no up to date Risk profile for Exploitation with the last one done in 2019. The multi-agency data sets are also in place to support wider conversations.

What are we doing?

Get Safe and Get Safe+ will be implemented in 2023/24, training on Get Safe and Get Safe+ for all Partners and personnel in Herefordshire is programmed to start in November 2023. Multi-Agency Child Exploitation 1 and 2 (MACE 1 and MACE 2) terminology will be fully adopted aligning the Herefordshire system to other child exploitation approaches across the country. This include monitoring and responding to children who go missing.

What difference have we made?

It is difficult to evidence the impact of fast-paced change to the Herefordshire child protection framework and especially to keep young people safe from exploitation. Outcomes will appear over time. We now review all young people over 18 who are long term missing and this includes our response to unaccompanied asylum seeking children, UASC. We completed a review of all the young people who were on CP plans for contextually safeguarding and these were appropriately closed.

Comparative data from the Herefordshire Council Child Exploitation Team for the years 21/22 and 22/23 shows that more return home interviews have been carried out in 2022/23 and more children have been identified as vulnerable during that year. Risk exploitation and risk exploitation reviews have remained the same with only a slight increase in review meetings.

To strengthen this impact the focus is on gaining multi-agency data sets and impact.

Quality and Effectiveness Subgroup

Heather Manning - Chair

This group is central to changing and improving quality and effectiveness of multi-agency frontline practice. It will scrutinise the work and performance of the safeguarding partner agencies and other relevant agencies in delivering their statutory safeguarding responsibilities and in addressing any local safeguarding priorities identified.

The subgroup has endeavoured to remain active through a challenging period, which brought about some loss of continuity and organisational memory. Significantly, memberships at meetings declined due to changing personnel's within organisations (e.g. the group has had three Chairpersons).

Emphasis on multi-agency perspective has been encouraged and is evident in the recent activities of the group. Accomplishments include the 2022 Section 11 Audit to ensure partner agencies are fulfilling their responsibilities to safeguard children and promote their welfare, specifically picking up themes from recent serious case reviews.

The group has oversight of multi-agency and single agency audits, in order to analyse performance data consisting of quantitative information relevant to safeguarding children. The group has now absorbed the Multi-agency audit group functions into its remit to provide more leadership and accountability for this area of work.

Performance Data

There have been on-going and determined efforts from partners to develop a meaningful dataset to inform the group. The aim is to improve analysis capacity so that the partnership receives a multi-agency picture of activity related to the agreed priorities. Development of a partnership data set has continued to be challenging. Following changes in chair through 2022, it has now been agreed to start with a very small data set which is held by the local authority but which does contain multi-agency information. This will be kept under review. The work to improve the Q& E dataset will enable partners to have a more holistic view of safeguarding performance and support more meaningful discussion during the meeting. The review of the dataset will ensure that the performance data from across the partnership is available for scrutiny. This supports partners in understanding safeguarding effectiveness, and in identifying any gaps in safeguarding provision so that we are clear on where to target improvement activity.

These initial data strands have been agreed as –

- Contact by source and referral by source to include the conversion rate per agency
- Strategy discussion by agency involvement,
- Strategy discussion resulting in s47 enquires
- Assessment outcome - CIN, accommodation, and No Further Action
- Child Protection Plan – total figures and category

Initial data discussion has started but it is noted that further detail is required to ensure data is accurate and can therefore effect system change. The members will all have sight and input into the performance dashboard to capture the key performance indicators of each service and intervention they provide. Moving forward, there will be specific meetings focusing solely on the narrative of this data in the aim of capturing what is or isn't working well and why. This will thus inform the directive for the group to explore. The group has continued with its multi-agency audit plan by employing regular health checks as a standing agenda item. This means agencies provide internal audit briefings to the subgroup via diary invitations to partner agencies for them to present. This has proved useful in highlighting any concerns in the aim to assist with good practice.

What has been achieved in the year?

- The audit group has now been subsumed into the QE subgroup.
- The regional audit tool for Sec 11 and The Care Act was finalised and has been completed by all relevant agencies.

- The walk the floor proposal and proforma for reporting were finalised and some visits have taken place.
- The HSCP Escalation process is robust and QE subgroup members have oversight of all escalations and outcomes to ensure any themes are acted upon

What are the challenges?

- Procurement of a permanent chair and vice chair
- Agency attendance has been variable and inconsistent at times.
- Robust multi-agency data set to include analysis and narrative.
- Delays in completing the Neglect Task and Finish group work – this has now been subsumed into the work of other subgroups.
- The Interim Neglect strategy is required to be finalised to become a 3 year Neglect Strategy.
- The merging of the audit subgroup with Q & E has been a challenge in terms of agenda size and limitations of time
- Time to spend understanding and analysing information in relation to QA activity and performance data has been challenging.

What are we doing?

- From 2023, a permanent chair is in place with a permanent vice chair. This will enable clear and consistent work to take place, which includes data set analysis, audit work and analysis and evidencing impact.
- The dataset will be grown to include information, as relevant, from partner agencies.
- A work plan of audits is in place for 2023-2024

What difference have we made?

The safeguarding partnership has historically had a lack of multiagency dataset and strategic analysis. We are almost overwhelmed with data, despite the knowledge of how much data individual agencies collate. The request will be made in 23/24 for a dedicated safeguarding children analyst to provide a richer interpretation of intelligence to safeguarding partners by way of producing succinct, timely strategic threat assessments that will strengthen decision making, improve the scrutiny of front-line safeguarding practice and enhance tactical decision making, which will in turn impact on front line practice. This will ensure we are able to fully understand and analyse the impact the partnership is having on the lives of children and their families across Herefordshire. There has been a journey around how performance is reported and analysed with a multi-agency lens. This led to further discussions around multi-agency audits and its inter connection with the Q & E group. This partly informed the decision for the audit subgroup to merge with Q & E.

Neglect Task and Finish Group

Jez Newell - Chair

Neglect has been a priority for the Safeguarding Children Partnership for the past 2 years. We know we need to do more to identify child neglect, ensure that children have their needs met by their parents or carers, and provide support where this is not the case.

The interim Child Neglect Strategy and a delivery plan were launched in December 2022. These set out the strategic aims of the partnership: to improve the recognition of neglect in families;

to improve agencies' responses to enhance the approach to child neglect across Herefordshire, and to ultimately improve positive outcomes for children, young people and families.

Herefordshire is a Graded Care Profile (GCP2) implementation local area. GCP2 is an assessment tool, developed and licensed by the NSPCC, to help identify and measure risk of neglect. Herefordshire began rolling-out GCP2 in 2017. Under the auspices of the neglect subgroup, an internal review of GCP2 implementation was undertaken. The purpose of this review was to understand how the GCP2 is used in Herefordshire, and what impact it is having on improving outcomes for children and families.

This review considered:

- GCP2 training between 2017-2022
- Online survey of GCP2-trained practitioners (160 practitioners contacted)
- GCP2 Mosaic case records up until Feb 15, 2023
- Dip sample of 10 cases from 2022 where Mosaic records showed that GCP2 had been completed

Findings from the review, whilst encouraging, recognised that more needed to be done to strengthen its use and evidence impact. From a peak in 2021 of training attendance and case records with GCP2 recorded, training and usage has since dropped. This could be in part due to training being delivered virtually after the first Covid lockdown in 2020 (some courses have now returned to in-person), and due to staff turnover.

There is evidence of GCP2 being used and having a positive impact for children in Herefordshire; however, this is not consistently embedded. Practitioners identified that the tool helps to focus the concerns around neglect and helps the parent/carer to understand those concerns, the impact that it is having on the child, and what needs to change. Application of GCP2 is, however, inconsistent and vulnerable to staff turnover. GCP2s are sometimes completed in isolation, with no evidence that the findings informed plans for the child or that the GCP2 was reviewed later in the child's journey. GCP2 trainers and practitioners who responded to the survey identified a need for refresher training to improve the quality of GCP2 application.

Some professionals reported not using GCP2 because their role does not involve direct work with families or visiting the family home. Education professionals who completed GCP2 training, in particular, reported this as an issue. GCP2 trainers explained that they suggest professionals in similar roles can complete a desktop GCP2 to help with their analysis/screening of neglect concerns, however this does not appear to be a widely used approach based on survey responses. In light of these findings, an action plan is now in place, which will be completed in 2023, overseen by the Development and Practice Group. This adopts the recommendations that were identified to strengthen the impact of GCP2 in Herefordshire. Briefings to report on the findings and recommendations have been done aimed at improving understanding across all agencies of the potential impact on children and young people who may suffer from, or be at risk of, neglect.

Examination of data on neglect, both locally and nationally, remains a work in progress. The clarity of the current data availability remains poor and further multi agency work is required to improve this.

The Neglect task and finish was concluded in March 2023 with ongoing work on finalising the Child Neglect Strategy, and neglect dataset being picked up by the Quality and Effectiveness Group and the Development and Practice Group taking on neglect training and tools. For a significant part of the year, there was a considerable lack of momentum in progressing the neglect task and finish group's work plan. This was primarily due to poor attendance and commitment at sub- groups. Key partners do not attend or are unable to attend (due to capacity). Other key partners attend and support the work; however, without the required consistent quoracy input from Children's Social Care and Public Health work is unable to be progressed. A 'back to basics' workshop is planned for June 23 which will address some of these issues of attendance and effectiveness of sub groups.

Audit Subgroup

Bec Haywood-Tibbett - Chair

The Audit sub-group is a sub section of the Quality and Effectiveness group. There was an auditor's reflective development session held on the 23rd of June 2022 to strengthen the group's effectiveness. The aim was primarily to provide a robust and consistent approach to assessing the quality of multiagency or single agency practice of case records and particularly in relation to safeguarding practice. This was a good attendance and engagement from group members.

However, no multi-agency audit was undertaken following on from this. As the audit subgroup was dormant for the majority of 2022 until it merged with the Quality and Effectiveness group in September 2022. Consistent agency commitment and engagement with the work plan from the group has been a challenge. This inertia was plagued primarily by capacity issues within all agencies to attend meetings consistently whilst meeting the demands of own organisations. Members when they do attend engage well with the subgroup priorities.

Mash Strategic Group

Rachael Gillott - Chair

The key priorities for this group were

- That the service has a strong, robust front door aligning to partnership 'Right Help Right Time' agenda.
- The development of an integrated effective and efficient MASH is a key priority for the partnership in response to recent evidence of the need to refresh the current provision
- To drive the work priorities for the MASH operational group which oversees monitoring of implementation for threshold and use of RHRT
- Drive the agenda for an integrated MASH with new operating procedures, review of RHRT and training delivery across the partnership

- Commission the operational group to undertake audits of strategy meetings/ section 47 as part of its quality assurance function
- The group will oversee the re-launch of the new RHRT/MARF
- Ensure capacity and appropriate timely response to safeguarding

What has been achieved in the year?

- Co-location and working - The work to move all key departments into Wilson House took place during the Ofsted Inspection in July. There was immediate recruitment for two social workers and an additional team manager. At the same time, the assessment team duty social worker, their manager and exploitation team also co-located. The additional staff and the number of partners within Wilson House working face to face, proved problematic, the strategy room was not sufficient to meet need noise and heat levels were significant, and there was no available breakout space. It was agreed by all partners that MASH would return to Plough Lane with a dedicated space provided by HCC with a large strategy room. Subsequently additional staffing in health and other partners has enabled the MASH team to grow. In September, the police were also able to relocate with increased capacity. This decision although difficult at the time, has already evidenced improving relationships, with a more cohesive and productive atmosphere.
- A Management Action Note was issued advising that all Strategy Meetings should be completed, within 2 days and any that were over 3 days should be notified to senior managers. Police colleagues committed to attendance and capacity. A RAG rating scheme with timescales was introduced for all contacts and referrals and then these were latterly linked to the Power BI dashboards to ensure staff and managers had a clear timely response and oversight to risk.
- A Quality Assurance Framework for the MASH was put in place including regular audits to ensure assurance at all levels. There were initially weekly 'learning reviews' of all children where a decision has been changed, those subject to 3 or more referrals and any escalations. To support relationships, restorative conversations took place to understand decisions and to encourage a learning and curious environment across partners.
- Bi weekly meetings are in place with key operational leads to review all escalations and any issues and learning from these are shared with staff and the Strategic Group
- Practice Development Leads were assigned to work alongside MASH to support reflection and review . This included dip sampling the following areas of practice to measure decision-making, quality of practice and impact for the child:
 - Contacts
 - Strategy discussions
 - S47 enquiries
 - Voice of the Child within assessments
 - Supervision

They were able to see evidence of improvement and the findings are included within the ongoing improvement plan. There was learning across all partners.

- Dip sampling and review has been a key part of the development with Dip sampling throughout Quarter 3 and a full diagnostic in Feb 23, it identified that:

"There is evidence of good working relationships between MASH and the Child Help & Advice Team (Early Help). If there is disagreement in terms of threshold decisions, there will be direct conversations and escalation to Service Managers if required. Consent is clearly evidenced in records, and if this not been gained by other professionals, this will be followed up first. Outcome letters are sent to referrers and parents/carers. Thresholds are appropriately applied with rationale clearly evidenced against the threshold document 'Right Help Right Time levels of need'

Record keeping (EH Contact Form) is comprehensive and of a high standard with clear evidence of the issues. Information from MASH is well considered, and there is evidence of agencies being contacted (where relevant), with parents/cares spoken with. There is clear and detailed management direction to the screeners, with a good summary of the issues, analysis, and recommendations, evidenced against the threshold document"

- The Children's Help & Advice line (CHAT) went live in January 2023 and has been well received. 60 calls were made in the first month, resulting in 35% Early Help Contacts. Strategy meetings are improving in timeliness and convened appropriately, and the threshold for section 47s is correctly applied.

"Most responses are timely and visits to children mostly take place the same day; medicals and police action are also expedited in a timely way. All children are considered individually by the strategy meeting and the section 47".

There was learning including quality of assessment, some lack of analysis, chronologies and response to Domestic Abuse, history of missed opportunities. Overall within the first Ofsted monitoring visit (March 2023), Ofsted noted that we knew ourselves well and concurred with the findings. The dip sampling continues and diagnostics will continue to be run 6/8 monthly to ensure that standards continue to improve.

- The Pre Birth Pathway was reviewed to ensure that the multi-agency response to women who were deemed vulnerable was implemented. This is now in place and identifies concerns and support needed at the earliest opportunity.
- The Professional Differences Protocol was reviewed and relaunched. The early escalations are brought to the Operational Group and any Stage 3's to the Strategic Group. One was raised to the Partnership. All have been resolved.
- Significant work was completed on enabling the sharing of data but specifically a MASH Dashboard. This is now in place although there is still ongoing work to refine

and expand this. A screen displays the current timescales for all work for MASH colleagues on a daily basis.

- Additional resource was placed within the MASH to support joint work on referrals with Early Help. A pilot was introduced to joint visits after screening .After 2 months this was reviewed and was not felt to have had the impact needed. Subsequently a CHAT line was put in place to support professionals and families being able to contact and get support at the earliest opportunity.
- The Standard Operating Procedures and the Multi Agency Referral Form were reviewed .There was considerable delay in this due to differences regarding the implementation of consent on referrals. This was agreed in December 2022.
- Herefordshire's joint protocol for 16/17-year-olds who may be homeless or threatened with homelessness was commenced and due to be implemented on the 1st May 2023. The overall aim is to reduce homelessness among 16/17 year olds and to provide a timely, same day joint response. There will be ongoing review and evaluation. It is envisaged the protocol will strengthen partnership working and improve relationships. The next steps following the launch is to ensure the workforce practice delivery aligns with our Joint Protocol for homeless 16/17 year olds, through training, inductions, refreshers and operational oversight to test out compliance. This has been scheduled for Autumn 23.
- Best Practice examples of Safety planning was shared across the Service. Safety Planning expectations and templates were reviewed with two versions being tested across the Service. This is due for review by Social Worker, Independent Reviewing Officer, Child Protection Chairs and partners in September 23.

Challenges

- Statistically we remain consistently and significantly an outlier for contacts and referrals for our population and there is management and partnership focus on this to understand this well. Work has been completed to understand this across partners. Initial reviews into Health referrals showed the ambulance service with 66%, 10% A&E and the rest from midwives health visitors etc. Families were informed of referrals rather than working with them and supporting them to give consent. Work was done to support the understanding of consent. Work has been undertaken to support more appropriate referrals with consent at the front door.
- Police remain the biggest referrer for contacts with the lowest outturn for referrals. There has been work across neighbours to understand this with areas of good practice noted in Telford and Wrekin. Internally we are looking to follow this model to ensure that contacts are screened by police for appropriateness and threshold prior to submitting to MASH.
- Re referrals have been dip sampled and some reductions were seen, currently the data is noted to be incorrect and action is being taken by the Management Information Team.

- The response to UASC has been identified as an area, which needs strengthening. This was initially due to the lack of expertise and the increase in the year of referrals. This is the subject of current work by the Heads of Service for Mash and Corporate Parenting and the Practice Development Leads
- Police capacity has significantly improved with no delays noted at Strategy discussions but there remains some challenges for attendance at key risk meetings.
- There remains some challenges with the Children's Operating System and the ability for Partners to have a single view access. This had led to a significant number of professional's being given access to Mosaic, which had caused some challenges including two data breaches, Mosaic records can still be viewed by Partners but is limited now to key people to ensure appropriateness of access and information gathering. This also encourages better information sharing in MASH

What difference have we made?

Quality Assurance work has been ongoing throughout the year. This has included Practice Development Leads completing a Review in December 22. They found that there had been significant improvement against recommendations. Core training had been completed across MASH, Management Oversight was improved, and Strategy Meetings were tracked and appropriately escalated. All Team Managers have access to Power BI Timeliness of responses and decision making on contacts into MASH have improved, the timeliness of assessments of children has improved, and timeliness of strategy meetings within MASH has improved.

Strategy meetings are being held in line with Working Together and overall we have good agency compliance, timeliness and recording.

We had our first monitoring visit on the 29th and 30th March. The feedback was balanced and positive. Ofsted did comment that we know ourselves. The strengths were recognised as well as areas for development.

At the end of March 23, referrals had dropped per month from 959 in October to 679.

Per 10,000 children ,statistically there is a gradual improvement in the data from October to the end of March:

- S47 enquiries had dropped from 480 to 266
- Rate of children starting a CP plan from 80 (raising to 120 in Nov) dropped to 47
- Open CP plans from 90 to 70 (although this still remains higher than statistical neighbours)

The co-location of staff in an appropriate workspace has enabled relationships to grow and with this comes appropriate challenge and curiosity to resolve any challenges. The MASH continues to grow with representatives able to sit within it from Housing and Domestic Abuse services. The exploitation team being co-located has also enabled more awareness and sensitivity to the response to exploitation. . Auditing evidences better decision making with fewer escalations. Services work together in a more cohesive way resolving differences at the first point. The Education and CHAT lines have improved communication with MASH. A

Permanent Head of Service and recent permanent Service Manager appointment continues to strengthen management oversight.

Data enables us to identify timeliness and issues for review.

Following a review of a number of children after the inspection the rate of re-referrals rose from 17 to 36, a rate of 21.5% in the 6 months as those children who had previously been closed were reviewed and re-referred. Children starting a CIN plan dropped from 849 to 683. Work continues across the Partnership to ensure the right response at the right time to families at the earliest opportunity to avoid escalation into Statutory Services.

Development and Practice Subgroup

Kerry Oddy - Chair

Development and Practice Group's overall purpose is to: "Develop and deliver the professional practice and development framework to support effective safeguarding of children in Herefordshire." (from D&P Terms of Reference)

More specifically, the group:

- ensures that local and regional **multi-agency policies and procedures** are developed, shared, and kept up to date,
- is responsible for the **HSCP learning and development offer**, including the training programme
- oversees the HSCP **website and other communication/dissemination** channels.

More recently, "**engagement**" with children, young people, their families, and practitioners was added to D&P's remit.

What has been achieved in the year?

Engagement and communications:

- The new Safeguarding Partnerships website was launched September 2022. Feedback has been positive, saying that the new website is more visually engaging and easier to navigate to find information. The website is averaging 1800 – 2000 visits per month, with the most popular pages being "Safeguarding Children Partnership" and "Concerned about a Child."
- The children's "Youth Hub" pages of the partnership website were published in March 2023. The Youth Hub focuses on topics that young people said were important to them, and topics that they previously struggled to find information about. After the launch, there have been approximately 1-20 visits to the Youth Hub every day. See Youth Hub overview video – <https://www.youtube.com/watch?v=d9zbWULqG5o>

- The Voice of the Child Toolkit was published, and Voice of the Child Conference held in June 2022, with 60 professionals from a range of agencies attending. [Voice of the Child Participation Toolkit](#)
- The bi-weekly Partnership Bulletin is used consistently as a means to disseminate news and information. The mailing list has grown by 30% in the last year, to over 900 subscribers.

Learning dissemination

- Three Practitioner Forums were held (24 June 2022, 22 November 2022, 24 March 2023). 60-80 practitioners from a range of agencies and voluntary organisations attended each event. Themes covered at Practitioner Forums were:
 - Findings from the National Panel into the murders of Arthur Labinjo-Hughes and Star Hobson,
 - Recognising and responding to child to adult abuse,
 - An introduction to the sibling sexual abuse project,
 - Briefing on County Lines Exploitation in Herefordshire,
 - Trauma-informed Care: Overview of approach and how professionals can be more trauma-informed in their practice,
 - Raising Awareness of Hate Crime and Services by Victim Support,
 - Private Fostering – raising awareness

Feedback from a Practitioner Forum delegates:

"Very clear, concise and informative. I like that the Multi-Agency approach brings more diverse knowledge and input."

"This was very informative and there were short sections that worked well for me."

- A broad safeguarding training programme is in place that is well attended by multi-agency professionals, with over 1324 course spaces attended. Some courses have returned to in-person delivery. See table below of courses run and attendance numbers.
- Six learning briefings were published in response to learning from case reviews: Professional Curiosity; ACES/Trauma-Informed Practice; Child Neglect; Routine DA Enquiries; SCR Matthew; Peer on Peer Abuse; Professional Differences.

Policies and procedures

Local Herefordshire multi-agency policy reviews completed:

- Professional Differences Policy – reviewed and published September 2022. Alongside this, we introduced a new process for logging and reporting escalations at Stage 2 or higher to the Q&E and MASH Strategic Groups. There has subsequently been an increase in reporting of escalations to the HSCP, and the escalations log has enabled tracking of escalations and there is potential to identify themes.

- Pre-birth handbook reviewed and published, with new pre-birth panel introduced (January 2023)
- Initial Child Protection Conference (ICPC) Professionals Guidance reviewed and published to reflect that the ICPC Chair holds the final decision on next steps (Jan 2023)

Governance, strategy and meetings

- HSCP Learning and Development Strategy (2023-25) drafted and endorsed by Development & Practice Group. Pending sign-off by SPB. The new strategy strengthens quality assurance of courses and evidencing impact. It is also more specific about training requirements for different staff roles, and course levels for HSCP courses.
- Development & Practice Group ToR and membership revised to reflect additional work on engagement. New members joined from Talk Community, and participation/ engagement officers from different agencies.
- Attendance and engagement at Development & Practice Group meetings has been good, with representation from a range of organisations, although not always consistent and members do not all contribute to discussions.

What are we working on?

- Mechanisms are not fully in place to evidence the impact of training. There is some evidence from course evaluations (“How will you apply the learning from this course in your practice?”). Post-course evaluations are being built into the training evaluations to gain a greater understanding of impact.

Participation and engagement work with children, young people, families, and practitioners, is underdeveloped – this will be expanded in 2023/24.

What difference have we made?

Course attendance: 1324 training spaces were attended on multi-agency safeguarding courses in 2022-23.

Courses Evaluation feedback

“The training really helped me to identify the different levels of need and use the indicators in the RHRT document to help me. It also helped me know who to liaise with when I have concerns and how to approach families when having any queries/concerns regarding the child's safeguarding.” (Right Help Right Time)

“I have not yet done scaling as part of an assessment and have learnt how to from the session. I also was able to identify the components of a good assessment.” (Early Help Assessment)

“Updated knowledge and given me the skills to ask questions. Has been a useful refresh for many in the office this morning just talking about the course.” (Curiosity Saves Lives – Domestic Abuse Multi-Agency Training)

"I intend to have a better understanding when working with children experiencing neglect. I will also use the assessment tools and knowledge from the training to aid my ability to carry out a graded care profile with a family I am working with. It will support me to identify the family's strengths and arrears in which they need support." (GCP2)

"Will focus more on family's strengths and positives and will work towards empowering families to see solutions to the concerns for which their children have been referred into department." (Signs of Safety)

"Learnt how YP talk about abuse, and that they don't always recognise the term DA. I will change and expand my use of language in clinical practice." Feedback on "Domestic Abuse and Young People's Relationships" (Feb 2023) from a Sexual Health Nurse

8. Funding and Support

The three Statutory Partner agencies contributed to the HSCP's budget for 2022-23, which funds the work of the HSCP, HSAB, and Herefordshire Community Safety Partnership. In addition, a range of agencies have provided a variety of resources, such as their staff time and support for the HSCP Team (HR, IT and legal). The three statutory partners' agencies financial contributions totalled £412,319.

The HSCP continues to be supported by the Partnerships 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 Partnerships team provides logistical support, administration and development support to the HSCP and 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 partnerships day to day function and that there was a need for additional partnership 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	22-23 Contribution £	%	Salary Costs	345,877
Children's Wellbeing	143,519	0.35	Transport costs	28
Adults Wellbeing	108,150	0.26	Independent chair/ Consultancy Costs	60,039
CCG, now ICB	95,550	0.23	Training expenses	0
Police	65,100	0.16	Office expenses	39,293
			Additional Income	-12,279
Total	412,319	100%	Total	432,958

9. Communication

HSCP communicates with partner agencies and Herefordshire residents primarily via the HSCP website. We also produce briefings for the children's workforce in Herefordshire which include a series of short videos

HSCP Website

The new Partnership website was published in September 2022 and the Children's information pages went live in March 2023.

The HSCP website includes separate sections for people working with children, for parents and carers, and for children and young people. Issues including Exploitation, Online Harm, Gangs and Child Criminal Exploitation, Harmful Practices, Radicalisation, Emotional Health and Wellbeing; Domestic Abuse, Bullying, Substance and Alcohol Misuse and Sexual Health have their own sections of the website with advice, signposting to resources, tips and information tailored to the specific audience. There are specific pages for young carers, children in care, licensed premises, and educational establishments. We have videos embedded, a news section and a live Twitter feed. The HSCP multi-agency training programme is accessed through the website and the Training and Resources section is a rich source of learning from audits, reviews and partnership events.

HSCP Youth Hub Web Pages

When we consulted young people in August 2022, they said that they struggled to find information about support that is available locally and they have spent frustrating hours navigating online content, trying to find the best resources and support. The Youth Hub web

pages were therefore designed with this in mind, with main purpose of the children's pages is to provide links to local and national support and resources on safeguarding topics that children said were important issues for them.

The Youth Hub Web pages were delivered for children and young people in Herefordshire in March 2023, so that they will have a platform to find local information and support to help keep them safe.

Following extensive consultation, the topics that were identified by professionals and young people as important to them, and which are featured on the initial pages are:

- Children's Rights
- Being safe at home (abuse and neglect)
- Child exploitation and trafficking
- Mental health and Risky Behaviour
- Exploitation and Criminal Activity
- Bullying and Hate Crime
- Neurodiversity
- Gender identity and sexuality
- Care experienced young people
- Who's Who and What's What – glossary of safeguarding terms and professional roles
- See screen shots below of a selection of pages. If requested, we can provide a demo of the pages.

10. Self-Assessment (interim)

Herefordshire assesses the effectiveness of local safeguarding arrangements in various ways, including Section 11 safeguarding self-assessments. The Section 11 Self-Assessment is carried out in a two-year cycle but it is noted that Herefordshire has not undertaken a Section 11 Self-Assessment since its inception in 2019.

In 2022, the partnership undertook a "mini" interim self-assessment, to gain assurance from agencies on their effectiveness in safeguarding children and young people. A limited number of partner agencies were asked to participate:

- Wye Valley NHS TRUST
- Herefordshire and Worcestershire Health and Care NHS Trust
- NHS Herefordshire and Worcestershire Clinical Commissioning Group now ICB
- West Mercia Police
- West Mercia Youth Justice
- Herefordshire County Council
- National Probation Service

The audit was overall positive, with responding partners reporting good adherence to requirements and able in provided narrative to give site examples of good practice. However only one agency, Wye Valley Trust submitted actual evidence attached to the audit template. Even the lowest scoring areas are identified as areas for development scored well, with a

number of partners able to identify good practice or the changes they intend to make to improve the way they work. No single area came out as 'inadequate' across the audit as a whole, evidencing generally a good standard of work with children and families in Herefordshire.

The key pattern identified in this audit was that partners are clearly confident in their systemic and strategic work and planning; policies and procedures were by far the highest scoring criteria across the partnership. The weakest scores (comparatively; the lowest score was still relatively high) were visible in person-centred areas of work such as partners incorporating the voice of the child into their work. This suggests that all partners have strong frameworks within which their work is undertaken, and that future development should focus on ensuring staff, children and young people are able to shape and influence partnership culture and practice.

It was hard to validate the assurances from the agencies who have responded to the S11 request based on the simplified returns and lack of evidence. However, it was noted that there was no evidence of any immediate risk to any child or young person as a result of poor organisational performance, and nothing of immediacy for the partnership or Board to seek to action at this time.

11. Priorities going forward

The partnership remains committed to the HSCP Strategic Plan and within that framework has set the following priorities for 23/24.

- Plan a 'back to basics' workshop to review governance and improve the effectiveness of the Board and Sub Groups
- Continue the development of HSCP performance data set and analysis
- Complete the work to finalise a Neglect Strategy and Plan
- Align the work of HSCP with relevant sections of the Children's Services Improvement Plan and the Improvement Board
- Deliver Get Safe as our new multi-agency approach to child exploitation
- Deliver a programme of multi-agency audits
- Continue with the effective arrangements for Rapid Reviews and Local Child Safeguarding Practice reviews through the Joint Case Review Group
- Focus on embedding the learning from case reviews
- Complete the section 11 and section 175 audits of partners and schools compliance with safeguarding guidance and responsibilities
- Continue improvements in MASH and the 'front door' arrangements
- Resolve the structure and purpose of the Business Unit/Partnership Team post 2024

12. Key messages from the Independent Scrutineer

As noted in last year's annual report, 22/23 was always going to be a challenging year for the HSCP given the Ofsted judgement and subsequent establishment of a re-focused Improvement Board and the requirement to comply with the statutory improvement notice issued by the DfE.

I started work as the Independent Scrutineer for the HSCP in October 2022. In November 2022 I set out some preliminary thoughts on the partnership and made four specific recommendations in light of the Ofsted judgement that Herefordshire Children's Services was inadequate and that partnership working was not effective:

1. That Partners needed to ensure that the Multi Agency Safeguarding Hub was resourced and managed to provide a more effective 'front line' for safeguarding children and young people.
2. That Partners should complete the review of the Safeguarding Business Unit.
3. That HSCP needed to develop a clear relationship with the Children's Services Improvement Board and other partnerships such as the Children and Young People's Partnership.
4. That HSCP should align the annual business plan with those areas identified as needing improvement within the Children's services Improvement Plan to ensure those partnership elements will be delivered.

With regard to these recommendations, the sub group report on the MASH within this annual report outlines the real progress that has been made by HSCP in this area. It is pleasing to note that in the Ofsted letter, following the first monitoring visit in March 2023, the inspectors made positive comments about progress in the MASH:

'Since the last inspection when services were judged to be inadequate, protective responses through the MASH have been improved, meaning that most children's needs are now promptly identified and responded to at the point when referrals and contacts are made. This has been achieved through increased capacity, and partnership changes, combined with clear and helpful management oversight.' (Ofsted letter May 2023 – published by Herefordshire Council).

Positive comments were also made about the improvement in Early Help provided to families, which has a high level of partnership engagement as noted in this annual report.

Nevertheless, partners recognise there is more to do given the high number of contacts received by the MASH that do not result in any "Level 4" statutory intervention. This indicates that further work is required to ensure that the application of thresholds set out in Right help Right Time still varies considerably amongst partners. This also means that some families may be subject to assessment when other pathways might have been more appropriate.

It is important to note that partners are aware of the need to address such issues and strengthen effectiveness of the MASH.

The review of the Business Unit was not completed but was paused to allow some key new appointments to be made. Plans have been made to conclude this review in 23/24.

More progress was made to align the HSCP Business Plan with the Improvement Plan and whilst a new business plan was not finally agreed until after March 23, good progress was made. There is now clarity around what the partnership needs to deliver in relation to those areas for improvement identified by the Improvement Board. Progress against these priorities does, however remain slower than anticipated but, as parts of this report show, staff capacity and churn, given the extent of the improvement programme, is a challenge for the HSCP.

In my November analysis, I also identified that the partnership suffered from 'inertia' in that action against key decisions did not appear to happen quickly enough between meetings of the Board. I am pleased to report that a considerable amount of effort has been made by partners to re-vitalise and re-focus the work of the HSCP sub groups, much of this completed after March 23 but beginning to have impact as we move into the 23/24 year.

Similarly, HSCP moved to agree four key priorities for the sub groups this year, going into 2023/24:

- Review and implement a Neglect Strategy
- Continue to Improve the MASH
- Review the approach to child exploitation by adopting the Get Safe model
- Implement a trauma informed approach across the partnership

To deliver the above, partners have identified the need to ensure they have good multi agency data and analysis; good multi agency and single agency audits; a learning and development strategy and menu to support staff across the partnership.

As outlined in this report the sub groups have made some progress during the latter half of 22/23 but a lot of the work is planned to be delivered and begin to have impact in 23/24.

The absence of reliable and regular multi agency data remains a challenge and this undermines the effectiveness of partnership working. Some key data, for example the problem profile for child exploitation, is not up to date. The Child Exploitation profile was last completed in 2019. Again, partners are aware of this and have set plans in place to address the data issues during 23/24. Some key decisions were made in 22/23 to support this work e.g. agreement to a small number of performance indicators to allow the partnership to grow its ability to deliver and use data to inform the work of the HSCP. This annual report for example does not contain the breadth of multi-agency data that characterises more effective partnerships.

A more positive area is the work of the Joint Case Review sub group, which has good processes in place to consider cases for Rapid Review. As noted in this report decisions to undertake Rapid Reviews and LSCPRs were made by the sub group in 22/23 but the completion of these reviews will be in the 23/24 year. The partnership still has work to do; however, to comply with

the timescales required by the National Panel and Working Together 2018 for full LCSPRs, but there have been mitigating factors impacting on timescales.

There is evidence to suggest that escalation is now being used more effectively with many issues handled at the informal stage, particularly in the MASH. This is another area for review during 23/24 and it is monitored by the Quality & Effectiveness Group.

There are, though, some key challenges to be managed in 23/24. Attendance of key agencies in meetings that are essential to good safeguarding and meeting children's needs is not consistent and is under review.

The partnership has also needs to develop a better relationship with schools and other education settings who are under-represented in partnership sub groups and the Board. This is despite strong relationships existing between the Education service and schools including support for safeguarding. Partners are working on addressing this in 23/24.

Overall I have to conclude that in 22/23 that the HSCP was not fully effective but that there has been improvement in some key aspects of the partnership work. Much planning has been completed to improve matters in 23/24, which indicates that more progress will be made next year.

Kevin Crompton
Independent Scrutineer