



Herefordshire Safeguarding
Children Partnership

Yearly Report 2024-25



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1. Foreword from the Delegated Safeguarding Partners

Throughout the past 12 months, the partnership has experienced consistency in partner contributions and membership, healthy scrutiny and challenge, and has driven forward the plan set out in last year's annual report.

We are pleased with the progress that has been made, notably in strengthening the multi-agency quality assurance framework, implementing our Working Together 2023 plan, and providing strong leadership to drive the partnership agenda. We have also developed our joint work with Worcestershire – enabling comparisons of data and promoting collective initiatives between the two areas to expand our sharing of good practice and learning across the shared multi-agency footprint.

Ofsted monitoring visits to children's services have had findings of improved practice at pace and strong practice in multi-agency working.

We have come together to provide this Yearly Report of our activity in 2024-25 and establish our priorities for the upcoming year 2025-26 with a continued commitment to our children and families in Herefordshire. We aim to ensure our children and families experience a good, coordinated multi-agency response to keep them safe. In addition, we are driving forward the Department for Education (DfE) Families First Partnership Programme to ensure families receive support and protection through a seamless system, based in our Restorative approach, that aims to provide Family Help early and enable parents to care for their own children well.

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Partnership Chair for the
Multi-Agency
Arrangements and
Director Children's
Services

Helen Wain

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Mercia Police

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Chief Nursing Officer,
Herefordshire and
Worcestershire Integrated
Care Board

2. About the Yearly Report

Working Together 2023 (WT23) requires each Local Authority to establish local arrangements for safeguarding children and young people. In Herefordshire, this is called the **Herefordshire Safeguarding Children Partnership (HSCP)**. 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 overarching responsibility for these arrangements is between the Safeguarding Partners, who are Herefordshire Council, West Mercia Police and the NHS Integrated Care Board (Herefordshire and Worcestershire). Other 'relevant' agencies also have a duty to safeguard children and young people under WT23.

The Safeguarding Partners must jointly report on the activity they have undertaken each year. This Yearly Report must be published by September of the following year. The focus of the Yearly Report is on activities achieved, evidence of impact, challenges, and next steps. The report must include:

- What the partnership has done as a result of the multi-agency child safeguarding arrangements, including on child safeguarding practice reviews,
- How effective these arrangements have been in practice.

This Yearly Report of the Herefordshire Safeguarding Children Partnership covers activity between 1st April 2024 and 31st March 2025.

3. Area Profile

Herefordshire is a predominantly rural county, situated in the south-west of the West Midlands region bordering Wales. The city of Hereford, in the middle of the county, is the centre for most facilities; other principal locations are the five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington.

Official population estimates from the Office for National Statistics (ONS) put Herefordshire as one of the 25% smallest local authorities in England. On the other hand, it is one of the biggest geographical areas. With 87 persons per square kilometre, it has the fourth lowest population density of all English upper-tier local authorities.



The [Herefordshire JSNA Summary - 2024](#)

provides information about the profile of Herefordshire's population and the drivers of recent change:

Figure 1. Population

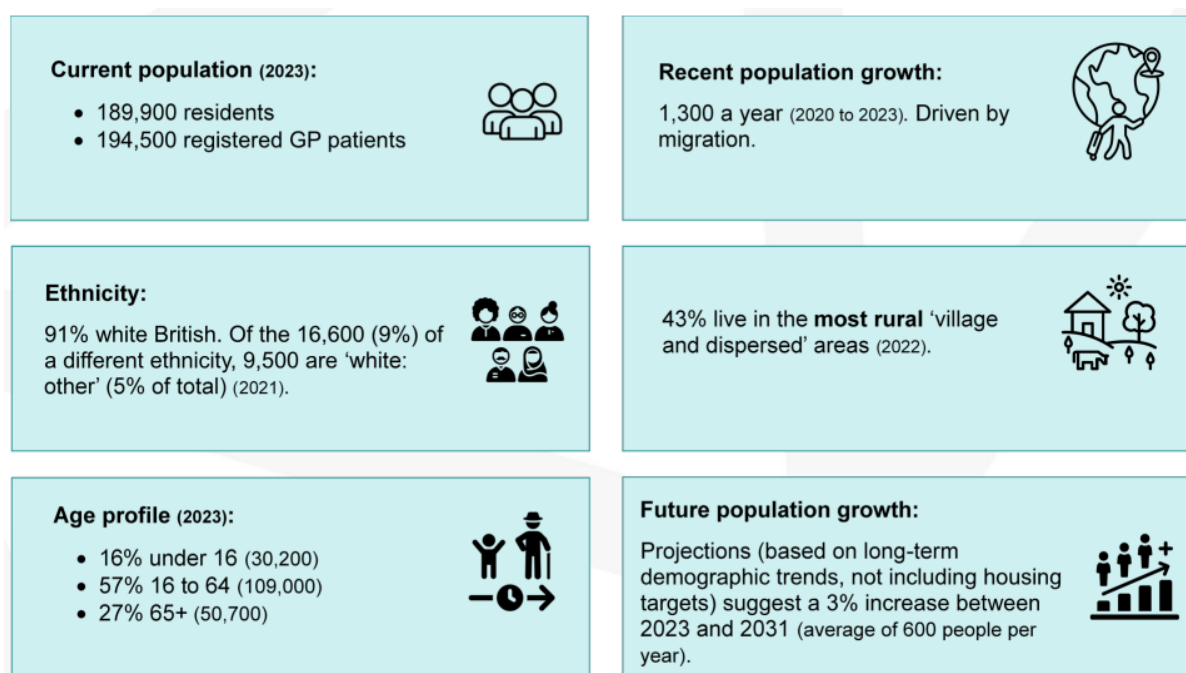
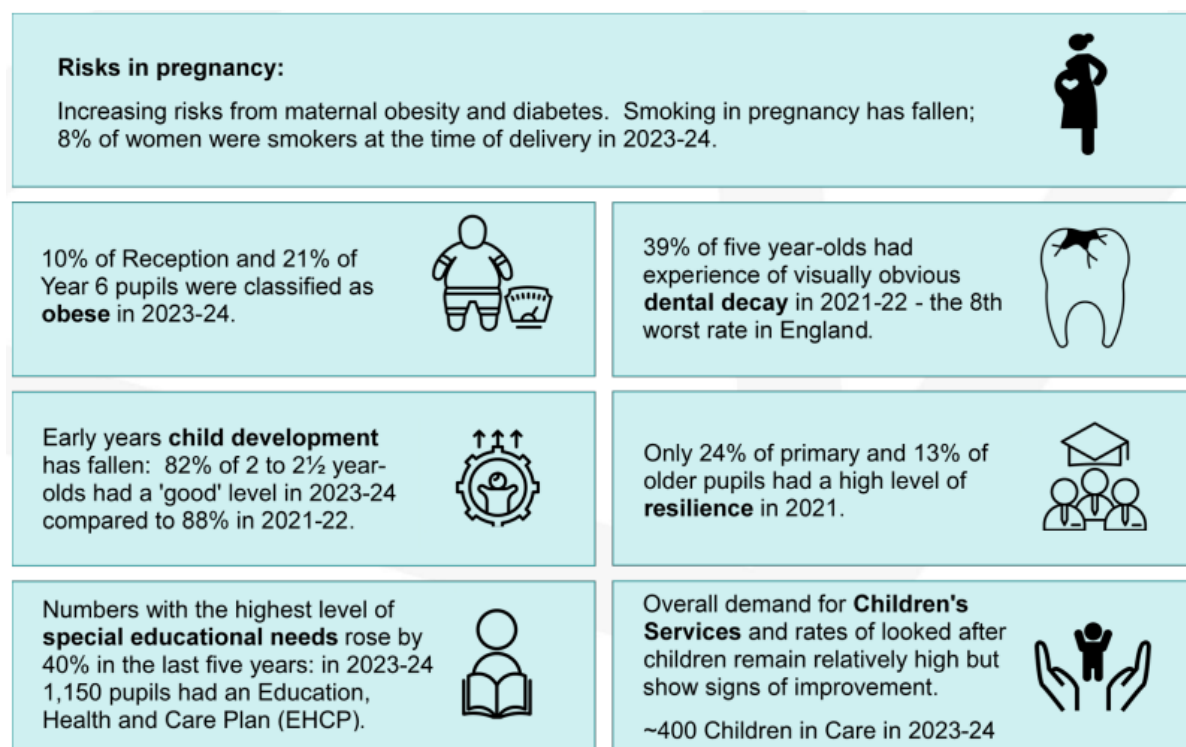


Figure 2. Children and young people in Herefordshire



Overview of the three Safeguarding Partners

The three Safeguarding Partner agencies for Herefordshire are: Herefordshire Council, West Mercia Police, and the Herefordshire and Worcestershire NHS Integrated Care Board. As its name suggests, the ICB stretches across both Herefordshire and Worcestershire. West Mercia Police covers four local authority areas: Shropshire, Telford and Wrekin, Worcestershire, and Herefordshire, with a local policing command in each area.

Childrens Services

During the reporting period, Herefordshire Council Children's Services initiated a significant change in how its services are delivered by introducing a locality-based approach to delivering early help and safeguarding and support services. This created three hubs – one in Hereford city, and one site each in the market towns of Leominster and Ross-on-Wye. This development has enabled the services to work more closely with families and partners in the local communities. The locality model is also the first step towards implementing the Families First Partnership Programme approach and compliments the Restorative Practice approach that is being embedded in Herefordshire.

Integrated Care Board

The HWICB is a statutory organisation responsible for integrating NHS services with local authorities and partners across Herefordshire and Worcestershire. A key part of its mandate is to ensure that all commissioned services safeguard and promote the welfare of Children and Young People (CYP).

Key Safeguarding Activities within 2024/25:

- Continued proactive engagement with core partner agencies, reinforcing joint safeguarding efforts.
- There has been ICB representation on all sub groups, contributions to multi-agency audits, implementation of recommendations from both national and local **Child Safeguarding Practice Reviews (CSPR)**, Chairing of Rapid Review panels, along with offering expert advice and expertise to partner agencies and health colleagues.

The implementation of the **Child Protection Information Sharing System (CP-IS)** across the health system has been led by the Designated Safeguarding Team, this initiative facilitates secure information sharing among health providers and key partners. The Designated Doctor has continued to contribute to **The Child Death Overview Panel (CDOP)** providing safeguarding oversight during reviews of all deaths of Children and Young People Herefordshire and Worcestershire, ensuring thorough consideration of any safeguarding concerns.

Statutory Inspections in the Reporting Period

Herefordshire Council Children's Services has been under an Improvement Notice from the Department for Education since May 2021 (non-statutory Improvement Notice in 2021, followed by a statutory notice in July 2022). During the reporting period 2024-25, Herefordshire Council's Children's Services moved into Phase 2 of its Improvement Programme.

There were two **Ofsted monitoring visits to Children's Services** in the reporting period. The [first](#), in October 2024, covered the protection of vulnerable children to extra-familial risk,

and found that, overall “Children at risk of extra-familial harm in Herefordshire benefit from a committed specialist team which reduces risks for many of these very vulnerable children.”

In relation to partnership working, Inspectors found risks were “promptly identified” and “collaboration and timely information-sharing between partners has improved, which is helping to protect vulnerable children through targeted interventions and/or disruption activity.”

While there were some areas for improvement, including quality of risk management plans, and ensuring that supervision effectively addresses drift, inspectors were overall positive about the support for vulnerable children at risk of exploitation and extra-familial harm.

The second [monitoring visit](#), in February 2025, focused on Child and Family Assessments. Inspectors found that, “Since the last monitoring visit in October 2024, the local authority has started to build up some pace in the improvement of services for vulnerable children.”

Inspectors found that “Thresholds are appropriately applied” and assessments were “comprehensive” with partner agency views being captured. Inspectors specifically noted “range of professionals and agencies are involved, and they make an important contribution to assessments as well as provide the support which families need.”

The final Ofsted monitoring visit was completed 17-18th June 2025 and whilst this was an extremely positive report on the continued pace and quality of improvement it is not formally within this annual reporting timeframe.

The [2023-25 HMICFRS PEEL Inspection of West Mercia Police](#) was also completed during the reporting period, however as the report was published in May 2025, it was not available before April 2025. On the core area “Protection of Vulnerable People,” West Mercia Police received an overall grading of Requires Improvement. While positive areas were noted (including neighbourhood policing and using feedback from victims to improve services), areas for improvement included performance data, use of ancillary orders, management of adult and child safeguarding risk assessments, and staff safeguarding training. The findings of the inspection will be presented to the Safeguarding Partners in 2025.

The **Herefordshire and Worcestershire Health and Care NHS Trust** received a robust improvement plan following its inspection by the CQC in 2023 (report published January 2024). The findings concluded staff knew how to:

- Recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.
- Discuss safeguarding concerns with their colleagues and the clinical leads in the team.
- Access the Trust safeguarding team, who provide advice and support.
- How to make a safeguarding referral and who to inform if they had concerns.

There were two risks related to safeguarding on the Trust risk register, one related to the Trust not providing information in a timely way to partner agencies, and the other related to the risk of abuse or neglect to children inappropriately assessed or mitigated.

Whilst this inspection was outside of the reporting period of this annual report for 2024-25, it is important to highlight all “must do” actions have now completed.

In addition, CQC were assured that Trust safeguarding systems and processes were well managed, and risks were mitigated. Staff in the Trust were up to date with safeguarding

training and knew how to recognise abuse and when to report it. There was also recognition that there was positive leadership in key areas of the Trust, which included safeguarding.

There have been no CQC inspections at Wye Valley Trust within this reporting period.

Contributions of the Safeguarding Partners

The partnership's governance arrangements are detailed in the [Multi-Agency Safeguarding Arrangements](#). Each Safeguarding Partner agency plays an essential role in the leadership of the partnership, in addition to contributing to the day-to-day functioning.

In 2024-25, the Director of Children's Services of **Herefordshire Council** held the role of Partnership Chair for the multi-agency arrangements. Herefordshire Council also held the Chair of the Development and Practice Group, the Child Exploitation and Missing Children Group, and the Multi-Agency Safeguarding Hub (MASH) Group.

The Herefordshire and Worcestershire NHS Integrated Care Board Designated Nurse has continued to Chair the Joint Case Review Group in 2024-25, which includes overseeing case reviews and Chairing the Rapid Review process. The Designated Doctor is also the Vice-Chair of the Quality and Effectiveness Group.

West Mercia Police contributed through Vice-Chairing roles to Development and Practice Group, Joint Case Review Group, MASH Group, and Child Exploitation and Missing Group.

Appendix A provides an overview of the HSCP governance structure and descriptions of sub groups.

In addition to the leadership roles detailed above, all three Safeguarding Partners:

- provide data for the partnership dataset,
- participate in multi-agency audits, including taking turns leading audit exercises,
- provide trainers for the delivery of multi-agency training,
- contribute to case reviews and embedding the learning from reviews,
- actively participate in all partnership sub group meetings and activity – the quoracy for all sub groups requires representation from each of the three safeguarding partners,
- contribute to the partnership budget, as detailed in Section 14 (Funding) below.

Lead Safeguarding Partners

WT23 established the role of the Lead Safeguarding Partners (LSP), to provide an active role in ensuring strong, joined-up leadership and clear accountability for effective multi-agency safeguarding arrangements. The LSP are the Chief Officer for Police, Chief Executive for the Local Authority, and Chief Executive for the ICB.

Herefordshire and Worcestershire decided to develop a **joint LSP Group**. This model reflects the reality that two of our Statutory Partners (Police and the ICB) work across multiple areas. Meeting as a pan-Herefordshire and Worcestershire LSP group, across the ICB footprint, allows for a greater, holistic understanding of risk across geographical jurisdictions, enables the sharing of promising and good practice, ensures consistency of funding and resources, and provides leadership for the Delegated Safeguarding Partners.

The LSPs met twice in 2024-25 and made the following key decisions:

- Agreed the **Terms of Reference** for the Lead Safeguarding Partners Group. The TOR details that the group will meet twice per year and that the Chair will rotate between the LSPs.
- Agreed the revised **Multi-agency Safeguarding Arrangements** (September 2024).
- Agreed the **HSCP Yearly Report 2023-24**.
- Agreed the plan for **Independent Scrutiny**, which consisted of an increase in days for independent scrutiny and revised activities in line with WT23.
- Agreed the **partnership budget** for 2025/26 and began discussions about new funding arrangements.
- Agreed the proposal to develop a **joint Herefordshire and Worcestershire Quality Assurance Group**, which would join the respective Quality Assurance Groups from each area three times per year.

Safeguarding Partners Board (Delegated Safeguarding Partners)

Reporting to the LSPs, the Safeguarding Partners Board (SPB) consists of the Delegated Safeguarding Partners from the three statutory partners, plus the Chair of the Safeguarding in Education Group – recognising education as a strategic partner. SPB's role is to make decisions on behalf of the Lead Safeguarding Partners, hold their sectors to account, and drive the work of the partnership. In 2024-25, the SPB was Chaired by the Director of Children's Services.

The SPB met seven times over the course of the year, which was an increase from four meetings in 2023-24. There was a representative from each of the Safeguarding Partners at every SPB meeting, in some cases this was from a Deputy to the DSP. **Appendix B** details the membership and purpose of the SPB, as well as attendance from the DSPs at each meeting.

The Safeguarding Partners Board made the following key decisions in 2024-25:

- Increase frequency of **Safeguarding Partners Board** meetings to six-weekly, which has improved oversight and engagement of the Delegated Safeguarding Partners,
- Reviewed the format and increased frequency of the **Quality and Effectiveness Group**, which has helped to drive the quality assurance agenda forward at greater pace,
- Agreed the **HSCP Chid Neglect Strategy**,
- Agreed the **HSCP Engagement Framework**,
- Agreed the **Think Family Approach** for Herefordshire,
- Agreed revisions to the **Multi-Agency Professional Differences Policy**,
- Oversaw the implementation of **WT23** to completion,
- Confirmed the creation of the **Education sub group** now Chaired by the Service Director for Education, Learning and Skills,
- Contributed to the **Children's Services Improvement Programme (Phase 2)**,

- Received regular **Highlight reports** from the sub groups,
- Received updates and discussed the changes to the **West Mercia Police Harm Assessment Unit (Vulnerability Hub)**.
- Reviewed and amended the **process by which sub groups feed into the board** to have greater opportunity for deep dive, increase line of sight, and ensure the board fulfil its purpose to value their good practice and drive improvement as required.

Future Plans

Moving forward, the Lead Safeguarding Partners will continue to develop their role, providing strong and effective strategic leadership.

With the potential impact of changes to roles within the HWICB (due to government-initiated ICB reforms in 2025-26), and West Mercia Police responses to the PEEL inspection review, the partnership will monitor and respond to any changes in staff representation from these two partner agencies.

The Safeguarding Partners will also continue to receive progress reports and support implementation of the Families First Partnership Programme, ensuring that strong multi-agency practice underpins effective support and protection for children and families in Herefordshire.

4. Implementing changes to Statutory Guidance and the National Reforms

Stable Homes, Built on Love (2023), set out the government's strategy for reforms to children's social care. In 2024, the **Keeping Children Safe, Helping Families Thrive** policy paper was published by the new Labour government, which also introduced the Children's Wellbeing and Schools Bill. At the end of this reporting period the bill was being debated in the House of Lords. The reforms have the overarching aims of supporting family networks, keeping children safe within their families, protecting children from extra familial harm, and ensuring that children in care, and care leavers, have stable and loving homes.

Activities and Achievements

Working Together 2023

The Department for Education's statutory guidance **Supporting local areas to embed Working Together to Safeguard Children and the National Framework** (updated October 2024) states that multi-agency safeguarding partners should have:

- published and submitted a yearly report by September 2024
- published revised multi-agency arrangements by December 2024

Both required actions were completed in September 2024.

The HSCP formulated the **Herefordshire Working Together 2023 Implementation Plan** to drive forward the required changes to multi-agency practice and processes. The Implementation Plan is laid out in line with the five chapters of WT23, with activities and objectives detailed for each chapter heading. Learning briefings and presentations were

offered to practitioners to ensure a wide understanding of the changes in WT23, which included a presentation at the Practitioner Forum in April 2024, which was attended by 90 multi-agency professionals.

The [Multi-Agency Safeguarding Arrangements](#) were revised to align the **HSCP governance** with WT23, and this was approved by the Lead Safeguarding Partners in September 2024. As a result of these governance changes, the partnership has experienced an improved pace of work, increased engagement with schools and education providers, greater oversight by leaders in the three statutory Safeguarding Partners agencies, and more effective independent scrutiny.

These changes were:

- Introduced the **Lead Safeguarding Partners Group**, to provide greater oversight by the Safeguarding Partners.
- Established the **Partnership Chair for the multi-agency arrangements**, which in 2024-25 was the Director of Children's Services.
- Created the **Safeguarding in Education Group** and introduced an **education representative** on the Safeguarding Partners Board (Delegated Safeguarding Partners), which has improved the representation of education at a strategic level.
- Strengthened links with **voluntary and community organisations** by increasing representation on HSCP sub groups
- Reviewed the plan for **Independent Scrutiny**, including increased days, to strengthen scrutiny activity and its impact.
- The **Joint Case Review Group** also reviewed its procedures for both LCSPR and Safeguarding Adult Reviews, in response to the new requirement for notifications to be made upon the death of a care leaver. Case review pathways were reviewed to ensure that there was clarity about the appropriate process and steps to ensure that deaths of care leavers are properly notified and considered for reviews.

National Reports

The Child Safeguarding Practice Review Panel (National Panel) undertook three reviews within the reporting period. These were considered by the various sub groups of the partnership to reflect on how the findings relate to practice in Herefordshire and develop appropriate responses to embed the learning locally. As a result of the National Panel reports:

- Following the publication of the [Safeguarding children in elective home education report \(May 2024\)](#), the Safeguarding Partners Board sought assurance from the safeguarding education team in Herefordshire Council on how Herefordshire fulfils its duty under section 436A of the Education Act 1996 (i.e. the duty to make arrangements to identify children in their area who are not receiving a suitable education). This assurance was provided at the SPB meeting in July 2024. The ensuing discussion resulted an agreement that elective home education (EHE) would be an audit theme for 2024-25, with the proposal that the audit should focus on good practice examples where children returned to school after a period of EHE (see details of EHE audit in Section 9 of this report). This was decided in

recognition of, and to build on, positive practice examples that were demonstrated in Herefordshire.

- The National Panel published “[I wanted them all to notice: Protecting Children and Responding to Child Sexual Abuse within the Family Environment](#)” in November 2024. At the time, Herefordshire had recently completed a multi-agency audit on the effectiveness of multiagency working with children where child sexual abuse has been identified (2023) and had subsequently commissioned training in 2023-24 for professionals and a learning event at the Practitioner Forum in April 2024. Herefordshire has developed a local action plan to respond to the recommendations in the report, which builds on the activity already undertaken in 2023-24 and 2024-25. Joint work between Herefordshire and Worcestershire is planned in 2025-26 to further embed the learning from this report.
- Towards the end of this reporting period, the National Panel published “[It’s Silent: Race, Racism and Safeguarding](#)” (March 2025), which examines the impact of race, ethnicity and culture on multi-agency practice where children have suffered serious harm or died. The HSCP is developing a local action plan in response to the recommendations, which includes a review of the LCSPR Toolkit, a reflective workshop for Rapid Review panel members, and exploring how practitioners are supported to recognise, discuss and challenge internal and institutional racism.

5. Analysis of Challenges in Implementing 2024-25 Priorities

The HSCP Yearly Report 2023-24 outlined 17 priorities for the year 2024-25. The majority of these activities were completed as planned and have therefore progressed the HSCP’s agenda. **Appendix C** provides a brief summary of progress against all priorities for 2024-25.

There were, however, some challenges, which are outlined below:

- **The HSCP Child Neglect Strategy** was updated in 2023-24 and sets out the HSCP’s commitment and common vision to addressing childhood neglect. As part of the strategy’s aims, the HSCP should develop a child neglect dataset, to help understand the prevalence and characteristics of neglect in Herefordshire and monitor the impact of efforts to protect children from the harm caused by neglect. Due to the development of the multi-agency dataset in 2024-25, completion of the child neglect dataset was not completed and will now form part of the multi-agency data set as this continues its development.
- One of the requirements for local authorities to align with WT23 was to publish a revised **Levels of Need (Right Help, Right Time)** policy. Herefordshire’s ambition was to ensure that families could input to this review through a series of workshops with Herefordshire families. Although four community workshops were organised, only one took place as unfortunately, there was limited interest in the consultation events planned, indicating that different approaches may be required to gain families’ feedback. With the development of locality hubs, this has created new opportunities to gain families’ feedback as we move into the Families First Partnership Programme. The Right Help Right Time policy is now being reviewed

alongside Worcestershire Safeguarding Children Partnership in an effort to provide the ICB and West Mercia police with a single document/threshold reference for application of needs across the Local Authority areas they service. The expectation is that it will be signed off by LSPs in September 2025.

- While 2024-25 saw the publication and promotion of a **Think Family Approach** for Herefordshire, evidencing the application of this approach was not completed. This will be incorporated into our Family Help assessment and plan to be developed in 2025-26.

6. Impact and Learning from Independent Scrutiny

Statement from Kevin Crompton, HSCP Independent Scrutineer:

The Yearly Report provides a good description of the work and effectiveness of the Herefordshire Safeguarding Children Partnership (HSCP) for the year 2024-25. It shows that the partnership has focussed on the delivery of the 2024-25 priorities and on the delivery of some key areas of work, for example quality assurance. The HSCP demonstrates many of the attributes of a good and effective safeguarding partnership.

The full report of the Independent Scrutineer appears as **Appendix D**. In summary:

- The Independent Scrutineer noted that the HSCP has made significant progress since October 2022, with improvements in partnership effectiveness and capacity by the end of 2023-24 and further advancements in 2024-25.
- **Implementation of Working Together 2023:** The HSCP successfully implemented the requirements of WT23, including a new plan for independent scrutiny approved by Lead Safeguarding Partners.
- **Meeting Frequency and Leadership:** An increase in HSCP meetings and focused leadership from the Interim Director of Children's Services has improved partner engagement and oversight of practices.
- **Sub group Effectiveness:** All sub groups are effectively led with annual workplans monitored, and the Joint Case Review sub group continues to perform well despite increased demands from Adult Safeguarding Reviews.
- **Quality Assurance Initiatives:** Development of a Quality Assurance Framework, a multi-agency dashboard, and a program of audits have enhanced oversight of partnership practices.
- **Education Sector Engagement:** The establishment of an Education sub group has strengthened ties with the education sector, leading to the identification of key issues such as reporting of private fostering cases.
- **Training and Development:** A program of training courses is overseen, with evaluations indicating effectiveness, and the Child Exploitation Strategy has been revised to enhance risk management for vulnerable children.

- **Partnership Relationships:** Strong relationships among partners are evident, with effective use of escalation processes to resolve issues, and good collaboration within the Multi Agency Safeguarding Hub (MASH) has improved decision-making and case management.

To improve the partnership needs to:

- Continue to maintain the pace of improvement.
- Continue to maintain the current work programme on quality assurance and avoid 'starting again' which delayed progress in the past.
- Refine the performance data set to ensure a regular cycle of reporting and analysis of key data.
- Refine the Multi Agency Audit approach to provide more focus on partnership working rather than the strengths of single agencies.
- Ensure that the lessons learned from audits and other reviews have been implemented and have improved practice.
- Ensure there is sufficient capacity to deliver the HSCP work programme.
- Review the evaluation of the impact of training and development on the lived experience of service users.
- Capitalise on the new Children's Services locality model to strengthen safeguarding practice at local level.
- Work with West Mercia Police to establish the impact of the PEEL findings on local practice and agree plans to improve practice where appropriate.
- Monitor the implementation of the recommendations set out in the CE profile.
- Continue to review the partnership work on capturing the Voice of the Child and young people.
- Review the plan for independent scrutiny for 2025-26.
- Work with the Lead Safeguarding Partners Board to ensure that both boards are compliant with the expectations of WT23.

7. Voice of Children and Families

Activities and Achievements

This reporting period saw a significant shift in partnership culture to regularly seek feedback from children, young people, and their families, that directly impacts on the work of the partnership. The [HSCP Engagement Framework \(2024-2026\)](#) was approved and sets out the partnership's commitment to engaging with children, young people, parents and carers, and how we will ensure that their voice is influential by informing decisions and how services are designed.

The framework also details how the HSCP supports practitioners to hear the Voice of the Child. One of the ways in which this was achieved is through emphasising the importance of

the Voice of the Child in every HSCP multi-agency training course. To further strengthen practice, **Direct Work with Children and Young People** training was co-produced and co-facilitated by the Social Care Academy and Care Experienced Children and Young People (Youth Educators). This course is available every quarter for multi-agency practitioners to attend. The training is underpinned by Restorative Practice and works toward sharing direct work tools which support practitioners to understand children's wishes and experiences through communication, connection and engagement.

The [Voice of the Child Toolkit](#), published in 2022, also remains a key tool to promote listening to children and young people in Herefordshire, and the HSCP continues to regularly promote the toolkit.

Multi-agency audits now routinely include auditors speaking with parents or carers as part of the audit activity. This feedback is discussed as part of the audit findings and helps to triangulate information and determine the impact of any services and support that families received.

Evidence of Impact

The *Direct Work with Children and Young People* course has already had an impact on practitioners' approaches to seeking and listening to the voice of children, as is evidenced from the course feedback. For example, one attendee said:

"I took a lot from the young peoples experiences and how they received certain write up styles"

In 2024-25, we also sought the views of children, young people, and their families to directly influence the development of new tools and approaches:

- Feedback on the **HSCP Engagement Framework** was sought from a group of care leavers. This resulted in clarifying some of the language in the document and including more information about inclusion of different cultures and ethnicities within participation work, as well as recognising that children need to understand their rights in order to be able to fully participate in any process.
- Feedback on the **Think Family Approach** was sought from parents and families through the Families for Change Group and the Lived Experiences Advisory Group. This resulted in amendments to emphasis organisations working together and coordinating their work, which was a benefit of the Think Family approach that families really valued. We also added questions to the practitioner checklist to emphasise consideration of family dynamics, and in particular understanding of how some behaviours, for example patterns of coercion and control, will affect how parents present themselves to professionals.
- The **Home Conditions tool** that forms part of the Child Neglect Toolkit was brought to a group of Young Educators, facilitated by the Social Care Academy, to seek their views. The young people commented that the tool would be more effective for use alongside a family if it was more visual and strengths-based, for example if it started by seeking the views of family members before making any observations or judgements, and revising language that may be offensive to families. Revisions are underway to improve the Home Conditions Tool in light of this feedback so that it can be used alongside families, rather than as a professional's tool.

- The **SAFE Team** has now established a feedback questionnaire for children, young people and families that have been supported by them. They are asked their views at the time of closure from the SAFE Team, and six months later. The feedback shows overwhelmingly positive responses to the support received, and has informed areas of future focus to ensure young people continue to feel safe after closure. Further details of this feedback and how it was used to shape the service is provided in Section 13 of this report (Get Safe).
- In October 2024, Children's Services implemented a new method for **service user feedback** at the end of an intervention. One question was specifically added to seek the views on how the partnership worked together. In March 2025, the service was able to report feedback from 109 families, with 37% reporting they thought professional worked "Fairly well" and a further 44.5% stating "Very well."

Future Plans

In 2025-26, the partnership's ambition is to receive more information from partners on feedback that they collect from children, young people and their families about the direct services that they received, **with a particular emphasis on how they experienced agencies working together**. We also want to understand more about how agencies are responding to this feedback to shape their services.

8. Multi-agency Audit and Quality Assurance Activity

The role of the Quality and Effectiveness Group (Q&E) is to support the improvement and development of services offered to children and young people in Herefordshire by delivering a multi-agency programme of quality assurance through focusing on two key areas:

- audits
- key performance indicators

The Q&E Group has been effectively chaired by three experienced interim leaders through 2024-25. From July 2024, the Q&E Group began meeting every six weeks rather than the previous arrangement of quarterly. This has been to support increased momentum and completion of agreed actions. Continuity of purpose has been sustained during this period, with a particular focus on:

- Continued quality assurance activity through auditing and feedback processes. The areas chosen for this activity have been informed by emerging national and local reviews and guidance, for example best practice learning for children who have successfully been supported into education settings after a period of elective home education.
- Continued scrutiny and focus on multi-agency practice by developing the multi-agency data dashboard, checking the involvement of the right agencies at all stages of the child protection process and ensuring children and families get the correct support at the right level at the earliest opportunity.

Activities and Achievements

During this reporting period, four multi-agency audits were completed, capturing the experiences of 37 children. These activities, with examples of learning and follow up are summarised below.

Pre-birth practice including the service provided when parents are care experienced

Multi-agency audits of practice for 11 unborn babies (August to October 2024) were completed to evaluate the effectiveness of the service provided and to identify development opportunities. This audit was identified as an area for enquiry as part of the Herefordshire Improvement Plan and to evaluate the impact of the temporary cessation of the Pre-birth Panel. The audit concluded that:

- Referrals were of a good quality – comprehensive and appropriate in the application of thresholds.
- Referrals were allocated in a timely way, in most cases within 24 hours and with clear and safe rationales when allocation took longer.
- Good management oversight was evidenced.
- Strategy meetings were held when appropriate.
- There were a small number of late referrals and presentations that resulted in some late or rushed assessments.
- The prebirth protocol was identified as not being fully aligned to practice expectations and requirements.

As a result of this audit:

- the prebirth protocol has been revised to ensure the content meets requirements and to make it more succinct.
- the multi-agency Pre-birth Panel has been resumed, with revised Terms of Reference and processes, to support timely multi-action to understand and address the needs of unborn babies and their parents.
- multi-agency quality assurance of the pre-birth panel work will take place every four months, with findings reported to the Q&E Group; this will include feedback from parents and practitioners on practice quality and impact.

Successful reintegration into an education setting for children who have been electively home educated

This multi-agency audit was undertaken to explore best practice learning for children who have returned to an education setting after a period of elective home education. This was a follow-up action agreed by the Herefordshire Safeguarding Children Board as part of the reporting in response to the National Panel's [Safeguarding children in elective home education report \(May 2024\)](#).

Six children were identified who had returned to an education setting. The children were identified in summer 2024 and had all successfully been sustained in their education setting at the time of the audit (February 2025). The audit concluded that:

- There was good multi-agency information sharing and collaboration to understand and address the needs and risks for children.

- Good quality analysis was evident.
- Specialist services were accessed to support the specific needs of the children including timely progression through the EHCP process and advice from CAMHS.
- The needs of the children were centred through flexible and creative approaches.
- A proactive and sensitive approach to the needs of young carers by a school was impactful in supporting a child's return to school.
- Services were responsive when a child wanted to return to an education setting.
- Sensitive and accessible support was provided by specialist services to parents to navigate the system successfully, in particular the SEND and Inclusion Teams.

Learning and improvement points included:

- Some parents being anxious and resistant to accepting Early Help support, and reporting feeling overwhelmed by the number of services involved.
- A need for greater multi-agency awareness of duties and available services for electively home educated children, including when to refer a child to the Inclusion Team.
- A need for additional guidance to prevent suspensions when children have challenged behaviour.

Work will be initiated through 2025-26 to share the best practice learning and follow up on the learning points with improvement actions.

Observation of Strategy Meetings

This audit involved six multi-agency colleagues observing and evaluating the quality of multi-agency practice in 12 Strategy Meetings over an eight-week period (February to March 2025). This audit was undertaken to benchmark practice against national multi-agency practice standards and to test out the impact of improvement actions taken in response to issues identified through analysis of the Herefordshire multi-agency data sets.

Issues identified in scrutiny of the partnership dataset included concerns about the sufficiency of multi-agency attendance at Strategy Meetings and ensuring minutes are shared to all relevant agencies. Extensive action has been taken to address these concerns including additional multi-agency management oversight and follow up action on any concerns on a case-by-case basis.

Scrutiny of the multi-agency dataset through this reporting period has shown improved confidence in the accuracy of the data and a reduction in concerns about the reliability of appropriate multi-agency involvement. This has included recent consideration of rates and numbers of repeat Strategy Meetings. This shows that repeat Strategy Meetings in Herefordshire are consistently around 12%, or 1-2 per month. This indicates that decision making in Strategy Meetings secures progress and effective action for children.

The audit provided an opportunity to scrutinise practice quality and impact of improvement actions, bearing in mind issues and progress considered through this reporting period.

The audit concluded that:

- All key agencies were represented in the observed Strategy Meetings.
- Information sharing was clear and comprehensive.

- The child and family's voice were heard and taken into account in most cases.
- Respectful child centred scepticism was appropriately evident.
- Professional curiosity and empathy were evident, including examples of effective use of a trauma informed lens to understand the needs and risks for the children and family.
- Practitioners were experienced and knowledgeable, demonstrating a good, applied understanding of significant harm.
- The rationale for decision making was clear and appropriate.
- Extra-familial harms were appropriately addressed.

Learning and improvement points included:

- Ensuring a clear rationale for any delays in Strategy Meetings taking place that centres the impact for the child.
- Ensure contributions from all relevant invited agencies, in particular out of area schools, GP practices and adult health services.
- Ensure the views of the child are explicit and considered in all Strategy Meetings.
- Clarity on whether there is to be a single or joint enquiry in all Strategy Meetings, and the rationale for this decision.
- Ensure the sexual health of children is considered where sexual abuse is an issue of concern; Practitioners should be aware that attendance at SARC is a package of care that looks at sexual health, relationships, counselling and onward referrals, not just forensic evidence.

Overall, multi-agency practice in the observed Strategy Meetings was of a good standard. This indicates positive impact and progress on the quality of practice during this reporting period as a result of sustained multi-agency scrutiny, challenge and related action to improve this key area through additional management oversight and guidance. Work will be initiated to share the best practice learning and follow up on the learning and improvement requirements from this audit.

Child Protection Case Conferences

This audit involved five multi-agency colleagues observing eight Review Child Protection Case Conferences over a four week period (February to March 2025). As for the Strategy Meeting audit, this audit was undertaken to benchmark practice against national multi-agency practice standards and to test out the impact of improvement actions taken in response to issues identified through analysis of the Herefordshire multi-agency data sets.

Issues earlier in the reporting period included concerns about multi-agency attendance at Child Protection Case Conferences (CPCCs) and having sufficient input from partners. Professional Guidance expectations and requirements at Child Protection Case Conferences have been revised in consultation with key multi-agency stakeholders to clarify multi-agency attendance requirements and inclusion of WT23.

The audit concluded that:

- Sufficient multi-agency and multi-disciplinary attendance at CPCCs were evidenced.

- Relevant information was shared to understand, safeguard and promote the wellbeing of children.
- Written reports were in most cases provided when a key agency did not attend the CPCC, and these were effectively used to share and analyse information.
- In most observed audits the practitioners knew the family well.
- Practitioners effectively brought expertise, perspective and challenge to evaluation of circumstances, safety and wellbeing of the children.
- Considered discussions and appropriate application of thresholds and the CP Plan category.
- Discussions probed and challenged information provided, with concern to understand the detail of what was happening and the implications for children.
- Step downs to CIN were robust and comprehensive.
- CP Plans reflected the concerns, with clear and (in the main) timed actions.
- Planning was clear with all professionals were responsible for elements of the plan

Learning and improvement points included:

- Ensuring sufficient multi-agency attendance at all CPCC and that professional reports are accurate and include all relevant information (noting that in one case corrective action and learning was taken due to missing and incorrect information in a police report; the midwife was absent at one conference, but this was due to exceptional circumstances and health input was provided by other health partners; and in one case GP details had not been secured for the father).
- Ensuring that parents are provided with the report for the CPCC in a timely manner, noting that in two observed CPCCs the social work report had been provided less than 24 hours before the CPCC.
- Ensuring systematic and assertive approach to advocacy for children, noting that none of the children old enough to have an advocate had one.
- Whilst the views of the children were judged to be well represented in most cases the auditors for two CPCCs concluded that they were not able to hear a full understanding of the wishes of the children.
- Parents would benefit from being provided with information on CP Plan categories and the significant harm threshold before the CPCC, in an accessible format, to prepare and empower them.
- All parents to be invited to CPCCs, noting that in one case a father was not invited to the CPCC.
- Ensure Family Group Conferences (FGCs) are consistently and assertively offered to families of children who are subject of a CP Plan, noting that the use of FGCs was not fully embedded in practice.

Overall, multi-agency practice in the observed Child Protection Case Conferences was judged to be of a good standard. Multi-agency colleagues have used scrutiny and feedback on issues of practice concern to improve practice. Respectful and productive working

relationships with families and amongst professionals were apparent. Work will be initiated shortly to share the best practice learning and follow up on the learning and improvement requirements from this audit.

Dog bite audit (Single Agency Wye Valley NHS Trust)

In addition to the multi-agency audits outlined above, single agency auditing has supported multi-agency safeguarding practice. Notably, the Wye Valley NHS Trust undertook an audit to evaluate practice for a sample of 31 children who attended A&E as a result of dog bites in 2024. This audit was undertaken in response to serious attacks by dogs of children nationally, and in acknowledgement that dog bite injuries are always preventable. This audit concluded that:

- There were missed opportunities for multi-agency assessment of needs and circumstances of the children
- The voice of the child was not always captured
- Lack of professional curiosity

As a result, the Keep Me Safe suite of guidance to professionals and parents has been updated to include guidance on preventing dog bite injuries. This guidance has been launched with professionals through a series of webinars and is available on the Herefordshire Safeguarding Children Partnership and NHS Herefordshire and Worcestershire website: [Keep me safe -Herefordshire and Worcestershire Integrated Care System](#).

Overarching practice themes from multi-agency audits – strengths and development areas

An analysis of the learning from multi-agency audits undertaken throughout the year reveals the following themes:

| Audit best practice themes | Audit learning and development themes |
|---|---|
| <ul style="list-style-type: none">• Good multi-agency communication to understand and address the needs of children and families• Respectful, sensitive and purposeful communication with families was evident• Multi-agency expertise was used effectively to collaborate with families to resolve issues of concern | <ul style="list-style-type: none">• Wishes of children being consistently secured, heard and taken into account• Providing families with information to prepare and empower them |

Evidence of Impact

In 2024-25, the multi-agency and single-agency audit programmes have provided assurance about the strength of practice in key areas. The learning identified and subsequent actions taken will further strengthen practice. Notable impact already in place is the resumption of the Pre-birth Panel to support timely multi-agency action to understand and address the needs of unborn babies and their parents and awareness raising for professionals about preventing dog bite injuries.

Future Plans

In addition to sustaining its programme of multi-agency audits, in 2025-26, the Q&E Group will build on the best practice themes, and areas for improvement themes, by progressing the learning and actions from each audit.

Herefordshire and Worcestershire Q&E and QAPP sub groups will join during 2025-26 to share six monthly data, supporting both LA's and their shared partners to review patterns and trends in data and to share learning from local and national case reviews.

9. Use of data and information sharing

Activities and Achievements

Ensuring that children and families receive the right help at the right time remains a priority for the Q&E Group. One of the priorities for 2024-25 was to continue the development of the HSCP performance dataset and analysis of this data. The Q&E Group has worked through this reporting period to refine and extend the multi-agency data set into a collated dashboard using 12 strategic themes to support systematic evaluation of key performance indicators. The data dashboard is at the earlier stages of development, but already it is providing insights into multi-agency progress and development areas.

The 12 strategic themes are:

- Referrals and contacts
- Strategy meetings and S47s
- Child Protection
- Multi-agency meetings
- Children in care
- Achieving outcomes
- Agency pressures
- Partnership activity
- Leadership
- Neglect
- Right Help Right Time
- Exploitation

What data is telling us

Referrals

Contacts in this reporting period have been consistently completed in timescale (97%), indicating that the needs of children and families are considered in a timely manner. The number of contacts has reduced compared to the previous reporting period and continues to progress to being closer to statistical neighbours. The number of contacts that met threshold is overall stable at around 29% and improved on the previous year (20%). This indicates continued progress to proportionate and targeted intervention with families. Repeat referrals for assessment, at 22.3%, have reduced from the previous year 23.5%.

A priority for the MASH in 2024-25 was to work with partners to improve the number of contacts that meet threshold, in order to promote partners' application of the levels of need and ensure that families are supported with the right services. This requires shared management of risk and a joint approach to the application of a strength-based Restorative Practice approach. The improvements in the conversion rate of contacts to referrals meeting threshold in the reporting year shows progress in this area, which was due to MASH workers continually raising and discussing with partners where threshold was not met at the point of contact, strengthening of management in the MASH, and ongoing workshops and conversations with partners, including the invitation for schools and early years to join coffee mornings in the MASH. The Ofsted monitoring visit, reporting on Child and Family Assessments in February 2025, found appropriate application of Thresholds.

Strategy meetings and S47s

Development work has been completed to ensure the accuracy in the data regarding strategy meetings and agency contributions to them. This is significant progress to address what had been a persistent concern of the Q&E Group, to have an accurate line of sight on practice. Most (91.5%) of strategy meetings were completed in timescales in the last six months of this reporting period, showing an overall timely response to multi-agency joint working.

There has been a reduction in the number of strategy meetings and s47s being completed compared to last year, and an increased number of s47 being Joint and not single agency child protection enquiries. This data reflects the impact of audit and challenge bringing about a change in practice (increased Joint s47 enquires), and appropriate application of threshold and Restorative Practice for s47 by Children's Social Care (reduction in s47).

Child protection

Overall Child Protection numbers have reduced to 40.8 at Q4 from 57 at Q1 in 2024-25. Herefordshire are now in line with England averages. This performance outcome concurs with the evidence of considered and appropriate multi-agency evaluation and decision making, and restorative partnership with families that was noted consistently in the observation audit of Child Protection Case Conferences (February to March 2025).

Child protection visits to children have been sustained at a consistently high rate (96% in timescale) in this reporting period, indicating appropriate direct contact to monitor and support children who are subject of a Child Protection Plan.

Neglect continues to be the primary category for children who are subject of Child Protection Plans, followed by emotional abuse. Categories of physical abuse and sexual abuse are consistently low. Whilst this continues to a subject of scrutiny and challenge, the observation audit of Child Protection Case Conferences did not indicate concerns about category decision making by the multi-agency group at Review Child Protection Case Conferences. The high rates of neglect indicate a need for continued focus on effective assessment and intervention at all stages of a child's journey when there are concerns about neglect.

A more recent addition to the data dashboard has been Police data (age and sex) on victims and suspects in crimes of abuse against children – cruelty and neglect and sexual abuse. This data shows that in respect of cruelty and neglect there are slightly more male suspects (53%). The majority of suspects (47%) are aged 30-39 years. Victims are predominantly under 10 years (68%), with similar rates for boys and girls.

In terms of sexual abuse, in line with national data, most victims are female (69%) with 81% being aged 11-17 years. Strikingly, 51% of suspects are aged 11-17 years, showing high reported rates of child-on-child abuse.

Work is in hand to partner with Worcestershire Safeguarding Children Partnership to create a comparative data set. This will include Herefordshire and Worcestershire data on charges and convictions for neglect and cruelty of children. This will assist in understanding practice across two local authorities and provide challenge and practice learning opportunities.

Children in care

The number of children in care has reduced from 115 per 10k down to 100 per 10k this year. Supported by Children's Social Care Prevention Team data this indicates that multi-agency working with children and families is successfully supporting children to remain safely or return safely to their networks of care and support.

Data on children in care currently provides a quarterly update on the numbers of children in care and the timeliness of Initial and Review Health Assessments for looked after children. During Q3 of 2024–25, the Herefordshire Children in Care Team within Wye Valley Trust, faced some challenges in the timely completion of Initial Health Assessments (IHAs) and Review Health Assessments (RHAs). These delays were primarily due to workforce constraints and issues in obtaining consent. As the statutory commissioner for health services, the HWICB collaborated closely with Wye Valley Trust to address these challenges.

This approach aimed to ensure that the health needs of Children in Care and Care Leavers in Herefordshire were met, in alignment with the Statutory Guidance on Promoting the Health and Well-being of Looked-after Children (Department of Health & Department for Education, 2015). By the end of Q4 of 2024–25 significant progress had been made, resulting in notable improvements in both the timeliness and completion rates of health assessments.

Police intervention and outcomes

Data in respect of Police Custody Outcomes shows stability in custody outcomes, with low numbers of children charged and remanded (3) and 1 detained for court in the reporting period. Over half of Police Custody detainees are aged 16 and 17 years old. Strip searches of the children by the Police are recorded to have taken place for 3 children in the reporting period. All these children are boys age 17, and all are from Black and minoritised ethnic backgrounds. The Quality and Effectiveness Group sought, and received, assurances from West Mercia Police about appropriateness of strip searches.

Evidence of Impact

In addition to providing assurance of safeguarding systems, the partnership dataset prompted a number of responses by the Q&E Group. These included:

- Seeking assurance of appropriateness of police strip searches (which was received and assurances provided).
- Providing further guidance to the Youth Justice Service about LADO processes.
- Informing an area of focus for the joint Herefordshire and Worcestershire dataset, to include a comparison of charges and convictions for neglect and cruelty of children.
- Informing the focus of two multi-agency audits (Strategy Meetings and Child Protection Case Conferences), and then supporting the findings of these audits through triangulation of information.

Future Plans

This year saw significant progress in developing a multi-agency dataset, with multiple sources of partner data that provides a holistic picture of safeguarding responses and aids the identification of emerging trends and areas for potential scrutiny. In 2025-26, the partnership will sustain this momentum, receive further health related data on A&E child presentations and build its ability to effectively scrutinise and respond to the data provided.

10. Learning from Serious Incidents

The Joint Case Review Group (JCR) is made up of multi-agency partners and oversees all case reviews undertaken. This includes Safeguarding Adult Reviews (SAR), Child Safeguarding Practice Reviews (CSPR) and Domestic Homicide Reviews (DHR). The group also responds to national case reviews and seeks assurance across the partnership that learning has been embedded in systems and practice. Upon completion of each Rapid Review/scoping meeting, the partnership publishes a learning briefing when relevant, outlining the key learning for multi-agency practitioners. Recommendations for improvements to practice and systems are also identified and assigned to a lead person and agency to progress. Progress of these actions is monitored by the Joint Case Review Group.

Activities and Achievements

In 2023-24, JCR members recognised that work was needed to improve the quality of scoping documents received from agencies for Rapid Reviews, as these were often very detailed, without the analysis required. In 2024-25, a learning workshop, delivered by the Head of Safeguarding and Designated Nurse at HWICB, was held on this topic with JCR members (who either complete or quality assure agency scoping returns). The aim was to promote good practice and expectations for agency scoping returns. The impact is expected to be seen at the next Rapid Review.

In 2024-25, one Rapid Review was undertaken (see Rapid Review “David” below). While this Rapid Review did not meet the criteria to progress to a Local Child Safeguarding Practice Review (LCSPR), learning was identified and is being addresses across the partnership. While the circumstances of this case were unique in comparison to Rapid Reviews completed in previous years in Herefordshire, there were two **common areas of learning** that were also reflected in serious incidents from 2023-24, which will be a focus for JCR in 2025-26. These were:

- practitioners’ understanding the effects of parental acrimony and alienation on a child, and ability to minimise these effects, and
- the management of information sharing when a child and/or family crosses local authority boundaries.

In addition to the Rapid Review, there was one referral for a potential Rapid Review, however a partnership triage discussion determined that this case did not meet the criteria for a serious incident.

Rapid Review “David” was completed in December 2024. While activity to embed learning is continuing in 2025-26, the HSCP and/or its partners have already undertaken the following actions:

- Children's Social Care reviewed how placement decisions are made for children at risk of exploitation, with the process now involving contact being made with local commissioning teams for children where these risks are highlighted. The SAFE Team (child exploitation and contextual safeguarding specialist team) undertake support with this. This process was strengthened in 2024 and, ongoing, all residential placements are reviewed by a multi-agency panel called Better Outcomes, which seeks to provide assurance that the placement is meeting its requirements.
- Where a child is at risk of exploitation, mapping is undertaken with all relevant agencies to track patterns of incidents between and within areas. An audit of Return Home Interviews was completed in August 2024, and work will be undertaken to promote professional curiosity in these interviews and improve the identification of hotspots and exploitation concerns so that these can be better understood.
- Educational resources about knife crime, and links to training for professionals, was disseminated via the partnership's bulletin starting March 2025.
- The HSCP's Resolution of Professional Differences Policies was reviewed and promoted to professionals through a presentation at the Practitioner Forum in April 2025.
- A presentation about the National Referral Mechanism is confirmed for the partnership's Practitioner Forum in July 2025.
- In-house and externally commissioned training on parental acrimony and alienation has been developed for Children's Social Care. This will be offered to practitioners in 2025 and additional support is being explored, including the possibility of a mediation service.

LCSPR "Child HN" was published in March 2024 and activity to embed the learning continued into 2024-25. In response to this learning, the HSCP and/or its partners have:

- Disseminated learning following the completion of the Rapid Review through a published learning briefing and presentation at the partnership's Practitioner Forum in April 2024 (attended by over 90 practitioners). Single agency staff presentations were also delivered to Children's Social Care (staff briefing) and at the Wye Valley NHS Trust's Safeguarding Forum.
- Delivered a presentation on risk to children from poor diabetes management at the partnership's Practitioner Forum in October 2023.
- Reviewed Elective Home Education procedures to strengthen links with families who electively home educate, and to better identify children who may become more vulnerable through home education.
- Strengthened Child in Need processes, including revising the Child in Need template and plan, and ensuring that minutes of Child in Need meetings are disseminated following meetings.
- Revised the HSCP Child Neglect course to incorporate the learning from HN and strengthen Think Family messages within the course.

- Introduced a new course on Direct Work and Voice of the Child, who is co-delivered by young people.
- Wye Valley NHS Trust are piloting the introduction of youth workers into the Diabetes and Epilepsy teams, to support young people transitioning into adult services. They are also identifying ways to introduce psychological support for children into the diabetes team.
- The Community Safety Partnership has secured a resource for minute-taking of MARAC meetings.

Challenges

There has been some delay and challenges in implementing two of the learning activities from LCSPR HN, notably:

- Wye Valley NHS Trust have not been able to appoint a psychologist or mental health professional to the children with diabetes team due to difficulties in recruitment, particularly as funding is not available for a full time post. The absence of a mental health professional in the team has been put on the Integrated Care System's Children and Young People Risk Register. Alternative options have been explored, including seeking support from the health psychology team, however there was no capacity for this team to assist.
- The regional West Midlands policy on Children and Families who Move Across Local Authority Boundaries was to be reviewed to strengthen procedures about children who move where there are safeguarding concerns and chronic health conditions. Due to the re-commissioning of the regional policy procedures in 2024, a new policy has been adopted from the new provider, which was not available until early 2025. The new policy will now be reviewed to ensure it addressed the learning from LCSPR "Child HN," as well as from Rapid Review "David."

Evidence of Impact

The Joint Case Review Group recognises that evidencing the impact from reviews remains a challenge. With the planned activities to embed the learning from LCSPR "Child HN" now nearly completed (with the exception of the two outstanding actions explained above), the JCR Group will revisit the learning from this LCSPR in 2025-26, to understand the impact that these activities have had and whether this has resulted in a positive change for children and families in similar circumstances. It is hoped that this activity will create a process that will strengthen our ability to monitor and evaluate impact for future reviews.

Future Plans

In 2025-26, JCR will complete the activity to embed learning from Rapid Review "David" and LCSPR "Child HN," and will continue to develop its ability to evidence impact in learning from serious incidents. JCR will also pay particular attention on learning in relation to the effects of parental acrimony and alienation on a child, and information sharing across local authority boundaries, as these were common areas of learning in reviews in both 2023-24 and 2024-25.

In response to the National Panel report Race, Racism and Safeguarding, published in March 2025, JCR is reviewing its processes and templates alongside the West Midlands Multi-Agency Safeguarding Arrangements Group that manage the LCSPR Toolkit. JCR

members will also seek to undertake a reflective workshop in 2025-26 to strengthen panel members' confidence to explore issues concerning race, culture and ethnicity robustly, and to challenge racism when it occurs in practice.

11. Representation of Education

WT23 creates a duty to ensure that education settings are fully engaged, involved and included in local safeguarding arrangements, including at the highest level of decision-making. The HSCP has therefore reviewed its governance arrangements to increase the representation of education and ensure strong lines of communication with existing education forums.

Activities and Achievements

The new **Safeguarding in Education Group** was established, meeting twice in the reporting period and continues to meet on a quarterly basis. The Group brings together representatives from a wide range of settings within the education community, with approximately 16 members at the Group's inception. The Safeguarding in Education Group builds on already established groups that provide a direct line of communication with education providers, including the primary and secondary heads forums and Designated Safeguarding Leads Network.

The Chair of the Safeguarding in Education Group has become a member of the Safeguarding Partners Board, which enables education to be represented at this strategic level and for a direct line of communication the group.

Safeguarding reviews with School Improvement Officers: Herefordshire Council's safeguarding education team completed a series of safeguarding reviews with School Improvement Officers throughout the year to advise on compliance with the Single Central Record (SCR), and the processes for raising and investigating concerns. Following these reviews, a set of recommendations were made to schools. Eight schools in total received a SCR visit including one secondary school with the remainder primary settings. This helped to support the outcome that all schools inspected by Ofsted during the reporting period were judged to have effective safeguarding arrangements; there were no schools that received ineffective safeguarding judgements or a grade 4 judgment of inadequate.

Safeguarding Training and Development in Schools

A series of webinars were held with school leaders to provide updates on safeguarding processes and highlight best practices.

Training was also provided to school governors on safeguarding practice, including compliance with the Single Central Record, to ensure those scrutinising schools have sufficient knowledge to do so.

Bespoke safeguarding training has also been offered to Early Years providers to address safeguarding concerns specific to their settings.

Further, the **Designated Safeguarding Lead (DSL) Networking** events continue to be held three times per academic year and in this period have covered topics of child neglect, exploitation, the Prevent Duty and a talk from Leeds Relational Centre on Restorative Practice. 32 representatives from schools attended the in-person meeting in September 2024, and over 60 attended the virtual events.

Self-Assessment of Schools' Adherence to Safeguarding Duties

The Section 175 audit is completed every year and provides a self-assessment of schools' adherence to safeguarding duties. The audit was completed in January 2025, with findings including:

- Overall, fewer schools graded themselves as "5," and more schools graded themselves as "4" compared with the previous year (scale 1-5 with 5 being the highest score). This was attributed to changes in staff and some schools not feeling as confident.
- Positively, an increased number of children were reported to have been supported by their school through the Early Help offer. Most schools have also promoted their Early Help offer on their school websites.
- There was an increase in children reported to be on part time timetables (PTT), and an increase in requests for Elective Home Education (EHE), which emphasises the importance of all professionals understanding PTT and the requirements around this and EHE.
- The number of Domestic Abuse Notifications (Operation Encompass) remains high, however has dropped from the previous year, which raises a potential concern of instances going unreported.
- Interestingly, schools reporting knowing of over 30 private fostering arrangements, while the Council's reporting states that there are no children in known private fostering arrangements. This either indicates that schools are mis-reporting private fostering in their records (and therefore may not understand the definition), or notifications to the Council are not being made as required.

Challenges

A challenge remains in securing representation from independent schools on the Safeguarding in Education Group, and therefore to ensure that this group is equally consulted with.

Restorative Practice training has been received in most schools following the Attachment Research Community (ARC) programme. This meant that the Restorative Practice training was not seen as pertinent to many school settings, who had already embraced and put in place restorative principles in their settings. However, education partners were invited to join the Restorative Practice in Practice multi agency workshops where agencies looked at how we can implement Restorative Practice together. See section 12 (Multi-Agency Learning and Development Programme) for a breakdown of attendance of Restorative Practice training by agency.

Evidence of Impact

While the Safeguarding in Education Group's agenda is a dynamic agenda there has already been impact in sharing information about children who are electively home educated or on part-time timetables with community policy officers, to improve policing's understanding of why children may be in community centres during the school day, and address concerns of anti-social behaviour.

In addition, the Group has supported the review of the Right Help, Right Time Levels of Need document, providing feedback on how the document is used in day-to-day practice in education to help ensure that it remains relevant and practical for education practitioners.

Future Plans

- The Safeguarding in Education Group will continue to develop its agenda and build on the impact of the Safeguarding in Education Group, including seeking representation from independent schools.
- Continue to strengthen restorative practice approaches, bringing together the approaches already in place in schools with the safeguarding approach.
- Act on the findings of the s175 audit, notably on private fostering, EHE/PTT, and Domestic Abuse Notifications
- Plan for how best to support schools in preparation for changes to the Ofsted framework coming into effect September 2025, including changes to how safeguarding will be inspected.

12. Multi-Agency Learning and Development Programme

The Development and Practice Group oversees the delivery and effectiveness of multiagency training and its impact on practice and outcomes for children and young people. It is also responsible for maintaining up to date partnership policies, procedures and guidance.

Activities and Achievements

Learning and Development Priorities

In 2024-25, the Development and Practice Group progressed the priority areas of the HSCP Learning and Development Strategy (2023-25), which were:

Child Neglect – 50 professionals attended the Understanding Child Neglect course in the reporting period, bringing the total number of professionals who have now attended the course to 105. Unfortunately, attendance on Graded Care Profile 2 courses remains low, with 21 professionals completing the training in the reporting period. The partnership also continues to promote use of the Child Neglect Toolkit, and has introduced a Home Conditions Assessment Tool as part of the Toolkit.

Child Exploitation and Contextual Safeguarding – Exploitation and Vulnerability training continues to be offered, with 74 professionals attending the course in the reporting period. In addition, the annual contextual safeguarding conference was held in March 2025, attended by 164 delegates (see information in Section 14).

Trauma-Informed Practice – Following on from Trauma-Informed Practice courses offered in 2023-24, and owing to their popularity and the positive impact on professional practice, these courses were re-commissioned for 2024-25. 152 professionals attended the Principles and Foundations of Trauma-Informed Practice course in 2024-25, meaning that 334 professionals have attended the course since it was first offered in 2023.

In addition to the three priority areas for learning above, a further priority area for learning in 2024-25 was the rollout of **Restorative Practice** training for multi-agency professionals – which was also a priority in the Children’s Services Improvement Programme.

During the reporting period, the HSCP and senior Children’s Social Care representatives worked collaboratively with Leeds Relational Practice Centre, as an Improvement Partner, to support the implementation of a Restorative Practice approach. Several launch events took place, both in-person and online throughout late 2024 and early 2025, with 61 professionals attending. The launch events were followed by a series of **Restorative Practice in Practice** workshop sessions. These aimed at bringing together partner agencies working with children and families in Herefordshire to introduce the methods and tools for an effective formulation approach to improve outcomes. **A total of 197 professionals attended the Restorative Practice in Practice workshops, providing a strong base to support restorative approaches in multi-agency environments.**

Another learning priority in the reporting period, was the promotion of the **Think Family Approach**, in response to an identified need to improve support to children and families by considering the whole family in safeguarding responses. The Think Family Approach, including [‘Practitioner and Organisational Checklists’](#) was published via the Safeguarding Partnership website and disseminated amongst partners in July 2024. In addition, the Think Family Approach is embedded within safeguarding training, promoting a response to the whole family when assessing and responding to risk. It is recognised, however, that at the end of the reporting period there was limited understanding of how well Think Family Approaches have been embedded in practice, owing to challenges in measuring the impact of this approach.

Policies, Procedures and Guidance

The HSCP maintains multi-agency policies and procedures and works with the West Midlands Regional Safeguarding Procedures Group on additional regional procedures. In 2024-25, the regional group re-commissioned the provision of the regional procedures website and procedures manual to a new provider, Tri-X, due to the previous provider discontinuing its service. This was a significant piece of work to ensure that the new procedures reflect local policies, were updated to align with WT23, and that the procedures were accessible and easy to find for professionals. The migration to the new provider was successfully completed, although there is some ongoing work to ensure that links to policies across different documents and websites are up to date.

The **Multi-Agency Professional Differences Policy** was reviewed during the reporting period, which was a routine review to update it in line with WT23. While substantive changes were not made to the policy, the document was revised to be more focussed and ensure guidance was clear. Promotion of the professional differences policy was then undertaken amongst partner organisations and promoted via a range of methods, e.g. the Partnership website, Partnership bulletin, as well as April 2025’s Practitioner Forum, alongside the revised Herefordshire Safeguarding Adult’s Professional Differences Policy. Monitoring of professional differences has found that these are being resolved at earlier stages of escalation, and within expected timeframes, which indicates a healthy culture of professional challenge.

Further, a **Home Conditions Assessment Tool** was developed in September 2024, to complement our existing suite of neglect tools and resources. The tool supports a more comprehensive understanding of a child’s living environment and assists professionals to recognise potential child neglect. While the tool was developed for use by practitioners, it is hoped to adapt it so that it can be completed collaboratively alongside the family. Feedback

from young people was sought on the tool, and once this feedback is incorporated into the tool in 2025-26, it will be more appropriate to complete the tool alongside family members.

Multi-agency training programme

In 2024-25, **1540 learners** attended the HSCP's multi-agency safeguarding courses, which was an increase from 1372 learners in 2023-25.

HSCP courses are attended by professionals from a range of organisations, with the highest attendance from Herefordshire Council employees (663), followed by Health professionals (286), the Voluntary and Community Sector (190) and Education professionals (188).

The breakdown of partnership courses and attendance can be found in **Appendix E**.

Learning Events

Two Practitioner Forums were held during 2024-2025. The Practitioner Forums are half-day learning events that are jointly organised by HSCP and the Herefordshire Safeguarding Adults Board, and cover a range of topics relating to safeguarding children and adults. The joint format promotes a Think Family Approach by ensuring that professionals who predominantly work with children or adults have the opportunity to participate in learning activities that they may not normally encounter in their usual work.

The Practitioner Forum in April 2024 saw 87 delegates attend and hear presentations on:

- Working Together 2023 Updates
- Learning from Case Reviews – LCSPR – “Child HN”
- Recognising and Responding to Child Sexual Abuse, presentation by the Lucy Faithful Foundation
- Solutions 4 Health, an overview of sexual health services in Herefordshire

The second Practitioner Forum, in October 2024, saw 62 delegates attend and hear presentations on:

- Restorative Practice – what is it and why is it important?
- Our Voice – Young People's Perspectives
- Herefordshire All Age Carers Strategy
- An Introduction to Herefordshire's Sexual Violence Strategy

Further, as part of the *Keep Me Safe* campaign, a series of webinars were organised starting in late March 2025 to introduce the new ***Keep Me Safe...When I'm With Dogs*** guidance. The purpose of the Keep Me Safe Strategy is to provide consistent and coordinated messages to practitioners across Herefordshire and Worcestershire about a particular safeguarding theme to reduce the numbers of children who are seriously injured or die across Herefordshire and Worcestershire.

Learning briefings

A Learning Briefing on '**Homelessness: Understanding the Duty to Refer for Public Services**' was published in September 2024, which highlights when referrals should be made, by whom, and to which service, when working with someone who is homeless or threatened with homelessness. This was in response to learning from a case review about homelessness support, particularly for young adults. Training and dissemination of information on this protocol became available for services working with 16 and 17 year olds, housing

teams, staff from providers of commissioned services, and officers involved in planning and commissioning services for 16 and 17 year olds who are homeless or threatened with homelessness.

The Partnership Bulletin

The bi-weekly Partnership Bulletin is used consistently as a means to disseminate news and information. The mailing list has grown to over 1000 subscribers, and the partnership regularly receives feedback on the usefulness of information shared in the bulletin.

Evidence of Impact

Evaluations of training courses and events demonstrates a positive impact on professional practice, as practitioners are able to articulate how they plan to transfer their learning into practice. When asked how they intend to use the learning from a course in practice, examples of responses were:

“I will be more vigilant in my job role and listen more to children when they are speaking to me to understand if there is an underlying problem”

“Clearer understanding of Herefordshire’s Right Help, Right Time Levels of Need, and what to do if you are concerned about a child”

“I feel well informed with how to assess safeguarding risks and how to identify concerns. I feel more able to do this during visits with children and/or young people.”

“I will be able to confidently use the child neglect screening tool within my practise.”

Further, post course evaluations provided evidence of training principles and tools being applied in practice, which is asked three months after attendance on the course:

“Helped me understand the lived experience of the children I am working with and the recognition and level of neglect. I have used the neglect screening toolkit in practice which was very helpful to support referrals” [Understanding Child Neglect]

“Using a trauma lens to analyse and help formulate plans” [Principles of Principles and Foundations of Trauma Informed Practice]

Future Plans

Development and Practice Group are undertaking an update to the Training Needs Assessment in early 2025-26, which seeks to understand multi-agency training needs related to child sexual abuse, and race and safeguarding (in response to the National Panel’s reports).

This will inform HCSP training plan for 2025-26 / 26-27, alongside further embedding of Restorative Practice approaches.

The Home Conditions Assessment Tool will also be further developed to incorporate the feedback from young people, so that it can be used as a tool alongside the family.

13. Get Safe Approach to Child Exploitation and Contextual Safeguarding

The Child Exploitation and Missing Children Group (CE & Missing Group) oversees the response to child exploitation and contextual safeguarding risks in Herefordshire. The group also oversees other areas of contextual safeguarding, namely: children missing from home or care, trafficking, modern day slavery, gangs, forced marriage, honour-based violence, female genital mutilation, and exploitation through radicalisation (apart from what is overseen by the Channel Panel and Prevent Groups), as well as effective transitions between children's services to adult services.

In 2024-25, the CE & Missing Group progressed its work as planned, completing audits of Return Home Interviews and COMPACT, developing the feedback it receives from young people and their families, raising awareness through the Risks Outside the Home Conference and locality-based community events, developing its dataset, and progressing the Child to Adults Transitions Pathway. While a strong start has been made on the multi-agency dataset for child exploitation/contextual safeguarding, and on the child to adults transitions pathway, these are areas that will require further development in 2025-26.

The Get Safe model was implemented in Herefordshire in 2023-24, which strengthened the response to child exploitation and contextual safeguarding risks. This is a multi-agency response, led by the SAFE Team situated within Herefordshire Council. The positive impact of this model has been evident in 2024-25 and was reported on positively in the Ofsted Monitoring Visit in November 2024.

Activities and Achievements

The **Risks Outside the Home Conference**, planned by members of the CE & Missing Group, was held online on 19th March 2025 with 164 attendees present. Presentations included:

- Young people's experiences of trafficking and sexual exploitation
- County lines
- Female genital mutilation
- Radicalisation
- Online Child Sexual Exploitation Team (OCSET)
- Herefordshire's SAFE Team and Partners (introducing MACE 1, 2 and missing)

The highlight of the conference was two presentations by courageous survivors who shared their experiences and support they received from organisations. The presentations brought to life the lived experiences of young people who are exploited, the extreme means that traffickers will take for their own benefit, and the ongoing trauma and challenges facing these children and young people.

A series of **targeted participation and collaboration group work with children and young people** has also been undertaken by the SAFE Team this year. As a result of this, young people have actively contributed to the creation of posters, leaflets and other literature designed to explain and promote the Get Safe service. In early 2025, four community engagement events were held, nine primary and secondary schools, and 10 residential homes have received workshops for staff and children/young people. Future community events are planned in locality hot spot areas in 2025-26.

There have been improvements in **dataset reporting** to the CE & Missing Group throughout the year, although the ambition is to expand this data to include information from partner agencies. Data now includes the number of children missing, the length of missing episodes, children's ages, gender, ethnicity, disability, status (CP, CiN, CLA, none), children open to SAFE Team, number of referrals into the SAFE team and referring agency details.

Child criminal exploitation remains the most prevalent form of exploitation experienced by children and young people in Herefordshire. The data indicates a growing improvement in the early identification of children at risk of exploitation, allowing for intervention and support at the earliest opportunity. In early 2025, there was an increase in the number of referrals following child on child exploitation. The number of vulnerable children identified at significant risk remained stable during the year, which is reassuring that these children are being identified, and it is positive that this cohort is not growing.

A key activity for the CE & Missing Group in 2024-25 was to work with the Safeguarding Adults Board to develop a **Child to Adult Transitions Pathway**. The need for this was in response to a gap in support for vulnerable young people when they transition to adulthood if they do not have care and support needs under the Care Act (2014), and therefore are not eligible for support from Adult Social Care. The pathway builds on existing multi-agency responses for adults at risk and how this can be put in place for young people who are no longer in receipt of support from Children's Services.

While the pathway has been defined, there was limited evidence of it being used. It is thought that this may be due to uncertainty among professionals about how to establish the multi-agency groups for adults, who will lead this, and being able to explain this to the young person. Testing is underway to ensure that the pathway can be used effectively, which is expected to result in case studies that may help to bring the pathway to life. While training on the multi-agency responses in adults was offered in 2024-25, further training and briefings will also be offered in 2025-26.

The Child Exploitation and Missing Group also conducted an audit of **Return Home Interview** (RHI) in August 2024, to gather and analyse information in relation to 10 young people where a COMPACT notification was received by the SAFE team and a return home interview offered. Audits found that the return home interviews were offered in timescale and that positive engagement between the SAFE team, young person and their family attributed to exploring push and pull factors, including risky individuals and areas of concern. Further work is required to improve the quality of write-ups of the RHI and promote professional curiosity, including the exploration of push and pull factors in every RHI.

Further, audits were conducted by the SAFE Team and West Mercia Police in October 2024, to ensure that the **Police COMPACT** system effectively captures and responds to missing children, in line with Missing Persons West Mercia Police Policy. Audits found that children received responses in line with the Policy. For example, all children received safe and well checks from the police following their missing episode. Their views, wishes and feelings were appropriately captured, aligning with best practice guidance. Additionally, audits demonstrated effective information triangulation with appropriate services, such as Wye Valley NHS Trust (hospital services).

The **MACE 2** is a multi-agency meeting that receives intelligence from the public and partner agencies to identify and respond to hotspot areas, new issues, and people of concern. MACE 2 reports on its activity to the CE & Missing Group. In response to the intelligence shared at MACE 2, the following actions were undertaken in 2024-25:

- MATES operations on Vape Shops,

- Community Safety Partnership have been tasked with looking at problem solving in a hotspot area,
- Local Safer Neighbourhood Police Teams have been tasked to complete patrols in areas of concern,
- Child Abduction Warning Notices were issued to protect young people,
- Neighbourhood crime fighting team undertook drug arrests and warrants

Challenges

- Implementing the Child to Adult Transitions Pathway in practice has been a challenge, which is attributed to professional uncertainty about the model and how it can be applied within threshold for Adult Social Care intervention. Further work is required to support practitioners to understand the pathway and how to establish multi-agency groups around the young person and young adult.
- A review of membership of the CE & Missing Group identified a need to improve attendance and participation from the education sector. A representative from a further education provider has recently been secured, this will aim to enhance contributions relating to the needs and experiences of children and young adults.
- At the end of 2024-25, the Police Missing Co-ordinator post in West Mercia Police became vacant. While the post is being covered by other officers, minimising the impact of this, the absence of a dedicated role remains a vulnerability. The CE & Missing Group remains informed to monitor developments.

Evidence of Impact

The positive impact of the Get Safe approach and CE & Missing Group's work is evident in feedback from young people and parents/carers about the support they received, comments from practitioners on how the Risks Outside of the Home Conference helped to raise awareness and build their confidence in practice, and in the feedback from Ofsted following a monitoring visit to Children's Social Care in October 2024.

Feedback from young people and parents/carers is gathered at the point of closure to the SAFE Team, and after 6 months, which helps to inform an understanding of the impact of the SAFE Team. The feedback suggests that the SAFE Team provide an excellent support service to children, young people, families and carers, that allows them to feel heard and valued. This follow up feedback has evidenced that the children, young people and families feel that the intervention has been positive and kept the child or young person safe outside of the family home and online spaces.

An area of development is to ensure the SAFE Team continue to work closely with the Police and community to ensure children and young people continue to be protected from risky adults and perpetrators that they may have previously encountered, ensuring that support and signposting are provided for the future if they need further help following closure. This was evidenced with one young person who shared they do not feel fully safe in the community due to the potential of coming into contact with previous perpetrators, however, they are continuing to work with Police around a conviction and know where to gain support if needed.

Feedback from practitioners who attended the Risks Outside of the Home Conference demonstrated that the event was hugely beneficial to raise awareness of contextual safeguarding issues, and build practitioners' confidence in practice. 89% of attendees at the

Risks Outside of the Home conference said that they 'learned a lot.' Attendees also described how they plan to use the information from the event in their day to day practice. Responses included:

"I will use the information from today's event to better understand individual patient circumstances and lived experiences"

"I will be curious during my visits and support sessions with children and young people; by asking questions and not making assumptions, I will consider appropriate language use"

In response to the question "what part of the event did you find most useful?" responses included:

"The real life experiences, to hear the stories first hand is incredibly powerful and memorable."

"I attended all the sessions. Excellent content and all relevant, the personal experiences were all very powerful and informative".

Further, an **Ofsted monitoring visit** completed in October 2024 that focussed on the protection of vulnerable children from extra-familial risk had largely positive findings about the response to exploitation and contextual safeguarding in Herefordshire. Ofsted noted that *"Children at risk of extra-familial harm in Herefordshire benefit from a committed specialist team which reduces risks for many of these very vulnerable children. These risks include child exploitation, going missing from home or care and the risks associated with gangs, radicalisation, trafficking and modern slavery. The Get Safe team works effectively and reduces risks for many children who are vulnerable to or at risk of exploitation and other forms of extra-familial harm."*

Ofsted also noted the response from partners had improved. They advised, *"Most children vulnerable to exploitation risks who come to the attention of children's services are promptly identified. For these vulnerable children, collaboration and timely information-sharing between partners has improved, which is helping to protect vulnerable children through targeted interventions and/or disruption activity."*

Future Plans

Focus for 2025-2026

- Further work is required to embed the child to adult transitions pathway.
- Community events planned in locality 'hot spot' areas involving SAFE Team, Herefordshire Police Safer Neighbourhood Teams, Vennture, Turning Point, Youth Justice and any other partner agencies with a designated role in hot spot areas. The aim of these events is to be visible in the community; to support communities in identifying contextual safeguarding risks outside the home and learn how to complete a Get Safe Risk Assessment.
- The Terms of Reference for MACE 2 will be reviewed, to strengthen its role in identifying and responding to hotspots, emerging issues, and people of concern.
- Future audit themes will be identified, in addition to revisiting the Return Home Interviews audit.

14. Funding Arrangements

The three Safeguarding Partner agencies contributed to the partnership budget for 2024-25, with the total financial contribution totalling **£418,596**. This budget also funded the work of the Herefordshire Safeguarding Adults Board, and Community Safety Partnership. While the children's partnership, adult's board, and community safety partnership are separate boards/partnerships, in 2024/25 they were supported by a shared business unit. The funding arrangement therefore covered the costs of more than only the HSCP.

In addition to the base budget detailed below, a grant of £47,300 was received by the Department for Education to support the implementation of WT23. This grant was spent on additional capacity within the Partnership Team to support partners and drive the changes required under the new statutory guidance.

| Safeguarding Partner Contributions | | | Expenditure (HSAB, HSCP, CSP) | |
|---|------------------------|-----|--|-----------------|
| Agency | 2024-25 Contribution £ | % | Category | Expenditure |
| Herefordshire Council (Children's Services and Community Wellbeing) | £247,339 | 59% | Salary Costs | £278,597 |
| NHS Integrated Care Board | £101,857 | 24% | Independent Chair (HSAB) / Independent Scrutineer (HSCP) | £35,098 |
| West Mercia Police | £69,400 | 17% | Consultancy costs (Independent authors SAR, DHR, LCSPR) | £33,670 |
| | | | Training expenses (online platform) | £14,450 |
| | | | Office expenses | £35,140 |
| | | | Income not funded (income reduced in line with % MERS voluntary redundancy post) | £13,455 |
| Total Contributions | £418,596 | | Total Expenses | £410,410 |

The partnership budget was underspent by £8,186, primarily due to underspend on staffing and case review (independent author) costs. This is the first year since 2021-22 that the budget has not been overspent (overspend in the previous 2 years was due to costs of an external agency manager for the Partnership Team). The underspend has been added to the partnership reserves, which were at £18,061 at the end of the financial year.

As support for the Community Safety Partnership moved to Public Health during the reporting period, going forward this budget will fund the work of the children's partnership and adult's board only. However, for 2025-26, it was agreed that the budget for case reviews will continue to cover the costs of Domestic Homicide Reviews, until an agreement is reached on how these will be funded.

15. Future Plans

In June 2025, the Delegated Safeguarding Partners invited a wider group of partners to the Safeguarding Partners Board's meeting to review progress and impact achieved in 2024-25, and contribute to the development of a plan for 2025-26.

The following areas of focus for 2025-26 were identified:

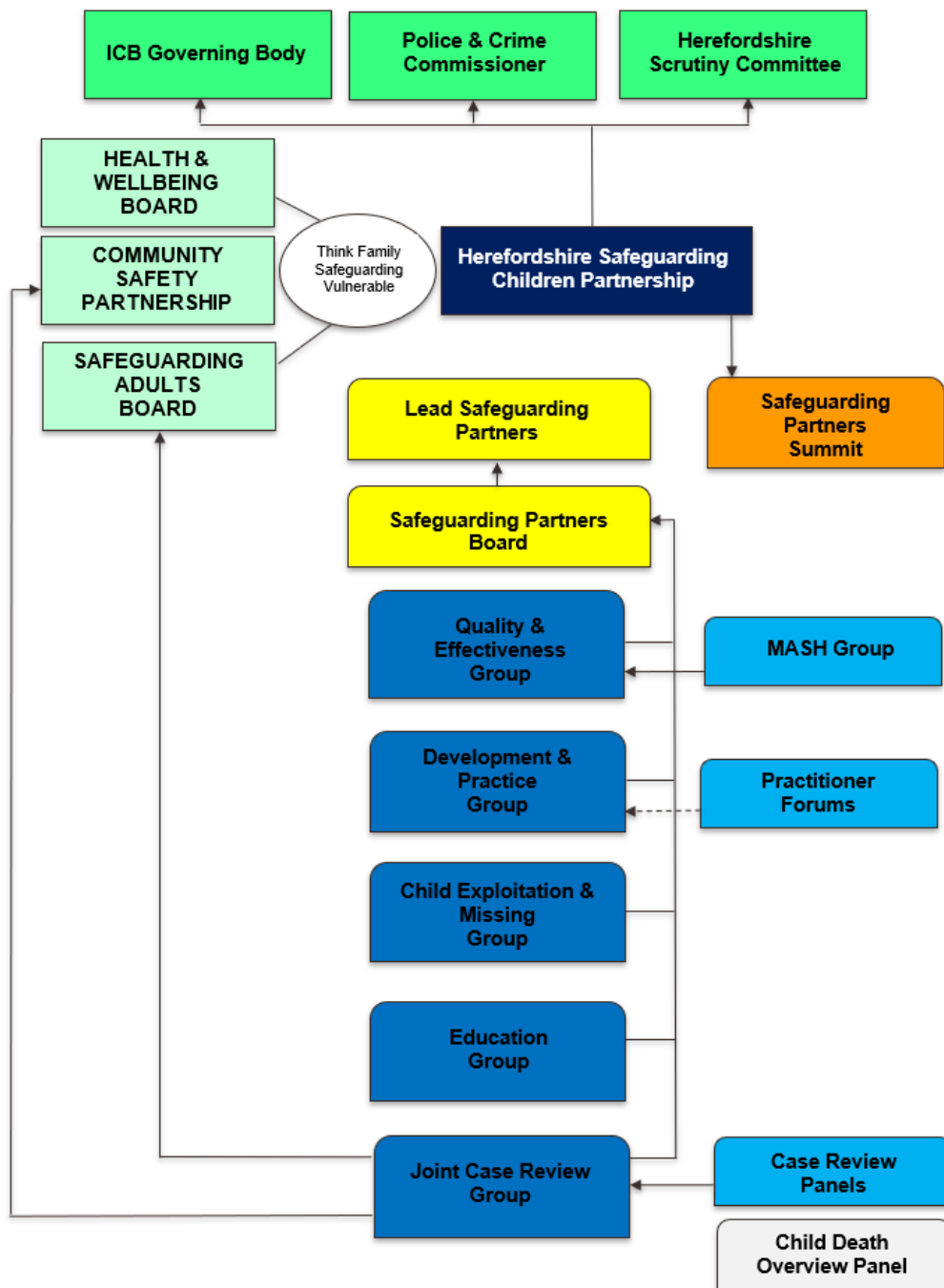
- 1. Vulnerable children leaving children's services**
- 2. Think Family**
- 3. Quality Assurance Programme – strengthening three key areas for effectiveness: data, audits and feedback**
- 4. Right Help, Right Time Levels of Need Document – joint development with Worcestershire**
- 5. Restorative Practice**
- 6. Multi-agency Response to Domestic Abuse and its Impact on Children**

Progress against the 2025-26 plan is monitored through the HSCP 2025-26 Business Plan.

Appendix A – HSCP Governance Structure

In 2024-25, the Safeguarding Partners Board was supported by six sub groups that carried out the day-to-day work to deliver the partnership's priorities.

The sub groups each have a designated Chair and Vice-Chair from one of the three Safeguarding Partner agencies. Below is a diagram of the HSCP governance structure, as well as a description of the role and Chairing arrangements for each sub group.



| Sub Group | Chair and Vice Chair 2024-25 | Summary of Group's Role |
|---|--|--|
| Quality & Effectiveness Group <i>Six-weekly</i> | Chair: Quality Assurance Lead for Implementation of Working Together, Herefordshire Council (temporary) Vice-Chair: Designated Doctor, Herefordshire and Worcestershire Health and Care NHS Trust | <ul style="list-style-type: none"> Oversee quality assurance activity, including performance data, multi-agency audits, and s11 self-assessment. Scrutinise the work and performance of the safeguarding partner agencies. Define operational impact of priorities work and new risks as well as identify the key area of learning for dissemination. Use audit, performance data and intelligence to assess the effectiveness of practice. |
| Multi-Agency Safeguarding Hub (MASH) Group <i>Monthly</i> | Chair: Head of Service for MASH and Assessment, Herefordshire Council Vice-Chair: Detective Inspector, West Mercia Police | <ul style="list-style-type: none"> Provide a forum for development and oversight of the MASH to ensure the continuous improvement of partnership arrangements, that they are effective, well understood and accessible. Reports back on the effectiveness of operational activity and adherence to the Quality & Effectiveness Group. |
| Joint Case Review Group <i>Quarterly</i> | Chair: Head of Safeguarding and Designated Nurse for Safeguarding Adults, Children, and Children Looked After (NHS ICB) Vice-Chair: Detective Inspector, West Mercia Police | <ul style="list-style-type: none"> Oversee case reviews, notably Rapid Reviews, Local Child Safeguarding Practice Reviews (CSPRs), Domestic Homicide Reviews (DHRs), and Safeguarding Adults Reviews (SARs). Action the learning from case reviews. Respond to the learning from national reviews, including the National Panel |
| Development & Practice Group <i>Quarterly</i> | Chair: Head of Service for Safeguarding and Review, Herefordshire Council Vice-Chair: Detective Inspector, West Mercia Police | <ul style="list-style-type: none"> Oversee the delivery and effectiveness of multiagency training and its impact on practice and outcomes for children and young people. Dissemination of learning and innovative opportunities including practice-learning events. Maintain up to date partnership policies, procedures and guidance |
| Child Exploitation & Missing Group <i>Bi-monthly</i> | Chair: Head of Service for MASH and Assessment, Herefordshire Council Vice-Chair: Detective Chief Inspector, West Mercia Police | <ul style="list-style-type: none"> Provide strategic oversight, scrutiny and challenge of the multi-agency approach and response to exploitation and contextual safeguarding. Provide a forum in which partners can agree, monitor and review the effectiveness of the HSCP child exploitation and contextual safeguarding strategies, framework, policies and interventions. Support the understanding of how agencies are working together to identify, respond, prevent and protect against contextual safeguarding risks. |
| Safeguarding in Education Group <i>Quarterly</i> | Chair: Service Director for Education, Herefordshire Council Vice-Chair: Safeguarding Children in Education Officer, Herefordshire Council | <ul style="list-style-type: none"> Enable engagement with a range of education providers and promote effective practice and intelligence reporting on emerging themes and trends within all education provisions. |

Appendix B – Safeguarding Partners Board

Representation of Delegated Safeguarding Partners at Safeguarding Partners' Board Meetings in 2024-25

| Safeguarding Partner Agency | Representation | % of SPB meetings attended |
|--|---|---|
| Herefordshire and Worcestershire NHS ICB | Delegated Safeguarding Partner (Chief Nurse) | 71% |
| | Deputy Delegated Safeguarding Partner or a Representative | 71% |
| Herefordshire Council | Delegated Safeguarding Partner (Director of Children's Services) | 100% |
| | Deputy Delegated Safeguarding Partner or a Representative | n/a |
| West Mercia Police | Delegated Safeguarding Partner (Superintendent Herefordshire) | 86% |
| | Deputy Delegated Safeguarding Partner or a Representative | 71% |
| Education Representative | Chair of the Safeguarding in Education Group (Service Director for Education, Skills and Learning, Herefordshire Council) | 100% <i>*attendance began in July 2024</i> |

*NB there was representation from all three Safeguarding Partners at every Safeguarding Partners Board meeting throughout 2024-25, either from the Delegated Safeguarding Partners, or their Deputy.

Membership

Membership of the Herefordshire Safeguarding Partners Board (SPB) consists of:

- Director of Children's Services (Herefordshire Council) – delegated by the Chief Executive of Herefordshire Council
- Superintendent Herefordshire – Local Policing Commander (West Mercia Police) – delegated by the Chief Constable of West Mercia Police
- Chief Nursing Officer (Herefordshire and Worcestershire NHS Integrated Care Board (ICB)) – delegated by the Chief Executive of the Herefordshire and Worcestershire NHS ICB
- Service Director for Education (Herefordshire Council) and Chair of the Safeguarding in Education Sub Group

The Independent Scrutineer, and DfE Improvement Advisor are also invited to SPB meetings.

In exceptional circumstances, if the Delegated Safeguarding Partner is unable to attend the Safeguarding Partners Board, their Deputy may attend as an alternative.

Terms of Reference

The SPB provides the local governance for the partnership that will primarily focus on safeguarding systems, performance and resourcing. This group is accountable to the Lead Safeguarding Partners. It will:

- a. Have strategic ownership of the safeguarding arrangements in Herefordshire, with stronger joint responsibility for the whole system
- b. Drive the work of the partnership, delivering on priorities and ensuring learning from practice and development opportunities have an impact.
- c. Be responsible for financial, strategic and reputational risk
- d. Be responsible for ensuring cross-partnership collaboration and agency participation, convening and supporting participation in the HSCP sub groups
- e. Have responsibility for ensuring that independent scrutiny of the partnership's effectiveness is regular and has impact and
- f. Review progress of priorities work.

Part of this group's agenda will include assurance and challenge sessions where senior officers from partner agencies are invited to provide evidence regarding the effectiveness of their safeguarding arrangements for children and young people within their agency.

The partners will report to their own internal management, quality and assurance processes to satisfy themselves of their own safeguarding responsibilities, evidence of which will be shared with the HSCP Quality and Effectiveness Group.

In supporting its working principles, Public Health exists both as a function to assist HSCP and as a commissioning partner with relevant agencies to improve health and wellbeing outcomes for children. A public health approach will promote and encourage the partnership and its relevant agencies to maintain those working principles by remaining outcome focused, maximising prevention, promoting greater integration of services and utilising epidemiological and other forms of intelligence research or evidence to promote planning and decision-making.

Appendix C – Overview of progress against 2024-25 priorities

Overview of Progress against 2024-25 Priorities

| Leadership Priorities 2024-25 | End of Year Update |
|--|---|
| 1. Complete the alignment of the HSCP with requirements of Working Together 2023. This is also a priority in the Children's Services Improvement Programme. | WT23 Implementation Plan was completed apart from revision of Right Help, Right Time Levels of Need policy (to be completed September 2025). |
| 2. Work with Herefordshire Council to support Phase 2 of the Children's Services Improvement Programme. | <p>The HSCP priorities aligned with the Phase 2 Children's Services Improvement Programme were completed, apart from review of Right Help Right Time, which will be completed September 2025.</p> <p>Although there was some delay to completing the audit on Multi-Agency Contributions to Child and Family Assessments due to other audit priorities, this audit was completed in Q1 2025-26.</p> |
| 3. Support the promotion of Restorative and Relational Practice approaches with multi-agency partners, alongside promotion of the Think Family Approach. This is also a priority in the Children's Services Improvement Programme. | <p>Restorative Practice and Restorative Practice in Practice training were offered throughout the year. 61 multi-agency professionals attended Restorative Practice Launch events, and 197 attended Restorative Practice in Practice workshops.</p> <p>Think Family Approach was published on the HSCP website and disseminated through agency leads. Guidance has been built into HSCP safeguarding training courses and is supported by the Restorative Practice Approach.</p> <p>There are challenges in understanding impact of the Think Family Approach – evidence of how it is being applied in practice will be explored 2025-26.</p> |
| Quality Assurance Priorities | End of Year Update |
| 4. Continue the development of HSCP performance data set and analysis–funding has been agreed to support this through a shared Herefordshire and Worcestershire project, which will further increase the number of agencies contributing their child safeguarding information, and simplify the gathering, processing and presentation of that information to the partnership. | The multi-agency dataset was developed throughout the year and now includes data from a range of sources and agencies. |
| 5. Deliver a programme of multi-agency audits. | Multi-agency audits restarted 2025. Four multi-agency audits were completed in 2024-25, and one single-agency audit was presented to the Quality and Effectiveness Group as it had multi-agency implications. |

| Quality Assurance Priorities | End of Year Update |
|--|---|
| 6. Monitor agencies' completion of actions identified in the section 11 self-assessment, and review section 175 audits of partners and schools compliance with safeguarding guidance and responsibilities. | Section 11 and s175 self-assessments are ongoing. The next s11 audit will be completed in 2025-26 (this is a bi-annual exercise). |
| Case Review Priorities | End of Year Update |
| 7. Continue with the effective arrangements for Rapid Reviews and Local Child Safeguarding Practice reviews through the Joint Case Review Group. | One Rapid Review was completed in the reporting period, and one potential serious incident was notified to the partnership but did not meet the criteria for a Serious Incident Notification. The National Panel agreed with Herefordshire's recommendations for both the Rapid Review and the Serious Incident Notification. |
| 8. Focus on embedding the learning from case reviews. | The Joint Case Review has monitored the implementation of learning and actions from case reviews, which have progressed as planned. |
| Herefordshire Policies and Procedures Priorities | End of Year Update |
| 9. Implement the HSCP Child Neglect Strategy. | This is an ongoing activity. While work has progressed to raise awareness and promote practitioner tools to identify and respond to childhood neglect, the development of the child neglect dataset has been delayed due to the development of the multi-agency dataset taking precedence. This will now be incorporated in the partnership multi-agency dataset. |
| 10. Agree and implement the HSCP Engagement Framework for Children, Young People, and Parents/Carers. This is also a priority in the Children's Services Improvement Programme. | HSCP Engagement Framework was agreed and published. Activity has progressed in line with the Engagement Framework and there is evidence of more opportunities taken to seek feedback from children, young people and families, and act on this feedback. |
| 11. Review and re-launch the Multi-Agency Professional Differences Policy. This is also a priority in the Children's Services Improvement Programme. | The Resolution of Multi-agency Professional Differences Policy was reviewed and re-launched. Promotion of the policy was completed. There is evidence of the policy being used by professionals, and of professional differences being resolved at earlier stages, which is an indication of healthy professional practice. |
| 12. Review and re-launch the Right Help, Right Time Levels of Need policy, in line with Working Together 2023. This is also a priority in the Children's Services Improvement Programme. | This was not completed due to challenges in engaging the Herefordshire community of families to feedback on the levels of need, which created a delay in revising the policy. The review is underway in Q1 (2025-26) and planned to be completed September 2025. |

| | |
|--|--|
| Herefordshire Policies and Procedures Priorities | End of Year Update |
| 13. Work with the Herefordshire Safeguarding Adults Board to strengthen the transition pathways for young people at risk of exploitation. | While the transitions pathway was defined and published, there is limited evidence of it being used in practice. This is an ongoing area for development in 2025-26 (focus area of Vulnerable Children Leaving Children's Services). |
| Herefordshire Learning and Development Priorities | End of Year Update |
| 14. Re-launch the Working Together to Safeguarding Children Level 2 (practitioner) and Level 3 (safeguarding leads) courses | These courses were re-launched with a multi-agency trainer pool and continue to run on an ongoing basis. |
| 15. Roll-out Restorative Practice training with multi-agency partners. This is also a priority in the Children's Services Improvement Programme. | Multi-agency partners were invited to join the Restorative Practice launch (61 attended), and Restorative Practice in Practice workshops (197 attended). |
| 16. Promote Think Family approaches across the multi-agency workforce. This is also a priority in the Children's Services Improvement Programme. | The Think Family Approach was published and promoted via agency leads, the Partnership Bulletin, and is embedded in HSCP safeguarding training courses. It is a challenge to understand the impact of the promotion of the Think Family Approach – this will be further explored in 2025-26. |
| Partnership Team Priorities | End of Year Update |
| 17. Support the transition of the Community Safety Partnership support to a new team outside of the Partnership Team, allowing the Partnership Team to focus resources on the HSCP and Herefordshire Safeguarding Adults Board | This is complete, as of March 2025, although some support is ongoing to hand-over Domestic Homicide Reviews that are already underway. |

Appendix D – Independent Scrutineer Findings

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. I set out a number of challenges for the HSCP and by the end 23/24 judged that, whilst pace and capacity remained issues, the HSCP had made good progress to becoming an effective partnership. The HSCP has now built on the platform established in 23/24 and has made further progress in 24/25.

The HSCP has made good progress in implementing the requirements of Working Together 2023. This included the agreement of a new plan for scrutiny which was approved by the Lead Safeguarding Partners in September 2024.

The HSCP is now supported by a well led and organised Business Support Unit which is benefitting from having permanent staff. The disaggregation of support for the Community Safety Partnership has also enabled the SBU to concentrate on support for the HSCP and the Herefordshire Safeguarding Adults Board (HSAB).

As this annual report shows the HSCP has made substantial progress in 24/25 and is now showing all the signs of an effective partnership. The increase in the number of meetings of the HSCP combined with the focussed leadership of the Interim Director of Children's services has improved the 'line of sight' of partners on practice. The board is benefitting from the attendance of the Service Director for Education, Skills and Learning who is now a formal member of the Board.

All sub groups are well led and have annual workplans which are monitored.

The work of the Joint Case Review sub group continues to be highly effective despite pressure that arose due to a significant rise in the number of Safeguarding Adults Reviews and Domestic Homicide Reviews which are also the focus of this multi-agency group.

The Quality and Effectiveness Group has developed a quality assurance framework, a multi-agency dashboard and a programme of multi-agency audits. Members of the group observed a number of Strategy discussions and some Review Child Protection Conferences. There is a library of audits and work is being undertaken to ensure that all single agency audits will be added to it. These tools are essential to the provision of 'line of sight' for the Board on partnership practice.

The addition of an Education sub group has strengthened the connection between the Board and the education sector. The latest S175 annual review of schools' compliance with Working Together 2023 and Keeping Children Safe in Education was presented to the meeting attended by the Independent Scrutineer. This was subsequently presented to the HSCP Board and enabled some key issues to be identified and debated. One example is that schools reported higher levels of private fostering than are recorded by children's services.

The Development and Practice Group oversees the programme of training courses. There is a process for regular evaluation of the effectiveness of training involving participant feedback post course and after 3 months.

Child Exploitation (CE) is also overseen by a sub group. A revised CE strategy and a new CE profile were delivered during the Year. In the meeting observed by the Independent Scrutineer there was evidence of partners challenging each other and good debate on local intelligence available to the Police and a voluntary sector partner. The group has overseen the effective implementation of 'Get Safe' which is a multi-agency approach to identifying children and young people at risk of or experiencing exploitation. The problem profile made a number of recommendations for the future work of the partnership in respect of tackling CE.

Relationships between partners are good at all levels and this is reflected in the confidence partners have in challenging each other when required. The escalation process is used, and the majority are resolved at levels 1 and 2. There have been no escalations beyond stage 2 this year. Stage 2 escalations are reported to the Q&E group so that they can be monitored and additional response made if required.

The quality of relationships is nowhere more evident than in the Multi Agency Safeguarding Hub (MASH). Despite challenges arising from the changes being made to the West Mercia Police Harm Assessment Units (HAU), the MASH data and audit work demonstrates a grip on referrals and timely decision making. Questions still remain about the high level of contacts from partners which do not translate into referrals. This is still the case for West Mercia Police but towards the end of the year there has been a slight improvement. When visiting the MASH, the Independent Scrutineer saw good examples of case management and was able to see first hand good use of performance data to review, and if necessary, change, practice. All key partners are represented within the MASH. There is also an effective out of hours emergency duty team.

The attendance of partners on the Restorative Practice (RP) introduction and training courses has improved. This is a very positive development as RP is being positioned as the main method for working with families, children, young people and carers across the safeguarding system. The positive benefits of this were observed in some of the observations of Strategy Discussions and RCPCs mentioned above.

As part of the Improvement Plan for children's services the Improvement Board receives performance data including an analysis of the monthly case audits undertaken by the service. These audits have provided evidence of good partnership working in individual cases. In addition, the service introduced a system to obtain more feedback from service users. This feedback also shows that the work of partners has improved.

Work with other partnerships is effective. The HSCP business plan is aligned with the Improvement Plan that is being overseen by the Improvement Board. All members of the HSCP are represented at the Improvement Board. Other members of the HSCP Board sit on and, in some cases, Chair other key partnerships such as the Community Safety Partnership (CSP), Health and Well Being Board (HWBB), and the Herefordshire Safeguarding Adults Board. Safeguarding issues are reflected within the Joint Strategic Needs Analysis (JSNA). Scrutiny of the 23/24 Annual report was undertaken by the Herefordshire Council Children's Scrutiny Committee. The Independent Scrutineer observed effective working between the HSCP and the CSP Domestic Abuse and Violence sub group in respect of the review of provision in the County to support those at risk or experiencing Domestic Abuse and Violence. This was part of the HSCP response plan to the Families Commission Report (2023). The HSCP and the HSAB have commissioned a joint learning review looking into support for former looked after children as they move into adulthood.

The Independent Scrutineer and the DfE Commissioner for Herefordshire undertook a joint review of the complaints process for children's social care. This had previously been criticised by external agencies and some families. The interim DCS has introduced a new

approach to complaints. Complaints are received by the Herefordshire Council complaints department. Once passed on to Children's services, they are assigned for action to a member of the quality team for response. They contact complainants in a timelier manner and there is evidence that this has improved the response to and resolution of complaints. Progress with complaints is monitored by the Interim DCS and her team. They receive a monthly update on the number of, and progress with complaints. The policy and processes for children's services complaints is compliant with required practice and is similar to best practice elsewhere.

This Yearly Report provides a comprehensive record of the work of the partnership in 24/25. It illustrates the improvement in focus on delivering key priorities. It illustrates the good work undertaken by all parts of the governance structure. It demonstrates a good 'line of sight' is held by the senior leaders of the HSCP. The Yearly Report outlines where progress has been made against the 24/25 priorities and in the main has delivered against those priorities.

The Lead Safeguarding Partners have established a Board that covers two local partnerships. Herefordshire and Worcestershire partnerships are overseen by one LSP Board and the other oversees safeguarding in Telford and Wrekin and Shropshire. This is compliant with WT23. The LSP made some key decisions in 24/25 on budget, independent scrutiny plans, and approved Yearly Reports in the required timescale. A key decision was made to develop a single Herefordshire and Worcestershire threshold document. Both meetings were attended by the Independent Scrutineer and evidenced good relationships between the LSPs.

What have the regulators said in 2024/25

Ofsted

There have been two monitoring visit letters published in the year.

In December 2024 the theme of the monitoring visit was the protection of children from extra familial risk. The visit took place in October 2024. In respect of the partnership Ofsted observed:

- The Get Safe team was based in the MASH and provides effective screening of children and young people at risk or experiencing child exploitation
- Regular Multi Agency Child Exploitation (MACE) meetings are highly effective and make good use of multi-agency intelligence
- The Get Safe team works effectively and reduces risks for many children who are vulnerable or at risk of exploitation and other forms of extra familial harm.
- Timely information sharing between partners has improved
- There was good use of Interpreters
- Leaders recognised that the take up and analysis of return home interviews needs to be improved

In March 2025 the themes of the monitoring visit related to partnership working were child protection enquiries, strategy discussions, section 47 visits and the use of Police Powers. The visit took place in February 2025. Ofsted observed:

- Strategy discussions are timely and well attended
- Information sharing was effective

- Social workers undertake thorough section 47 enquiries
- Views of partner agencies are captured in assessments
- That leaders have identified the issue that police do not always give sufficient priority to joint section 47 child protection investigations, or are not sufficiently forthcoming to assist in some instances (for example where their help might ensure the safety of social work staff), but there had yet to be an impact as a result of that recognition.
- That senior leaders had established a Partnership Executive Group led by the Council Chief Executive and involving Health and the Police.

Overall, the evidence from Ofsted confirms that the partnership is much better at ensuring that arrangements to safeguard children and young people are effective. In addition, since the Ofsted February 2025 Focused Visit, there has been evidence of an increased proportion of joint S47 enquiries. This data reflects the impact of audit and challenge bringing about a change in practice and appropriate application of threshold.

His Majesty's Inspector of Police Fire and Rescue Services (HMIFRS)

HMIFRS published the West Mercia Police PEEL Assessment 2023 to 2025 in May 2025.

There are a number of findings related to partnership working.

1. Overall, the Force needs to make better use of data and analysis to ensure it is operating efficiently and effectively
2. Positive findings
 - Online child exploitation team effective use of civil order and strong partnership working
 - Specialist teams making good use of orders to protect vulnerable children
 - Improved use of Clare and Sarah's laws but problems accessing data
 - Good use of victim satisfaction data to improve through training
3. Area for improvement
 - The force lacks confidence in its vulnerability data
 - There is different analysis of the same data
 - There is limited access to data from some safeguarding partners
 - The force needs to reduce the use of spreadsheets to hold data
 - The poor data means decisions are not well informed by evidence
 - The force experienced a significant backlog in harm assessments.
 - The force doesn't complete risk assessments of children quickly enough
 - Harm Assessment Unit assessments are of a poor standard
 - Only 4 % of assessments capture the Voice of Children and Young people.
 - The force could not explain why there were delays Multi-Agency Risk Assessment Conferences.
 - The number of MARACs being held is lower than expected and the force could not explain why

This report raises a number of issues that the HSCP will need to consider. West Mercia Police covers four safeguarding partnership areas, and it will be important to focus on how these findings have impacted specifically in Herefordshire. The partnership did experience

for example a significant backlog in Police contacts and referrals into the MASH during the Easter period (2025).

National Health Service

There have been no regulator reports this year on NHS safeguarding partners.

What can the partnership do to improve

HSCP has made major improvements in 24/25 but needs to maintain momentum in 25/26 to consolidate the improvement in the face of some challenges. All major partners have and will be experiencing changes at leadership level in some key roles during the coming year. The Integrated Care Board has to respond to the new government agenda for the National Health Service, and this will also affect NHS providers. West Mercia Police has introduced a new management structure, and the reorganisation of the Harm Assessment Units will not be completed until September 2025. Whilst not directly involved in local government reorganisation, Herefordshire's neighbouring authorities are and this might impact particularly on the positive work between the County and Worcestershire developed by the safeguarding boards.

All partners in the HSCP have limited capacity to support partnership working and this sometimes manifests itself in matters such as attendance at meetings or involvement in key work. For example, in the multi-agency audit observed by the IS not every partner was able to complete the required scoping documents within time or to the same standard. Whilst partners were able to work around this in meetings, and the required information was eventually produced it made the task more difficult. The HSCP needs to consider whether or not there is sufficient capacity to deliver all the priorities and work programmes to the level they have set. Alternatively, it may be necessary to re-prioritise the programme. The HSCP was due to undertake a review of priorities for 25/26 in May 2025.

More specifically the HSCP should:

- Continue to maintain the pace of improvement
- Continue to maintain the current work programme on quality assurance and avoid 'starting again' which delayed progress in the past
- Refine the performance data set to ensure a regular cycle of reporting and analysis of key data.
- Refine the Multi Agency Audit approach to provide more focus on partnership working rather than the strengths of single agencies.
- Ensure that the lessons learned from audits and other reviews have been implemented and have improved practice
- Ensure there is sufficient capacity to deliver the HSCP work programme
- Review the evaluation of the impact of training and development on the lived experience of service users.
- Capitalise on the new Children's Services locality model to strengthen safeguarding practice at local level
- Work with West Mercia Police to establish the impact of the PEEL findings on local practice and agree plans to improve practice where appropriate.

- Monitor the implementation of the recommendations set out in the CE profile
- Continue to review the partnership work on capturing the Voice of the Child and Young People
- Review the scrutiny plan for 25/26
- Work with the Lead Safeguarding Partners Board to ensure that both boards are compliant with the expectations of WT23.

Annex A - Evidence base

During the course of the last 12 months the Independent Scrutineer has:

- Attended: HSCP Boards, Q&E sub group, Improvement Board, CE group and Children's Scrutiny Committee
- Held regular discussions with the DfE commissioner
- Held regular discussions with staff
- Met with a small group of families
- Observed and participated in a complete multi-agency audit
- Reviewed some children's services case files
- Participated in developmental workshops of the HSCP
- Given regular feedback on key issues such as data and information
- Read all regulatory reports published during the year
- Participated in the regional Multi-Agency Safeguarding Arrangements meetings
- Read relevant information from ADCS, Care knowledge and the NSPCC national repository of case reviews.

Annex B - Framework for evaluating Partnership working (as agreed by the LSP September 2025)

| Leadership | Activity |
|--|---|
| <ul style="list-style-type: none"> • The HSCP partner leads are clearly identified and accountable; are developing, reviewing and ensuring funding for strategic HSCP activity; and are identifying and publishing agreed outcomes for HSCP activity to safeguard children • Delegated representatives of the three lead partners are strategically placed on relevant partnership meetings, sub groups and working groups | <ul style="list-style-type: none"> • Board has established a process to review 24/25 activity and report with a view to determining outcomes and review priorities • All agencies attend meetings but not always same person • Representation on groups is good • Work with other boards is good. NA case/Get Safe/transitions /DA review |

| Leadership | Activity |
|---|--|
| <ul style="list-style-type: none"> The three partner leads are working alongside other partnerships: Safeguarding Adults Board; Community Safety Partnership; Health and Well Being Board; Children's Improvement Board; Children and Young People's Partnership. The three strategic leads are ensuring the necessary HSCP annual reporting is in place; with the HSCP yearly report appropriately scrutinised. They are ensuring that a process is in place to review annual HSCP outcomes and for assessing forward planning procedures | <ul style="list-style-type: none"> Escalations – more stage 1 and 2 but no data on stage 1 none went beyond stage 2 none to stage 3 and timescale is better and reported to Q&E. Active participation in the Improvement Board |

| Engagement of Relevant Agencies | Activity |
|---|--|
| <ul style="list-style-type: none"> The wider safeguarding children partnership is informed and updated with current findings from research and local and national reviews. They are informed of local and national guidelines regarding safeguarding children in and outside of the home environment | <ul style="list-style-type: none"> National Panel reports Care knowledge Partnership Bulletin |

| Outcomes For Children and Young People | Activity |
|--|---|
| <ul style="list-style-type: none"> Children and Young People are consulted; and given opportunities to input into and influence the development and review of the HSCP desired outcomes for children. A communication strategy is in place (engagement strategy) to ensure that those impacted most by safeguarding concerns are aware of their right to be safeguarded and to play a part in developing initiatives to prevent, respond to, and report about safeguarding threats Opportunities are in place for C&YP to lead or co lead safeguarding initiatives focussed on improving outcomes for children; safeguarding training for adults and children; and, attending relevant meetings, working groups and sub groups. | <ul style="list-style-type: none"> The annual report contains examples of effective work to engage children and young people The HSCP has an engagement strategy and tool kit in respect of capturing the voices of C&YP Some Safeguarding partners have single agency systems in place. Young people are involved in the production of their Pathway plan. More work is required in the area of having young people lead safeguarding initiatives. Get Safe though is a good example of the partnership's commitment to such involvement. |

| Outcomes For Children and Young People | Activity |
|---|-----------------|
| <ul style="list-style-type: none"> Young People play a role in assessing and representing desired outcomes during their transition to adult services | |

| Quality Assurance and Information Sharing | Activity |
|--|---|
| <ul style="list-style-type: none"> Mechanisms are in place for the three core partners to collect, analyse, and share relevant multi-agency data pertaining to the safeguarding of children Agencies from the wider partnership are undertaking and sharing their own single agency audits of data pertaining to safeguarding children Relevant data from the full HSCP is being used to review the impact of safeguarding initiatives on desired outcomes for children Relevant data shared across the partnership is used to inform an assessment of gaps in data needed to identify priorities; and future safeguarding plans | <ul style="list-style-type: none"> Progress has been made but improvements can be made The NHS Dog bite audit is an example of single agency work influencing work of the partnership S11 tool has been launched S175 was done reported to Q&E Work being done on cross referencing single agency audits to MAA audits Ofsted feedback PEEL SEND Inspection Better audits Improved Board data |

| Learning From Local and National Reviews and Research | Activity |
|--|--|
| <ul style="list-style-type: none"> The full HSCP are aware of the criteria and process for referral of serious incidents Case reviews are adequately resourced to enhance learning, to embrace contextual as well as individual and family concerns and to involve the full range of strategic and operational staff to extract and embed learning. Learning from local and national reviews is cascaded and used to improve outcomes for children their families and communities Learning from case reviews is integrated into future HSCP training policy and practice | <ul style="list-style-type: none"> JCR operates good threshold RRs and LSCPRs resourced well SIN scheme revision EHE, CSA, Race national reports seen at Q&E How to talk about Race booklet produced March 2024 |

| Multi Agency Safeguarding Training and Workforce Development | Activity |
|---|--|
| <ul style="list-style-type: none"> • There is a transparent and clearly understood process for identifying, providing and evaluating HSCP training needs with all safeguarding partners. • The planning and delivery of multi-agency training is informed by the local safeguarding children plan; review of local data; local and national policy; legislative contexts; and up to date research findings • The take up and use of HSCP training is reviewed in all HSCP agencies including take up and use of training by children, young people and communities which has been offered by single agencies (i.e. online safety in school curriculums) • The three lead HSCP partners are assessing the impact of safeguarding children training on practice and using this to inform future HSCP training needs | <ul style="list-style-type: none"> • D&P monitors post course evaluations plus 3 months later. • Good training offer |

Appendix E – Multi-Agency Training Programme

Attendance at Multi-Agency Training Courses 2024-25

Early Help

| Event | Attended |
|---|----------|
| An introduction to early help and services available to support families | 64 |
| Early Help Assessment - How to run effective team around the family meetings (TAFs) | 17 |
| Early Help Assessment and TAF review training workshop | 44 |

Substance Use

| Event | Attended |
|---|----------|
| Delivering substance use brief interventions: Working with Young People | 26 |
| Drug and Alcohol Awareness Training | 45 |
| Overdose awareness and Naloxone Training | 43 |

Exploitation and Contextual Safeguarding

| Event | Attended |
|------------------------------|----------|
| Exploitation & Vulnerability | 74 |

Child Neglect

| Event | Attended |
|---|----------|
| Understanding Child Neglect (HSCP Course) | 50 |
| Graded Care Profile 2 (GCP2) Training | 21 |
| Graded Care Profile 2 (GCP2) Refresher | 3 |

Safeguarding

| Event | Attended |
|--|----------|
| Right Help Right Time (HSCP course) | 36 |
| Working Together to Safeguard Children Level 2 (HSCP course) | 87 |
| Working Together to Safeguard Children Level 3 (HSCP course) | 43 |

Domestic Abuse Courses

| Event | Attended |
|--|----------|
| Courageous Conversations in Domestic Abuse and Sexual Violence – Specialist Training | 22 |
| Domestic Abuse and Learning Difficulties in Adults | 5 |

| Event | Attended |
|--|-----------------|
| Domestic Abuse and Sexual Violence – Active Bystander Training | 53 |
| Domestic Abuse and Sexual Violence Training – Level 1 | 69 |
| Domestic Abuse and Sexual Violence Training – Level 2 | 46 |
| Domestic Abuse and Sexual Violence Training – Level 3 | 20 |
| Multi-Agency Risk Assessment Conference (MARAC) Awareness | 57 |
| Working with Perpetrators of Domestic Abuse | 31 |

Trauma-Informed Practice

| Event | Attended |
|---|-----------------|
| Trauma-Informed Organisations: Creating and Supporting a Trauma-Informed Organisation | 13 |
| Principles and Foundations of Trauma Informed Practice | 152 |

Restorative Practice

| Event | Attended |
|---|-----------------|
| Restorative Practice in Practice: Multi-Agency Formulation Forums | 197 |
| Family Formulation Launch Event and Online Briefings | 61 |

Additional Courses

| Event | Attended |
|---|-----------------|
| Direct Work with Children and Young People | 14 |
| Solihull Approach Parenting and Refresher Courses | 69 |
| LADO Training | 45 |
| Loss and Bereavement | 17 |
| Teenage Brain | 28 |
| Mental Capacity Act 2005 and DOLS – Understanding and Application | 88 |
| TOTAL | 1540 |

Breakdown of attendance by organisation:

| Organisation Type | Number of Professionals who Attended Partnership Courses |
|-----------------------------------|---|
| Adult Care Provider (Independent) | 21 |
| Probation Service | 7 |
| West Mercia Police | 19 |

| Organisation Type | Number of Professionals who Attended Partnership Courses |
|---|---|
| West Mercia Youth Justice Service | 9 |
| Education | 188 |
| Foster Carers, Residential care children, Childminders | 71 |
| Fire and Rescue Service | 10 |
| Health | 286 |
| Herefordshire Council | 663 |
| Housing Providers | 67 |
| Other | 9 |
| Voluntary and Community Sector | 190 |
| TOTAL | 1540 |