HALTON SAFEGUARDING CHILDREN PARTNERSHIP

YEARLY REPORT 2024/25

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1. Foreword:

Welcome to Halton Safeguarding Children Partnership's annual report which covers our work in 2024/25. It provides an overview of this year's multiagency safeguarding activity and reflects the hard work and commitment of all our partner agencies. Furthermore, the annual report evidences our response to new and emerging risks and the strength of the work to safeguard children in Halton.

As the Delegated Safeguarding Partners for the Halton Safeguarding Children Partnership (HSCP), our role is to ensure appropriate scrutiny of the effectiveness of our joint safeguarding arrangements and provide support and challenge to our local system partners. This report offers an opportunity for us to demonstrate our shared accountability and commitment to transparency of our local strengths and challenges.

The report is set out in a way which highlights the areas identified in last year's report where additional focus was needed, the work of the partners to address those areas, the impact this had and where further activity is still required. In addition, the work of the HSCP is underpinned by a commitment to promoting a culture of continuous learning and improvement across organisations and the annual report provides an overview of our shared learning and improvement activities including multi-agency audits and learning reviews, their impact and priorities for the coming year.

This annual report will detail some of the incredible work that has been undertaken in the safeguarding arena, and recognise the hard work, determination and dedication of colleagues who take their safeguarding responsibilities incredibly seriously and work tirelessly to keep children, young people and the most vulnerable in our communities safe.

As safeguarding partners, we are committed to working together effectively, embracing challenges, celebrating successes, and fostering continuous learning across the system to drive improvement. Safeguarding children is a shared responsibility, with their welfare as the top priority. By collaborating across organisations and agencies, we ensure that everyone recognises their role and fulfils their responsibilities to safeguard and support children effectively.

The past year has seen both challenges and opportunities in our shared mission to protect the most vulnerable members of our community. Through our multi-agency work, we have strengthened our partnerships, ensuring that the voices of children and young people are heard and that their safety and welfare remain at the heart of everything we do. Indeed, the creation of our Children and Young People's Plan and commitment to the Lundy Model embodies our desire to involve children at every possible opportunity. Furthermore, our focus has also been on improving early intervention with regard to neglect, identifying risks promptly, and ensuring that children and families receive the support they need at the right time.

This report highlights the progress we have made in achieving our strategic objectives and key initiatives and provides an overview of the challenges we face moving forward. As statutory partners, we remain committed to working together to continue improving our safeguarding practices and making a real difference in the lives of children across Halton.

However, we are aware that there remain challenges that we must overcome as a partnership in the year ahead. This includes managing organisational change across our statutory partners, addressing gaps in our approach to measure impact, further enhancing our collaboration with other local partnerships, and continuing to strengthen the quality, breadth, and scrutiny of our multi-agency dataset.

Therefore, our yearly report recognises the progress that has been made in working together to keep children safe from harm, the challenges that have been met and the work ahead of us. We are grateful to all our partners and their dedicated front-line staff for their support and steadfast commitment to safeguarding children in Halton. Safeguarding is a collective effort and without them we would not be able to achieve the ambitions of our partnership.

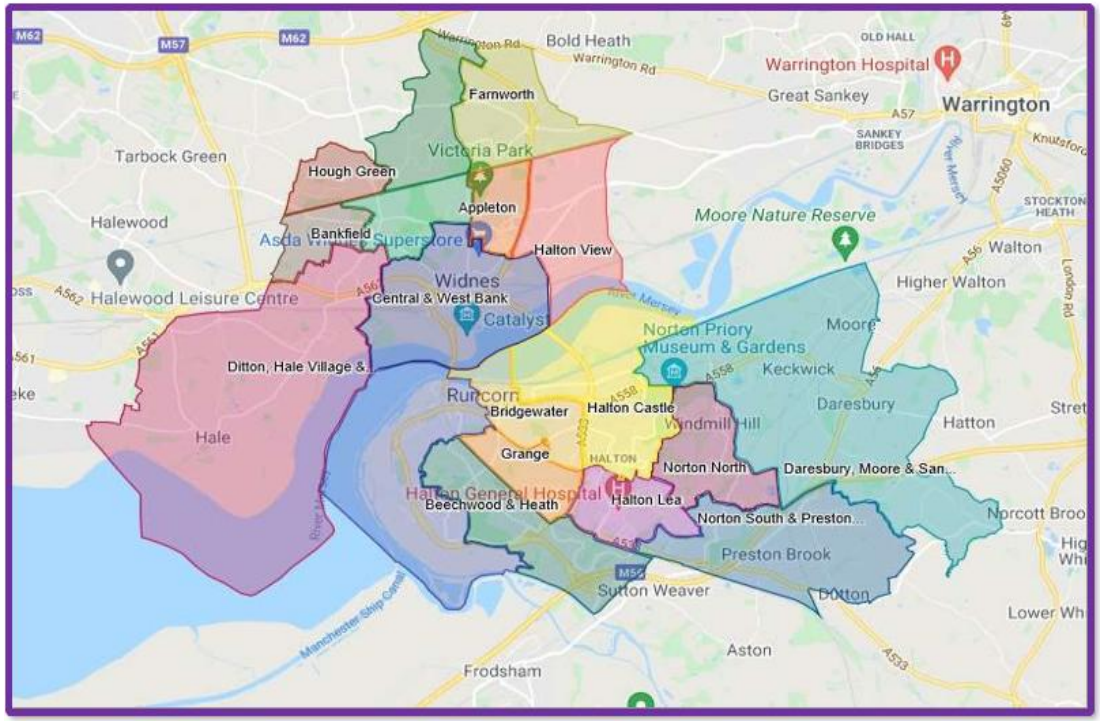
Zoe Fearon
Executive Director of Children's Services
Halton Borough Council

Denise Roberts
Associate Director of Quality and Safety Improvement
NHS Cheshire and Merseyside

Carlos Brunes
Detective Chief Superintendent
Cheshire Constabulary

2. Halton at a Glance

- Halton is a deprived borough, relative to England as a whole it is the 23rd most deprived of 317 districts.
- Almost 1 in 5 children under 16 are living in relative poverty in Halton. 56% live in the 20% most deprived parts of the country.
- For most health-related indicators, Halton fairs worse than NW and England.
- Fewer Halton children receive early developmental checks—up to and including the 2-2.5-year check—than the regional average but checks are better than England average.
- Lower proportions achieve a good level of development at 2-2.5-year check and by end of Reception year.
- A&E attendance rates are the highest in England, the majority being under age 5. As a result, hospital admissions are also higher.
- Admissions due to injuries are a significant problem, a leading cause of A&E attendance and the top cause of emergency admissions. Rates are statistically above England, but the gap has narrowed as rates have fallen.
- Halton has higher rates of vulnerable children & young people than national average.
- Halton has higher levels of SEND. Speech, Language & Communication problems as well as Social, Emotional and Mental Health needs are the top reasons.
- Number of Looked After Children (per 10,000) 134
- Average Level 8 attainment-42.8
- The under 18 conception rate is 22 per 1000, nearly twice as high as the English average (13 per 1000).
- The rate of Children subject to Child Protection Plans is 72 per 10,000, which is nearly twice the national average of 43 per 10,000 and higher than the Northwest (49)
- 42% of children aged 11 are classed as overweight.
- 24.1% of children in Halton live in relative poverty and this figure is rising.



What's it like to be a child in Halton?

27,546
Children & Young People

1 in 3
Children & Young People Live in Poverty

18.6%
Of Children & Young People Have SEND support

1782
Referrals to Children's Social Care

77.2%
Of schools are judged good or outstanding

1 in 3
Children aged 11 **overweight**

1,295
Children in Need

386
Children and young people are looked after

3. Halton Safeguarding Children Partnership

The Halton Safeguarding Children Partnership (HSCP) is a statutory, multi-organisation partnership coordinated by a Business Unit, which oversees and leads children's safeguarding across the Halton area. The Safeguarding Partnership is essential because no single agency can fully address the complex and multi-faceted risks that children may face. By working together, safeguarding partners can share information, resources, and expertise, ensuring that vulnerable children are identified early, supported effectively, and protected from potential harm.

The Halton Safeguarding Children Partnership local safeguarding arrangements Structure & Sub Groups - Halton Safeguarding Children Partnership provide detail about how safeguarding services are arranged and supported to meet the needs of our children and families. These arrangements were reviewed in 2024 following Working Together to Safeguarding Children 2023 and the new arrangements were published in December 2024.

3.1 How the HSCP is Structured: Working Together to Safeguard Children 2023.requires Safeguarding Children Partnerships to have processes in place to provide assurance that multi-agency practice is reviewed and operating well. The Halton Safeguarding Children Partnership continue to improve how we collaborate, scrutinise, assure, and drive the coordination of safeguarding activity. Within the partnership each sub-group has a clear term of reference and a Delivery Plan which align with the strategic priorities for the partnership. The HSCP Executive is made up of the three Delegated Safeguarding Partners (DSP) and Education as a 'fourth' core partner and have joint responsibility to ensure effective multi-agency safeguarding arrangements. DSPs chair the partnership on a rotational basis. For 2024/25 the chair of the Executive was Zoe Fearon (Executive Director of Children's Services, Halton Borough Council).

The HSCP has a structure of sub-groups who lead on the statutory requirements and shared priorities, reporting to and seeking feedback from both the HSCP Strategic Leadership Group and the Executive group on their work and impact. Sub-groups are chaired by and made up of representatives from across the Safeguarding Partnership's member organisations. The HSCP structure can be found Halton Multi-agency Partnership Arrangements – June 2024

The purpose of our yearly report is to reflect upon the effectiveness of services and the impact we have made together in the past year. The report sets out national and local contexts and it includes what has been achieved in our strategic priorities and workplans. It includes key findings from scrutiny activity and the steps we have taken in response. Recommendations from child practice reviews have been applied to learning. It links in with the work of other partnerships across Halton partnerships and includes activity in relation to the way we garner the voices of children and young people. Our quality assurance work includes

performance data and how this is used to help us identify where we are doing well and where we can do better. Data for this year's report has improved but continues to be an area we are developing with the support of our local northwest networks.

3.2 Our Shared Partnership Vision

We are committed to ensuring that vulnerable children and families in Halton are provided with high quality support and protection and achieve the best possible outcomes. Our mission statement is:

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

The objectives of the Halton Safeguarding Children Partnership are to:

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

To help meet these objectives, the safeguarding partners have agreed to:

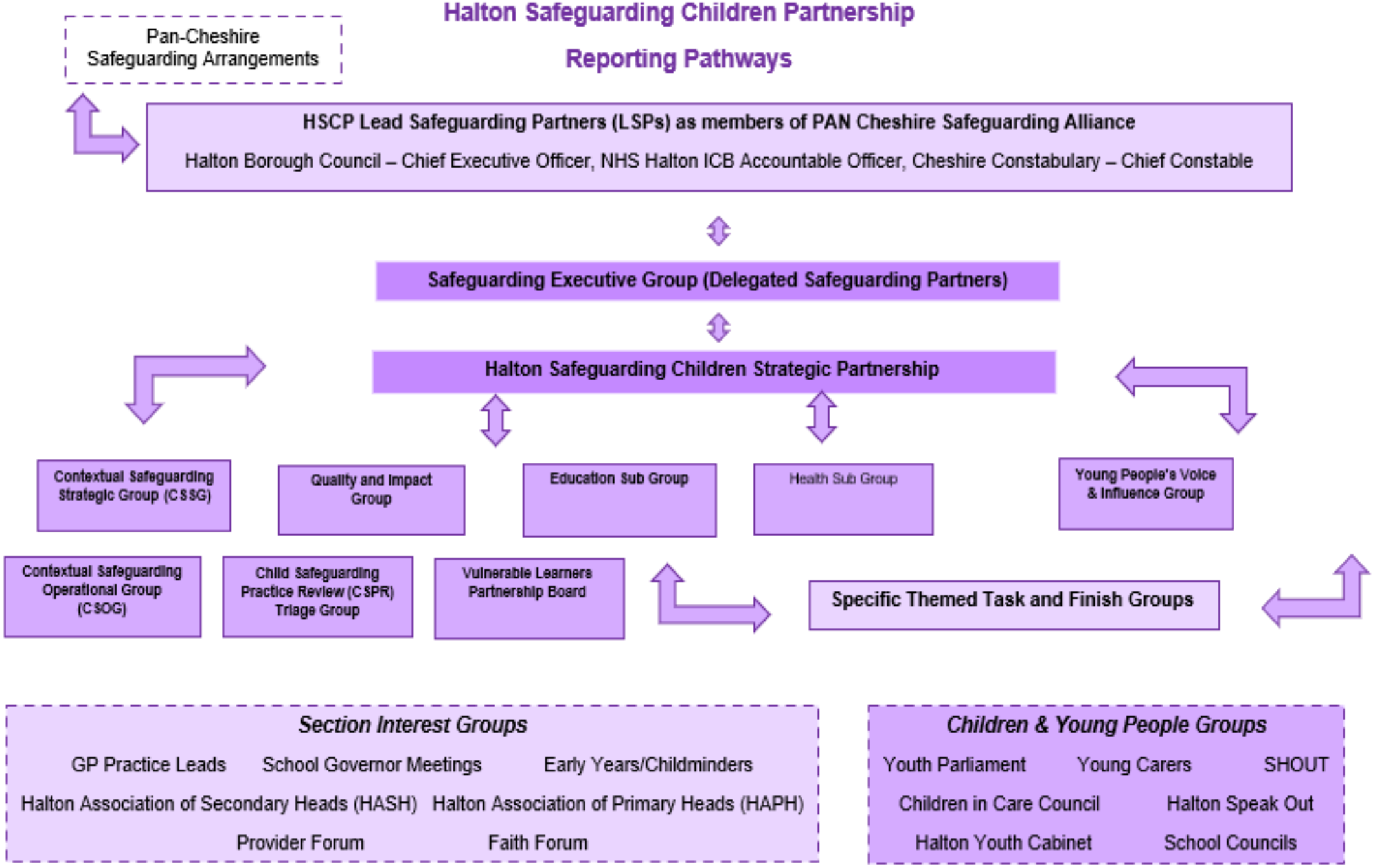
- Work collaboratively and creatively with children, young people and families using their strengths and assets.
- Lead on engaging with relevant agencies to ensure collective responsibility for building children's resilience and safeguarding.

- Further develop and promote the best of what already exists in Halton and think innovatively about multi-agency practice to improve outcomes relating to children's resilience and safeguarding.
- Lead on system change and work across the wider policy and partnerships landscape to develop and implement new ways of working and to identify opportunities to co-locate services that reduces duplication, improves practice and outcomes for children across the safeguarding pathway.
- Continue to develop our independent scrutiny framework to provide high levels of assurance across the children's safeguarding pathway.

The wider reporting arrangements agreed by the HSCP as a result of the diagnostic review that followed Working Together 2023 are captured below:

Halton Safeguarding Children Partnership

Reporting Pathways



3.3 Governance Arrangements

The updated Working Together 2023 guidance notes that the head of each statutory safeguarding partner will be referred to as the 'Lead Safeguarding Partner' (LSP), who will in turn appoint a 'Delegated Safeguarding Partner' (DSP).

The Lead Safeguarding Partners (LSP) group is the group within the Pan Cheshire Safeguarding Alliance that leads and drives the changes that the government have set out. The group is responsible for setting the Pan Cheshire strategic direction, vision, and culture of all-age Pan Cheshire safeguarding arrangements. This group is made up of the head of each statutory safeguarding partner agency. The Alliance covers the Local Authority geographical jurisdiction of Cheshire East, Cheshire West and Chester, Halton, and Warrington. Meeting on a Pan-Cheshire basis enables a sub-regional collaboration across Cheshire and Warrington aligned to the Cheshire Constabulary footprint, and covering 4 out of the 9 ICB places. The Alliance brings together the Lead Safeguarding Partners from each of the Statutory agencies (Chief Executive of ICB, CEX of the four Local Authorities, Chief Police Constable). Representation of Education as the future 4th Statutory partner is under consideration). On behalf of their organisations the LSPs speak with authority, take decisions, and commit them on policy, resourcing, and practice matters. The LSP group is established, robust and effective, with a clear commitment from partners to review and improve working methods, building on strengths and innovation within the strong partnership relationships that exist.

The Pan Cheshire Safeguarding Alliance is the high-level, over-arching local governance partnership that primarily focuses on safeguarding systems, performance, and resourcing. Safeguarding Alliance meetings take place 3 times per year, with exception meetings being arranged if an issue of Pan-Cheshire significance arises. The LSPs hold responsibility for the implementation of recommendations and learning from serious incidents, local and national child safeguarding practice reviews, although elements of monitoring these can be delegated. Standing agenda items for the Pan Cheshire Safeguarding Alliance include:

i. Highlight report from each Local Safeguarding Partnership Board in respect of progress against their action plan.
ii. Review of relevant Pan-Cheshire partnership themes from any inspection activity
iii. Approval of annual reports
iv. Review of financial arrangements for the alliance, and any related local issues
v. Horizon scanning of any national learning or developments, including opportunities to collaborate Pan-Cheshire
vi. Learning from local and national case reviews.

The Alliance is supported by Delegated Safeguarding Partners from each of the Statutory Agencies.

The Delegated Safeguarding Partners (DSP): The Safeguarding Executive:

The Executive Group sit directly under the LSP, this group consists of the three statutory partners and Education as 'fourth' partner:

- Halton Children's Services (Zoe Fearon)

- Integrated Care Board (Denise Roberts)
- Cheshire Police (Carlos Brunes)
- Education (Ben Holmes)

Executive meetings focus upon the rapid and decisive partnership action required to safeguard Halton children, young people and families who are at risk of harm and abuse. All the delegated safeguarding partners have equal and joint responsibility for local safeguarding arrangements. The Executive Group meet on a quarterly basis, focusing on scrutiny and assurance regarding key practice and safeguarding priorities. The meetings allow the Chair of the Halton Safeguarding Children Partnership Strategic Group the opportunity to provide evidence regarding the effectiveness of the safeguarding arrangements for children, whilst allowing the Executive Group the opportunity to challenge, scrutinise and seek assurance around this work.

3.4 Contributions of the 3 safeguarding partners to the partnership arrangements

The Police, ICB and Local Authority partnership leads share the Chairing of the Executive on an annual basis. Police currently chair the Executive having replaced the local authority in June 2025. In terms of sub-group chairing, the ICB chair the Health Operational Group, and the Police chair the Contextual Safeguarding Sub-Group and the Contextual Safeguarding Operational Group. The Local Authority currently chair the Strategic Partnership, the Young People Voice and Influence Group and the Quality and Impact Group. Furthermore, Education chair the Safeguarding Education Subgroup and the Vulnerable Learners Board. Finally, the HSCP Business Manager is the chair for the CSPR Triage Group. All roles operate on an annual basis, although they change at different intervals in the year, rather than all the chair roles changing at the same time. Wherever possible, the current vicechair steps up to become the chair of their respective subgroup.

3.5 Education at an Operational and a Strategic Level

Safeguarding partners have ensured there is adequate representation and input from education at both the operational and strategic levels of the arrangements. Historically, Education has enjoyed strong representation across the Partnership with the Director for Education and the Head of the Virtual School represented at the Executive. Furthermore, a Safeguarding Education Sub-Group comprises of safeguarding leads and/or Headteachers from a swathe of educational settings including Early Years, FE and Colleges, PRU, the independent sector, and primary and secondary schools. Following the publication of Working Together 2023, the role of Education has been enhanced further with the creation of a Vulnerable Learners Board that provides a focused multi-agency response to improving attendance, behaviour, and outcomes for the most vulnerable learners across the region.

Business Unit: The Partnership Business Unit undertake the management and support function of the partnership. Some of this support function includes facilitating subgroup meetings, overseeing the HSCP training offer, creating/amending strategies, and supervising learning reviews. The Business Unit staffing has remained stable over the past 12 months, allowing the team to grow in their skills and confidence to support the wider partnership. However, there remains a gap with no Quality Assurance Officer in post, something recognised by the HSCP on their risk register. The Business Unit continues to plan and move forward with joint strategic work with other partnerships within the region, making best use of some of the working practices and skill set of a diverse range of practitioners.

3.6 Overview of the Partnership's Subgroup Activities:

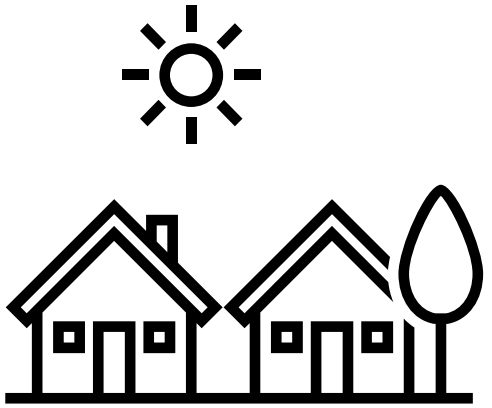
HSCP Strategic Leadership Group: During 2024-2025 the HSCP included five principal sub-groups, all of whom report to the HSCP Strategic Leadership Group. This group is central to decision making, having oversight to the entire cycle of reflective activities. This includes assurance and review, response and delivery, actions resulting from learning and the safeguarding experience of children, young people, and practitioners. In addition, the HSCP Strategic Leadership Group have responsibility for ensuring that the selected work priorities are delivered in such a way that they make a positive impact on the outcomes for children and young people in Halton. The five groups that report to the HSCP Strategic Leadership Group are:

- Quality and Impact Group (QIG)
- Contextual Safeguarding Strategic Group (CSSG)
- Health Subgroup
- Education Subgroup
- Young People Voice and Influence Group

Quality and Impact Group (QIG): The purpose of this group is to support, develop and improve frontline practice so that children and families are provided with robust, multi-agency support plans from Early Help to Child Protection and Pre-Proceedings. This group also takes a lead role, on behalf of the Partnership for performance and quality assurance by monitoring and evaluating the effectiveness of the work conducted by partners. The Group takes forward key actions and improvements identified by strategic leaders and the Safeguarding Partnership Executive and plans and coordinates learning activities. This will include learning from Local Safeguarding Practice Reviews and learning from national best practice.

Key achievements during 2024-2025:

- ✓ Revised the Quality Assurance Framework so multi-agency audits, S11 and s175 audits, CSPR Triage and Training reports are mapped onto our QA Plan on a Page and scheduled on an annual basis.
- ✓ They have analysed national learning and considered local learning themes with the assistance of a CSPR Triage Group, before making recommendations to the HSCP Strategic Group. Learning briefings have been completed and disseminated across the partnership with the support of the single points of contact (SPOCS) and the Business Unit.
- ✓ Sought assurance that groups working alongside the QIG have a function and clear points of reference.
- ✓ Facilitated three learning circles, one local reflective review and one rapid review, before submitting findings reports with recommendations to the HSCP Strategic Leadership Group for ratification.
- ✓ The QIG has supported initiatives including the adoption of more robust and transparent Professional Challenge and Escalation protocols to improve partnership working.
- ✓ Overseen the writing of a new Halton Neglect Strategy and the associated Neglect Assessment Framework and Practice Standards and Guidance.
- ✓ Facilitated an overhaul of the HSCP Training Offer with the creation of a digital suite of resources across numerous themes, produced by multi-agency partners for dissemination by single agencies.
- ✓ Revised the Practice Standards and Guidance for Strategy Meetings/Discussions and embedded changes through the multi-agency auditing process.
- ✓ Conducted an analysis of multi-agency provision in respect of supporting children as victims of domestic abuse, identifying areas where future focus is needed.
- ✓ Overseen the consolidation of Trauma Informed practice to compliment trauma awareness, for example with the creation of a trauma informed checklist to help agencies ensure their working environments are more trauma informed.
- ✓ Ensured single agency auditing findings are shared across the Partnership where applicable, boosting information sharing and inter-agency expertise.
- ✓ Identified areas of safeguarding provision that need enhancing, e.g. Child Sexual Abuse and collaborated with regional partners to adopt a north-west strategy that underpins the pathways espoused by the Centre for Expertise.



What difference has this made?

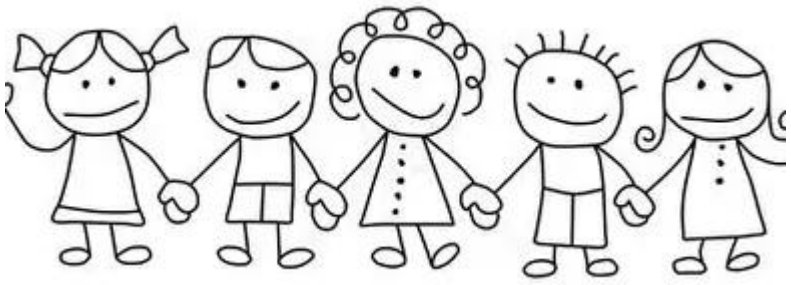
- ❖ The QIG have supported the Safeguarding Children Partnership in having a clear model to identify potential gaps in safeguarding provision, devise recommendations, and then share and communicate learning and new practices across the partnership.

- ❖ The QIG has developed a structured, and active learning approach, making links with a range of activity across the subgroups whilst simultaneously supporting the SCP's 3 key priorities in its Business Plan.
- ❖ The QIG now provides assurance to the HSCP that learning from local cases, Pan Cheshire themes, national practice reviews and the views of practitioners, children, and their families is factored into decision making and future planning.
- ❖ Analysis of quarterly CSPR reviews in 2024/25 consistently show that the vast majority of recommendations are being acted upon by HSCP, meaning safeguarding provision is increasingly robust.
- ❖ Practitioners report the new neglect screening tools being far more informative and useful in helping to improve conditions in the home.

Next steps:

- ➢ Make sure the key recommendations from QA activities that are upheld by strategic leaders, and the Executive are embedded, re-visited, and refined where necessary to ensure a partnership we are better at 'closing the loop.'
- ➢ Embed the new Quality Assurance Framework across the partnership, identifying more positive practice examples and sharing this wider.
- ➢ Ensure scrutiny of the HSCP dataset is decisive and effective in identifying gaps in provision and providing clearer evidence of progress against key objectives.
- ➢ Ensure the voice of children and families is consistently heard throughout all quality assurance activity.
- ➢ Introduce Quarterly Quality Assurance Newsletters to evidence how organisations are fulfilling HSCP priorities, including our cross-cutting themes, i.e. trauma informed approach, participation.
- ➢ Ensure S11 audit submissions are interrogated in future as part of a Pan Cheshire peer scrutiny approach.

The Contextual Safeguarding Sub-Group (CSSG): This group brings together senior officers from the three safeguarding partners and Education with responsibilities for child criminal exploitation, child sexual exploitation and modern slavery. It is responsible for the development, implementation and oversight of the All-Age Exploitation Strategy and underpinning action plans and associated work streams.



Key achievements during 2024-2025:

- ✓ The initiation of weekly multi-agency contextual safeguarding meetings that allow partners to scrutinise medium and high-risk referrals in a timely fashion and ensure support pathways are introduced holistically with sound contributions from relevant organisations.
- ✓ The Contextual Safeguarding Operational Group (CSOG) now meets monthly and focuses on emerging themes and trends before disseminating this intelligence across the partnerships via monthly reporting. Each month key themes and the actions being undertaken in response to these themes are documented and shared for scrutiny by strategic leaders, CSSG and Improvement Board members.

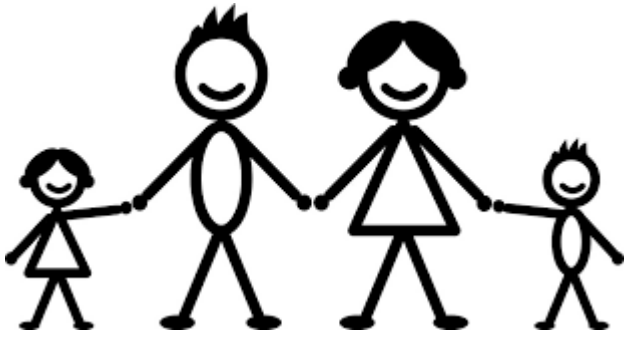
- ✓ A CSA strategy was written that included the launch of the ERASE tool. Practitioners received both digital and face to face training on the application of ERASE and the wider direction of the strategy.
- ✓ Missing from Home Protocols have been enhanced with the implementation of Operation Philomena. This has helped ensure children and young people are quickly located and returned to their care settings.
- ✓ Monthly Halton Operational Missing from Home meetings were introduced, and these are having a clear impact on the numbers of children going missing. Missing from Home Masterclasses were launched with high levels of attendance, especially from CSC and schools.
- ✓ Operation Yellow Darting has been launched to help address the spiralling threat posed to our young people by ketamine. This has culminated in a series of arrests, thereby disrupting distribution.
- ✓ The CSSG has helped to co-ordinate awareness raising events in respect of ketamine, including the publication of pamphlets, banners, and posters. These have been accessed by nearly 300 front line practitioners and managers.

What difference has this made?

- ❖ We now have detailed information about missing children, including personal details, vulnerabilities, and frequented locations, to aid in their swift recovery as a result of Operation Philomena.
- ❖ The percentage of return home interviews has improved from 36% in April 2024 to 86% in March 2025.
- ❖ The number of total missing episodes has fallen during the reporting period from 96 per month to 36 per month.
- ❖ There has been continued improvement in levels of children and young people's engagement. All repeat young people engaged with a return to home interview in the final 6 months of this reporting period. Moreover, there has been a significant decrease in declined incidents over the year.
- ❖ Themes and trends have been identified quickly, e.g. the burgeoning problems with ketamine has seen work streams quickly directed towards addressing this drug trend.
- ❖ Professionals feel more confident in discussing ketamine use with young people. They have a better understanding of ketamine, how it is used and how readily available it is in Halton. Moreover, they have a better knowledge of the symptoms to recognise and the knowledge to help parents and colleagues. They understand what resources and support services in respect of ketamine are available in the region and feel more adept at supporting with assessments and supervision and utilising the referral process for supporting children and families.
- ❖ Medium risk referrals are scrutinised on a weekly basis, whereas previously capacity was compromised with only high-risk referrals being routinely assessed.

Next steps:

- ➢ A robust Multiagency Child Exploitation Sexual Abuse Pathway must be implemented to ensure that children and young people who have experienced sexual abuse are referred appropriately, and in a timely way, for medical treatment and ongoing support.



- Continued work to minimise declines & ensure robust attempts to offer Return Home Interviews as standard practice.
- Continued focus on tackling ketamine with focused school-based initiatives complimenting parent and carer awareness raising sessions.
- Continued promotion of the Vulnerability Hub and use of the appropriate screening tools.
- Ensure there is a co-ordinated response in tackling all-age exploitation with strong connections between Adults, Children, and the Safer Halton Partnership.

The Education Subgroup: This group ensures that all children and young people within any educational provision, including universal childcare, remain safe. The group engages with providers' designated safeguarding leads and supports them in embedding effective practice whilst reporting on emerging themes and trends within all education provisions.

Key achievements during 2024-2025:

- ✓ Raised awareness of Operation Encompass, specifically the levels of information that Police can share whilst addressing the timeliness of Police's communication with educational settings.
- ✓ Creation of a Vulnerable Learners Board: This Board provides governance and accountability function to oversee, guide and enhance Halton's partnership working to improve the educational outcomes of vulnerable learners. Vulnerable learners include: all children with a social worker; children at risk of NEET; children who are not receiving full-time education in a school setting appropriate to their needs; children open to the Youth Justice Service; children who have EAL/refugees/asylum seekers/GRT; those who have been permanently excluded.
- ✓ Ketamine awareness sessions have helped ensure school staff are better equipped to support young people and signpost them to the right services in a timely manner.
- ✓ Over 95% of schools completed the S175 audit. This helped the Partnership to identify where further support was needed and where protocols need to be reviewed. This is currently being done in respect of referrals to front door.
- ✓ Professional Challenge and Escalation has been elevated with training sessions ensuring school staff understand the Pan Cheshire protocols and are confident in using them.
- ✓ Several training sessions focusing on Multi-Agency Plans (MAPS) have resulted in schools becoming more confident at leading on a MAP when they are the most pivotal organisation in respect of the plan.
- ✓ Private Fostering training sessions have ensured schools are cognisant around Private Fostering and they are rigorously checking for such arrangements at different intervals throughout the academic year. A poster campaign has been launched in respect of what private fostering means for parents/carers and children and professionals. The Pan Cheshire Partnerships have come together to create a training package for organisations to utilise to ensure there is a shared awareness and understanding of policy and procedures.
- ✓ Trauma Informed Practice has been enhanced with schools investing in Thrive. Currently, more than 81% of Halton schools are now using the Thrive approach.

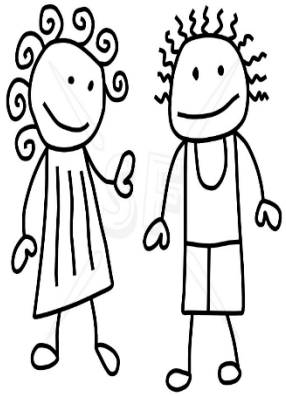
- ✓ The Education Subgroup completed an analysis of how well it is meeting the requirements of Working Together 2023, with the support of a DfE advisor. Moreover, the group was also scrutinised by the Independent Scrutineer. Both reviews were overwhelmingly positive on the role Education is playing in respect of safeguarding arrangements in Halton.

What difference has this made?

- ❖ There has been an increase in MAPS led by primary schools. In 2023/24 there were only 5% of primary schools leading on MAPS but by 2025 this figure has moved to 13% meaning there is a more equitable division of lead responsibilities with less onus on Children Social Care. This has alleviated some of the capacity issues previously experienced by CSC.
- ❖ There has been a slight increase in Private Fostering arrangements meaning young people's circumstances are being identified quicker and the right services made available far earlier than previously seen.
- ❖ The Attendance figures for Children in Care and Children in Care with an Educational Health Care Plan show increases for Academic Year 2024/25 compared to 2023/2024. For Children in Care, March 2025 was 92%, compared to March 2024 at 87.2% and for Children in Care with an EHCP, March 2025 was 91.5%, compared to 79.2% in March 2024. The highest percentage attendance for Children in Care is at our Primary Schools where attendance is now at 96.8%.
- ❖ The Thrive approach has contributed to a smaller percentage of primary school children missing school. The figures for 2025 show that overall absence in primary schools is 5.9% compared to 6.5% in 2023.
- ❖ Schools are now escalating in accordance with the Pan Cheshire Professional Challenge and Escalation procedures. There has been an increase in escalations at step 3 from 0 to 5 as schools are now aware they have recourse when there is professional discord.
- ❖ Data from the last academic year showed a reduction in suspensions for year 7 students, there was a reduction of suspension days from 168 in 23/24 to 67 in 24/25.
- ❖ The Attendance figures for Children in Care and Children in Care with an Educational Health Care Plan show increases for Academic Year 2024/25 compared to 2023/2024. For Children in Care, March 2025 was 92%, compared to March 2024 at 87.2% and for Children in Care with an EHCP, March 2025 was 91.5%, compared to 79.2% in March 2024.

Next steps:

- ➢ To ensure schools consistently receive timely support from front door services to help guide school staff decision making.
- ➢ To consolidate all the above in respect of Professional Challenge and Escalation, Private Fostering, trauma informed practice and schools leading on MAPS.
- ➢ To oversee a review of Operation Encompass to identify how effectively information is shared between Police, Early Years settings and schools.
- ➢ To enhance transition arrangements to ensure key transition points are seamless and effective, involving the voice of children at every opportunity.
- ➢ To ensure scrutiny of MAPS led by non-CSC is regularly reviewed by all sub-groups.



Health Operational Sub-Group: This sub-group provides a forum to ensure that providers and commissioners of healthcare in Halton work together in a coordinated and coherent manner to monitor and provide assurance to the Partnership on the safeguarding arrangements in place across the health economy. The arrangements are also used to cascade messages to the frontline and receive feedback on activity and approaches.

Key achievements during 2024-2025:

- ✓ Creation of a delivery plan to document how the health economy can support the HSCP Business Plan priorities.
- ✓ Helped in the creation of digital resources to share across the partnership that clarify best practice in s47, including child medicals.
- ✓ Brought together adult safeguarding board to ensure shared issues are tackled collegiately, as exemplified by the combined work on addressing ketamine use in our region by young people and adults.
- ✓ Raised the profile of support for children without a formal diagnosis but whose schooling is compromised by their physiology.
- ✓ Supported the continued focus on embedding a trauma informed approach across the health economy. This included Merseycare presenting multi-agency training sessions to help strengthen awareness.
- ✓ Developed a data set with the support of Merseycare to report on key performance indicators.
- ✓ Gained clarification around the referral process into ICART to address confusion between organisations and referrals being declined.

What difference has this made?

- ❖ At the end of March 2025 83% of our CIC had been recorded on Eclipse as having a Health Check, compared to 80% in March 2024. Currently work is progressing on the 903 (Children Looked After) Annual Census return and the Health figure is currently at 97%. We are now in receipt of up-to-date information on a regular basis from Bridgewater for those children who are placed out of borough.
- ❖ Current open CIC who have been looked after for at least 12 months should have had a dental check in the last 12 months. For March 2025 83% of that cohort have had a Dental Check recorded on Eclipse, compared to only 69% in March 2024.
- ❖ There has been a significant improvement in respect of referrals into ICART. Previously, Health providers were finding a large number were being returned because of insufficient information. However, this has now been resolved, and informative, comprehensive referrals are being processed in a timely manner.
- ❖ The number of children being awarded an EHCP has increased dramatically from 904 to 1524 between 2024-2025 (1319 in 2023).

Next steps:

- ➢ Enhance the available support to parents with learning difficulties and disabilities which as a consequence compromise their parenting capacity.
- ➢ Consolidate the work done in creating a co-ordinated approach that supports and caters for the needs of both adults and children.
- ➢ Consolidate the work done to accelerate support for children who do not have a formal diagnosis but whose behaviours are compromising their ability to achieve their full potential in school.
- ➢ Continue to address waiting times for CAMHS and key health check appointments.

Young People's Voice and Influence Group: The purpose of the group is to involve the young people of Halton in initiatives and developments relating to safeguarding across our region. The vision is to ensure that local communities, faith and voluntary sector organisations and statutory services work together to plan, design, develop, deliver, and evaluate safeguarding initiatives and strategies with young people's views and opinions integral to the process.

Key achievements during 2024-2025:

- ✓ Launched the Young People's Voice and Influence Group to help partners listen to and act upon the views of children who use our services, involving them wherever possible in setting priorities, planning, developing, and improving policy and training.
- ✓ Completed a baseline diagnostic assessment on how attuned partner organisations are in the Lundy Model.
- ✓ Completed a Train the Trainer programme to ensure partner organisations have at least one practitioner trained in disseminating the principles of the Lundy Model.
- ✓ Young Person's Panel established to explore barriers to engagement within Early Help.
- ✓ Direct work sessions were created and videoed by young people, and these are now shared with family support workers so they can see how children prefer such visits to be conducted.
- ✓ Re-wrote neglect screening tools so there is now a section for children to record their views on home life and their home environment.
- ✓ Worked with the other forums for young people across Halton to deliver agreed priorities.
- ✓ Shared examples of good practice between partner agencies and across Halton of engagement with young people.
- ✓ Expanded opportunities for children and young people to have a say about the nature and delivery of services to themselves and their peers.
- ✓ Ensured that structures are in place to embed best practice relating to engagement and participation in all the HSCP's work.
- ✓ Provided a framework for organisations to effectively involve children and young people in the development, delivery and evaluation of services that affect their lives.

What difference has this made?

- ❖ Young people report their Early Help visits are now taking place at times that they like, rather than being withdrawn from lessons. Some visits are taking place in the community rather than always in school time.
- ❖ Wishes and Feelings template are now said to be more child friendly and not 'dull, repetitive, forms.'
- ❖ Children report that direct work sessions are now more purposeful with themes relevant to them being explored, including anxiety and relationship building.

Next steps:

- To further develop an organisational culture of valuing children and young people's views and being proactive in facilitating their participation.
- To grow the number of children in our services who report that they have had opportunities to participate in decisions about their own lives and that they are satisfied with the process and the effect of their participation.
- To promote a joined-up approach to participation between all partner organisations.
- To ensure practitioners to develop and embed participation in their service area, department, or organisation.

3.7 Wider Safeguarding Arrangements

The HSCP does not operate in isolation, and there are a range of other multi agency partnership arrangements, which contribute significantly to the children's safeguarding agenda. We are members of the Pan Cheshire Policies and Procedures Group. This ensures we are up to date with the most recent changes as well as ensuring we work as effectively as possible with our cross-border partnerships. We recognise that many of our partners work across several local authority areas and therefore consistency in our safeguarding approach is paramount.

During this reporting period, progress was made in relation to several areas, including the creation of new strategies or revisions to existing practice for the following:

- The Pan Cheshire All Age Exploitation Strategy
- Was Not Brought Practice Guidance
- The PAN Cheshire Escalation policy
- FGM Guidance
- Safe Sleep
- Pre-Birth Guidance
- Rapid Review Referral Process
- Bruising in Children who are not independently mobile.
- Erase Tool

However, the HSCP recognises that there is more work to be done to strengthen its links with the other local boards and partnerships as we share many common themes, such as serious violence, domestic abuse, and exploitation. There are clear benefits to children, young people, families, and vulnerable adults coordinating specific areas of business across different partnerships. This is therefore one of the cross-cutting themes strategic leaders have identified as a key area for focus in 2025/26 and beyond.

4. Budget and Resources

4.1 Budget and Resources

Each of the local safeguarding partners contributes to the HSCP budget as well as offering their time and expertise to the activities of the partnership. These activities include participating in meetings, multi-agency audits and local reflective reviews, delivering training and ensuring the roll out of key learning and messages. The commitment, contribution, and engagement of partners in supporting child safeguarding in Halton is acknowledged and valued.

Income source 2024/25	**Amount**	**Comment**
Carry forward from 2023/24	£100,320	Underspend from previous year/s
Income Contributions 2024/25		
Halton Borough Council	£45,140	
Cheshire & Merseyside Integrated Care Board	£59,730	
Cheshire Police	£27,825	
Training & Inter-Authority Income	£4,110	
Education	£37,640	
Cheshire Probation Service	£2,020	
Grant funding (PCC re Ketamine)	£4800	
Total	**£181, 265**	

4.2 Changes to the funding arrangements:

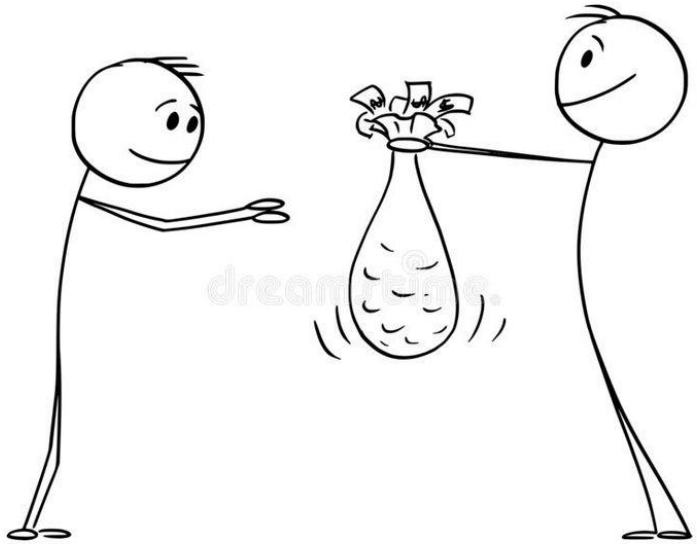
Income contributions from the core partners increased in 2024/25 by 5%, compared to a 6% increase that was enjoyed in 2023/24. Income received in respect of training was in line with previous years. The carry forward at the end of 2023/24 was much higher than previous years at £100,320. This was due to some staffing shortages, grant funding and expenditure that was committed in 2023/24 but not debited from accounts until 2024/25.

Expenditure for 2024/25 increased significantly from £178,636 to £214,412. This increase was largely accounted for by the employment of an Independent Scrutineer, the commissioning of a Young People's Plan, an increase in admin hours for the Business Unit and inflationary increases. Given that expenditure exceeded income for 2024/25, the HSCP used some of its reserves that were carried over from 2023/24.

4.3 An assessment of the impact and value for money of the funding received by safeguarding partnerships

Significant expenditure in the period was directed towards the following:

- ✓ The creation and continued hosting of a new HSCP web site
- ✓ A new online course booking facility and the associated costs of users booking onto HSCP training events
- ✓ The employment of an Independent Scrutineer
- ✓ An increase in face-to-face training events and with it a large increase in the hire of venues
- ✓ The continued appointment of a 0.8 Senior Administrator (the role was previously 0.5)
- ✓ An online system for facilitating statutory audits (s11 and s175).
- ✓ The commissioning of a Young People's Plan for Halton.



Expenditure 2023/24	Year End Spend	Comment
Salaries	£157,611	Business Manager/Training & Development Officer/Senior Administrator (0.8)/Head of Safeguarding (0.2)
Consultancy	£14,395	
Learning and Improvement	£13,175	
Learning and Improvement Project	£4,901	
Project Support	£10,687	
Training	£5,300	
Room Hire & Hospitality	£4,175	
Computer Equipment	£115	
Miscellaneous	£4,035	
Total	**£214,412**	

What has been the impact of the funding?

- ✓ New HSCP web site has resulted in a near doubling of visits to the site.
- ✓ Attendance at multi-agency training has shown a dramatic improvement for this reporting period. This has largely culminated from the reduction in professionals failing to attend a training event onto which they were booked. In the period April-September 2024, **936** multi-agency partners booked onto training events but only **543** attended the event (**393** no shows). This equated to an attendance record of only **58%**. However, in the period October 2024-March 2025, the attendance percentage improved to **87%** with **708** professionals attending the training events they booked onto (only **107** no shows).
- ✓ Statutory compliance re WT23 has been assured as the independent scrutineer provided useful guidance in helping the HSCP implement Working Together 2023.
- ✓ Central to the work of different partnerships and boards across Halton is our Young People's Plan. This ensures our key priorities are everyone's business and reviewed at regular intervals. It also brings together the work of different partnerships and boards across Halton and ensures a joined-up approach to tackling the priority areas articulated in the Young People's Plan.
- ✓ Audit completion rates are over 95%. Agencies' feedback is they find the online portal that is now in operation easy to navigate and purposeful. Moreover, audit findings have helped identify areas where partners need to enhance practice to ensure safeguarding procedures are more robust.
- ✓ By employing our own Senior Administrator, the HSCP has been able to ensure subgroup meetings take place in line with their terms of reference and that attendance is consistently high. All supporting documents and agendas are now distributed in a timely manner and actions implemented more

consistently. As a consequence, the number of subgroup meetings increased within a two-year period from 22 meetings in 2022/2023 to 56 meetings in 2024/25. Furthermore, Learning Improvement Trackers, Risk Registers, Policy Trackers and Action logs are all maintained with aplomb.

5. Progress against our Priorities

Priority work areas have their own dedicated section on each sub-group's delivery plan and progress is reported as part of a standard agenda item at all Safeguarding Children Partnership meetings. An overview of this progress is captured in Chair's reports that in turn are shared with strategic leads for the wider partnership and the Executive. This ensures work is progressed and subgroups are held to account.

5.1 Priority 1: Improving the quality and timeliness of our practice in relation to neglect.

Why we chose this.

Neglect has been a priority for the Safeguarding Partnership for several years and we know we need to do more so that children have their needs met by their parents or carers, and support is provided where this is not the case. Neglect is the most frequent reason for referrals to the Integrated Front Door. Furthermore, we recognise the distinctions and commonalities between poverty and neglect and that both are major adverse childhood experiences in young people's lives that can affect their futures.

What did we do in 2024/25?

- Hosted a multi-agency training day centred on 'Understanding Neglect and Local Procedures'
- Facilitated an awareness raising session exploring Neglect and Poverty in Halton, with contributions from Local Hubs team, Educational Psychology and Police.
- Hosted two Educational neglect trainings, delivered by the HBC Education Team.
- Cheshire Police have adopted the AWARE framework underpinned by an ACEs, trauma informed approach. AWARE includes a tool for front line officers to support them in being professionally curious in their interactions with children and families where they have concerns regarding neglect.
- Reviewed the HSCP Neglect Strategy and the related toolkits and assessment framework.
- Ensured the voice of Halton's children was acted upon in creating a new Home Conditions Tool and screening tool with places for children's views to be documented.

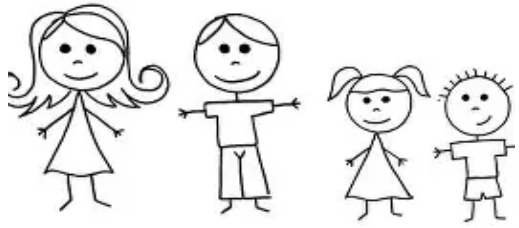
- Continued to expand the Family Hubs offer across Halton. The aim of Family Hubs is to provide families with multi-agency support to care for their children from conception, throughout the early years, and into the start of adulthood. Through joining up and enhancing services, all parents and carers can access the support they need when they need it.
- Conducted a Local Learning Review following a case for consideration with a theme of neglect.
- Produced 7-minute briefings disseminated to help raise awareness of practice and procedures.
- Strengthened the work of the Vulnerable Learners Board with a specific focus on Educational Neglect.
- Ensured numerous Partnership Briefings were disseminated along this key theme.

What was the impact for children and young people?

- Since launching the neglect strategy in 2022 the numbers of neglect as the presenting issue for Level 2 Early Help contacts has seen a downward trend. From 148 in 2022/23 the figure fell to 57 in 2023/24 and again to 31 in 2024/25.
- Practitioners are confirming an increase in confidence in identifying and evidencing neglect via pre- and post-course questionnaires.
- Actions undertaken by the Vulnerable Learners Board have ensure there is a comprehensive dataset that closely tracks children with additional vulnerabilities. This close support and oversight of children not regularly attending school has helped result in a lower percentage of pupils not attending school in Halton. For example, the percentage of children who are persistently absent from their primary school was 14.6 in March 2025 compared to 20.2 in 2022 and 16.4 in 2023.
- Family Hubs now provide a place where children, young people and their families can go when they need support. They provide an effective offer of early help enabling families to receive the right service at the right time. Indeed, Family Hubs are supporting families in achieving the best start in life for their babies. Support available from conception includes parenting support, infant feeding, parent infant relationships, education, and peri-natal mental health.
- Practitioners across Halton are delivering effective interventions to address the impact of neglect on children and young people. These interventions are varied and include support to both children and parents. In addition, multi-agency audit findings showed there is timely recognition and response to neglect. However, the support given to children and parents is largely reactive to family circumstances, rather than initiative-taking.
- Family friendly language is being consistently used in published materials.

Where do we need to do to make more progress in the future?

- Neglect continues to be a key challenge in Halton as the number of children requiring a child protection plan because of neglect has increased from 63% to 73% between April 2024 to April 2025.
- Recognise that there is often a strong correlation between poverty and neglect and therefore instigate more initiative-taking measures to address poverty, so instances of neglect are reduced.



- Scrutinise and analyse the measures taken to address poverty to identify the impact these actions are having on neglect across Halton.
- Increase the use of the neglect screening and home conditions tools by partner agencies working with families.
- Circulate HSCP partnership briefings throughout 2025/26 focusing on neglect and poverty alongside the relevant learning from local reviews. Learning from Rapid Reviews should be used to promote and strengthen early identification of risks, including educational neglect.
- Refine neglect indicators in the HSCP data suite and embed systems across agencies for data retrieval, allowing for reporting on usage.
- Conduct a multi- agency audit to evidence journey travelled before sharing with key partners to bring about further change in recognising and responding to neglect.
- Ensure ongoing liaison and sharing of best practice with other Safeguarding Partnerships.
- Ensure the Continuum of Need is consistently applied across all partner organisations.
- To get better at measuring the impact of our work by enhancing our Neglect assurance & impact measuring tools.
- Hold face to face events, create online recorded video messages, produce Partnership briefings, and use the HSCP web site to help relaunch the Neglect Strategy.
- Ensure all practitioners are aware of the services available in our region to support families and young people.

5.2 Priority 2: Safeguarding Children from Violence and Exploitation

Why we chose this.

Child exploitation continues to be a priority for HSCP to identify and reduce the number of children affected by exploitation. The focus is to ensure that there is a good understanding across the partnership of the complex and interrelated risks associated with child exploitation to enable support and intervention to take place at the earliest opportunity. Furthermore, Child Exploitation (CE) is increasingly being recognised as a major factor behind crime in communities in the UK; it also victimises vulnerable young people and leaves them at risk of harm.

What did we do?

- Created new weekly multi-agency contextual safeguarding subgroup meetings to ensure medium and high-risk referrals are scrutinised by all partners in a robust and timely manner.
- Revised the Contextual Safeguarding Operational Group (CSOG) so multi-agency partners now focus their monthly meeting around concerning themes and trends, before disseminating this intelligence across the SCP.
- Audited the efficacy of multi-agency strategy discussions and meetings to ensure consistent application of timescales and understanding on how such meetings are convened. Updated the Practice Standards and Guidance in relation to Strategy meetings and discussions. Produced monthly reports to

document the attendance and timeliness of strategy meetings. Held Partnership Briefings event to ensure partners fully understood their commitment to strategy meetings.

- Produced a multi-agency SWAY focusing on s47 before hosting an event for Police, Health, and CSC to share the hallmarks of how s47 enquiries should be conducted.
- Held two multi-agency awareness raising events centred on the increasing risks posed by ketamine. These events included the distribution of ketamine posters/z cards/banners to help raise the profile. Also, several organisations who support users presented at the events to ensure professionals have a clear understanding of referral pathways and potential sources of support to young people and families.
- Created a new CSSG Delivery Plan to compliment the Pan Cheshire All Age Exploitation Plan to make sure priorities and related actions are relevant to Halton. Targeted progress in four key areas: Early Identification; Proving High Quality Support; Stopping Perpetrators; Reducing Social and Cultural Barriers, alongside the 3 priorities in the HSCP Business Plan.
- Collected data and intelligence from multiple organisations (police, hospital attendances, Education, CSC) which is now scrutinised on a quarterly basis by CSSG for data trends in respect of serious violence and exploitation.
- Ensured the Vulnerable Learners Board meet bimonthly to provide rigorous oversight of the most vulnerable young people in Halton. Thus, there are greater links with the education sector, as it is accepted that excluding children at risk of exploitation increases the risk.
- During 2024/25, the HSCSP launched its new digital learning resource, accessible via its web site. The training includes content in relation to strategy meetings and section 47 enquiries and ketamine.
- Reviewed the Pan Cheshire Missing from Home protocols with input from commissioned provider, We are With You (WAWY). Produced quarterly reports that document trends in respect of children missing, return home interviews and repeat missing episodes.
- Operation Philomena launched by Cheshire Police to help provide a quicker response to situations were a young person goes missing.
- Created a new CSA strategy for Halton, based on the recommendations of the Centre for Expertise. Circulated partnership briefings in relation to CSA and facilitated a CSA conference that included speakers with lived experiences. Furthermore, the new ERASE tool was launched to support practitioners in identifying and supporting the victims of CSA.
- During 2024/25, the partnership has worked to strengthen co-location of services wherever possible in order to improve communication and partnership working. The co-location of police officers within ICART is an example of this and has been supporting the identification of children at risk of exploitation.
- Formation of Early Help Strategic Board.
- Ensured serious violence and exploitation is now included as an issue for other partnerships, including the Safer Halton Community Partnership, to ensure these priority areas are addressed collegiately.
- Hosted a conference ‘Lads Like Us’ to help professionals gain a better understanding of real-life experiences of exploitation and how to support young people with a more trauma informed approach.
- Created a trauma informed checklist to help partner organisations get a clearer understanding of how to create a working environment that compliments the trauma informed approach.

What was the impact for children and young people?

- Thresholds and Level of Need indicators are clearly defined and assist practitioners in having a shared understanding of the whole needs/risk of a child/ young person.
- Risks to children in care related to exploitation and being missing from home are quickly recognised, enhanced by the launch of Operation Philomena. Accurate and timely risk assessments lead to effective intervention and support, as evidenced by WAWY quarterly reports.
- Practitioners when trying to identify the correct level of need consistently seek advice and guidance from their line manager, and/or agency designated safeguarding lead.
- Effective signposting to appropriate services and advice means children and their families consistently access timely support.
- Practitioners in Halton feel supported through training and supervision to understand their role in identifying new and emerging threats, including online abuse, grooming, sexual exploitation, criminal exploitation, and radicalisation.
- Fewer children are persistently absent from school and by implication at risk of exploitation.
- S11 audit returns indicates over 90% of respondents are confident their agencies' workforce can recognise signs of exploitation in children / young people and take appropriate action.

Where do we need to do to make more progress in the future?

- Further review of referral, assessment, and intervention processes, in particular the role of the integrated front door, referral partners and assessment team.
- Targeted communications activity to raise awareness of exploitation across the partnership and the public.
- Ensure data underpins both the operational and strategic work of the SCP and is used effectively as a preventative and protection mechanism.
- Gather more feedback from young peoples' experiences of exploitation and use this to shape the complex safeguarding strategy and delivery plan. Create coherent lines of communication with children and young people in conjunction with the feedback they give in the focus groups, so they are kept informed via-a-vis the opinions they express.
- Continue to promote the use of the Operation Philomena Protocol for missing children and young people in care. Complete additional work around the Philomena protocol to ensure meaningful contact when children go missing. Ensure such work is undertaken around children who are not looked after but regularly go missing.
- Dip sample and deep dive audits to address how effectively toolkits and procedures/protocols are being followed.
- Ensure all the actions from 2024/25 are consolidated so they become genuinely embedded in daily practice.
- Update the training offer for partner organisations in relation to exploitation and contextualized safeguarding. Training offer to be rolled out to partner agencies in relation to the new Pan Cheshire All Age Exploitation Strategy to enable key agencies to review and monitor CE risk levels.

5.3 Priority 3: Protecting Children as victims of Domestic Abuse

Why we chose this.

According to Crime Survey for England and Wales (CSEW) from the Office for National Statistics 2024, approximately 1 in 20 people experienced domestic abuse in the Year ending March 2024 and approximately 2.3 million people aged 16 and over experienced Domestic abuse (1,612,000 females and 712,000 males). Furthermore, the National Panel recorded 50% of serious harm or child deaths in rapid reviews occurred in households where domestic abuse was present. It is a source of anxiety and poor mental health amongst school age children and can have life-long impact in terms of healthy relationships. The Domestic Abuse Act 2021 identified children as victims if they see, hear or experience the effects of domestic abuse. Finally, an Ofsted inspection in May 2024 reported that: 'Too many children live in harmful circumstances for too long before assertive action is taken, particularly when domestic abuse or neglect is a feature.'

What did we do?

- During this reporting period, we conducted Ofsted's JTAI benchmarking of how local safeguarding partners work together to help and protect children who are victims of domestic abuse. The exercise helped form some key recommendations, all of which were upheld by the Halton Domestic Abuse Board for implementation.
- A key finding from the JTAI benchmarking exercise was a need to improve the support available to perpetrators of domestic abuse. Hence, the Choices programme has been launched to support the perpetrators of domestic abuse. CHOICES explores topics including: The impact of domestic abuse on partners & children, healthy relationships, accountability, self-esteem & resilience, risk assessment & safety planning, triggers, positive parenting, and mental health. It aims to reduce instances of abuse and violence and improve understanding of individuals behaviour. The importance of working collaboratively and all for agencies to understand the Choices program is crucial to its success.
- We have established a pilot project called **'Breaking the Cycle of Domestic Abuse in Halton'** which looks to develop a multi-disciplinary support service that will implement a contextual safeguarding approach to address Domestic Abuse. This includes a behaviour change programme which provides immediate and longer-term support to both Perpetrators and victims of Domestic Abuse. Moreover, it ensures that the behaviour change programme is suitable for perpetrators at all risk levels and is able to offer support and actively engage the victim and whole family. Ultimately our goals are to reduce reoffending, make victims and children safer and support families to stay together, where appropriate.

- The Halton Domestic Abuse Partnership Strategy 2025/26 was written and launched at the end of this reporting period. In creating the strategy, we have listened to our local survivors, their children and working together have designed a clear pathway to the Partnership to ensure that we are and continue to be service user led. Halton has a long established strong multi agency partnership ethos, we recognise that no one agency can end domestic abuse, and we will continue to work in collaboration and challenge agencies to ensure that intervention models are based on best practise, evidence, and robust evaluation.
- As part of the **'Breaking the Cycle of Domestic Abuse in Halton'** Project, Remedi, now deliver targeted preventative programmes to young people (10-17yrs old) affected by adverse childhood experiences, that may be at risk of becoming or are currently a perpetrator of Domestic Abuse against anyone they are personally connected to (intimate partners, ex-partners, family members or individuals who share parental responsibility for a child).
- A service mapping exercise was completed to identify the offer from agency and commissioned services to families, schools, and communities.
- Operation Encompass, led by Cheshire Police, has had a positive impact in schools. Police have raised awareness with the Designated Safeguarding Leads in schools as to the limitations surrounding the level of information they are able to share. Schools have equally been able to voice any concerns they have in relation to the timeliness of information sharing. Poster awareness campaigns have been promoted, and this will continue to be an area for further development in 2025/26.
- A digital resource has been created with multi-agency input, and this is accessible via the HSCP web site. The resource provides a snap guide to the Halton Domestic Abuse Offer and it maps Halton's Domestic Abuse Response pathways. The resource also clarifies the role of the (Independent Domestic Abuse Advisor (IDVA) and some of the support they can offer. The resource explains the referral process and the support available to both the victims and perpetrators of domestic abuse.
- The IDVA Team are working closely with Police regarding Operation Jingles. The IDVA Team support high risk clients of which 85% are coming through on a 999 call when they are in crisis.
- Furthermore, a workstream is being compiled along with the Health Improvement Team to build links with the business community.
- We have progressed the White Ribbon Action Plan, predicated on the four key areas of Strategic Leadership, Engaging Men and Boys, Changing Culture and Raising Awareness.
- The IRIS programme has progressed well, with positive valuations throughout.
- Awareness raising activity has ensured professionals and community members are more aware of some of the local support services, including Refuge-SHAP, Women's Centre, Castlefield's, The Hope2Recovery program, the Authentic Voice Forum, and the Gateway program.
- We have continued to support and embed trauma informed working practice across partner agencies.

What was the impact for children and young people?

- Over the past 12 month we have noticed a decrease in repeat domestic abuse cases involving children that are being heard at MARAC (multi agency risk assessment conference) by 26%. This demonstrates the effectiveness of the work being offered to families with children impacted by DA at high-risk thresholds.
- Choices Programme – the service consistently supports 25 cases across a broad spectrum of ages, including children. This is a voluntary programme in which referrals are made from a wide range of Partners. The volume of people supported underlines how important the work is and the merit in it. Strong case studies are emerging and will be shared in 2025/26.
- Completion rates for the Choices program which works with perpetrators over a 26-week period have been extremely high at over 90%.

Where do we need to do to make more progress in the future?

- Identify available and relevant multiagency datasets and performance indicators to inform positive outcomes in respect of this theme.
- Ensure continued links between the work of the Halton Safeguarding Children Partnership, the Safer Halton Partnership, and the Halton Domestic Abuse Partnership Board to strengthen the response to children and young people who are affected by Domestic Abuse.
- Develop the Whole Housing approach to interface with our existing systems and pathways including Marac and the Integrated Front Door.
- Embed the learning within staff teams and across the partnership through models of joint working and shared learning events.
- Build the evidence base and financial case for the approach through high quality external evaluations that can be used to support future funding applications.
- Include performance measures that evidence sustained change.
- Create tools, materials and interventions that can be used by professionals, and families themselves.
- Audit Child Protection and Adults pathways to assure that adults safety plans link with child protection assessments and plans and vice versa.
- Implement and evaluate the HSCP Domestic Abuse training offer for 2025/26.
- Complete a full evaluation of Operation encompass and its effectiveness, linked to s175 audit.
- Ensure there is a reduction in waiting times for commissioned service, including perpetrator programmes.
- Review the efficacy of ‘Breaking the Cycle of Domestic Abuse in Halton,’ including the Choices program.

6. Key Achievements and their impact 2024/25:

ACHIEVEMENT	WHAT THIS MEANS
CSPR Triage Group	Learning recommendations from all CSPR are now scrutinised and gaps in current safeguarding provision identified. The CSPR Triage Group consistently make cogent observations before circulating these to relevant subgroups and partner agencies for actioning.
HSCP Digital Offer	Under the direction of the Executive, multi-agency partners have collaborated in the creation of digital learning resources that are now accessible from the HSCP web site. These digital resources enable organisations the opportunity to brief employees on a variety of safeguarding areas in a flexible and timely manner. These resources include themes such as strategy meetings and s47, domestic abuse and child exploitation.
Lundy Model	The HSCP embarked on its mission to embed the Lundy Model principles across multi-agency practice. This means we have started to improve the way we collect the opinions of children (voice), the places where such views are sourced (space), the people that listen to these opinions (audience) and the impact of such dialogue (impact). Work will continue throughout 2025/26 in embedding these principles with the continued support of 'Participation People'.
Introduction of the ERASE harmful sexual practice tool	Front line practitioners have started to become more adept at identifying and assessing children and young people who display sexually harmful behaviours and assessing levels of risk.
Educational Neglect Addendum 2024	There is now greater awareness of how low school attendance can be an indicator of neglect and how this needs to be addressed collegiately.
The Vulnerable Learners Board	There is now strong strategic oversight of our most vulnerable leaners and a measured approach to proactively identify, support, and help to re-engage learners in a timely manner.

Independent Scrutiny	Our Independent Scrutineer was appointed in the final quarter of 2023/24 and therefore the role was firmly consolidated in 2024/25. The scrutineer helped ensure the SCP was compliant with Working Together 2023 as well as scrutinising the partnership's self-assessment of itself.
6 Steps Self-assessment	The HSCP now has a much better handle on its strengths and areas for development having completed a comprehensive review of its standing against the Bedfordshire University 6 Steps Model.
The HSCP web site.	The Partnership is now better at sharing resources, new course information, toolkits, findings from learning reviews, governance arrangements, latest news etc.
The HSCP data scorecard/storyboard.	Quarterly data drops by all key partners and story boards facilitate the identification of emerging risks, alongside qualitative feedback.
Strategy meetings/discussions	Procedures for all multi-agency strategy meetings and discussions have been enhanced with tighter timescales being applied and attendance consistently at 100% across the 4 core partners.
Halton Children & Young People's Plan	The HSCP now has an over-arching Plan that identifies its key priorities for all children in the region between 2024-27.
Subgroup Delivery Plans	All sub-groups now have delivery plans with clearly defined actions, in addition to robust reporting arrangements, ensuring the key priorities of the HSCP command the lion's share of subgroup activity, time and effort.
Halton Neglect Strategy	The Halton Neglect Strategy now has more meaningful toolkits, including sound assurance tools and more a robust Home Conditions Tool and screening tool to identify risk quicker.
Partnership Briefings	Safeguarding messages and course information has been shared widely across the partnership via 30+ partnership briefings that have been emailed to several hundred front line professionals and managers.

Local Reflective Review, Rapid Reviews and Learning Circles	The arrangements for conducting our 3 types of learning reviews were revised with the purpose, protocols, key features, and a rota for chairing such learning events established. Since their inception, six learning events have taken place (see section 8).
Development of Quality Assurance and Performance	The Quality Assurance Framework has been revised, and this includes a QA Plan on a Page where partners can view the QA activity on a one-year calendar. This has formalised the timing of multi-agency audits, single agency s11/s175 audits and CSPR triage events.
Ketamine Awareness Raising programme	Extensive activity has ensured front line practitioners and managers are far more aware of ketamine use in our region and the support available to help young people who use the drug. Police arrests have disrupted the supply of the drug through Operation Yellow Darting, and this targeted activity will continue throughout 2025/26.
CSOG and weekly multi-agency contextual safeguarding meetings	The start of weekly multi-agency contextual safeguarding sub-group meetings mean referrals are now scrutinised in a timelier manner and support instigated in a timelier manner. The revamp of CSOG also means that these monthly meetings focus purely on identifying themes and trends of concerns and planning multi-agency actions to mitigate these emerging patterns of concern.
Trauma Informed Practice	We have seen an increase in training opportunities, the creation of trauma informed checklists and the collection of good examples where a trauma informed approach has been evident. This drive towards a trauma informed approach will continue throughout 2025/26 and beyond.
Private Fostering	There is a stronger awareness across partner organisations of what constitutes private fostering and ways to detect this, particularly from a schooling perspective.
LMS Booking System	Professionals are now able to book onto training courses much easier via the HSCP web site before sharing course impact statements and collecting certificates. This has resulted in an increase in course attendance and far fewer no-shows.

Pan Cheshire Missing from Home	New protocols in place with Operation Philomena now evident meaning partners are better informed at finding children when they go missing and quickly ensuring they return to their care homes at the earliest opportunity.

6.1 Key Challenges:

Multi-Agency Data	The HSCP has a dataset that encapsulates the key concerns that the three core partners and Education have and this scorecard is scrutinised on a quarterly basis. Accompanying this holistic scorecard is an accompanying scorecard that focuses more on the HSCP Business Plan priority areas. However, the collection of some of this data (particularly in relation to ketamine) has been difficult as some data is not available or it is dated. Furthermore, there needs to be more systematic analysis of the data provided.
Quality Assurance	The HSCP did not employ a Quality Assurance Officer in 2024/25 and as a result the measurement of impact has been harder to establish at times.
Transitional Safeguarding	Transition between children and adult services has been strengthened with representatives from both children and adult services attending Board meetings. Reports from both sectors are shared but there remains much work to do to ensure there is a seamless transition as young people become adults.
Voice of Children and Young People	Partner organisations are improving the way they gather the opinions from a cross-section of young people, however there is still a need to ensure such opinions are acted upon and have the degree of influence young people in Halton expect.
Embedding of Learning	Currently a lot of good work is done by the HSCP, but insufficient time and attention is directed to embedding learning and revisiting areas where gaps were previously identified. The Quality and Impact Group currently has a vast remit; therefore, it is proposed that a new Performance and Scrutiny Group is formed to ensure there is a more rigorous analysis of scorecards and data sets, with the Quality band Impact Group focusing more on learning and review.
Thresholds/Levels of Need	Scrutiny work tells us that threshold application is at times not consistent across agencies, resulting in inconsistent response to risk. This is documented on the HSCP Risk Register .

7. Engaging with Children and Families

The HSCP does not have a single mechanism, currently, for recording the voice of the child and capturing the opinions of families. Instead, the partnership seeks assurances from partners that children are at the heart of everything they do and that they actively engage with them. We have seen excellent examples of partnership engagement with young people and their families, and there is a page on the new HSCP web site that celebrates connection points.

In this reporting period, the HSCP asked partners to reflect on some of the most effective ways they work with children and families. Strong contributors included:

Family Hubs: Access to provisions and support for families to navigate information, advice, and guidance on each stage of parenthood.

Parenting and Healthy Relationships Team: Evidence-based programmes delivered to families by multiagency professionals from across the borough.

Warrington and Halton Youth Service: Personal Plans through activities/Co-produced clinic guides/focused time for listening and sharing views/ Opportunities to drive own healthcare.

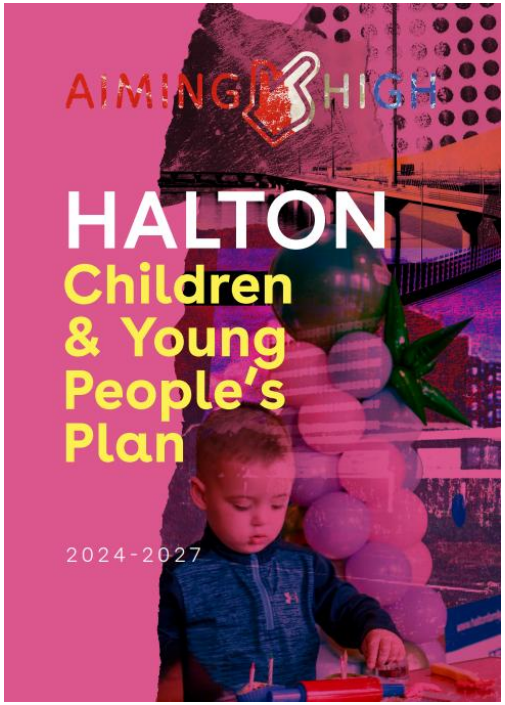
Mersey Care - Engagement & Participation team: Language matters: words and triggers. Developing plans to approach language informed by discovery.

Cheshire Fire and Rescue Team: Fire Action Plans with families/ daily and weekly education programmes/post-incident engagement with children and families.

Family Nurse Partnership: New Mum Star – Assessment/Collaborative goal setting/Strengths based programme and resources informed by attachment, self-efficacy, and human ecology.

Children and Young people's Mental Health Services: Co-produced support, guidance, pathways, process, advice, and conversation.

(0-19) Services Mersey care Foundation Trust: Quality Improvement plans, and new processes and guidance informed by patient feedback, conversations and listening to the views of young people and families.

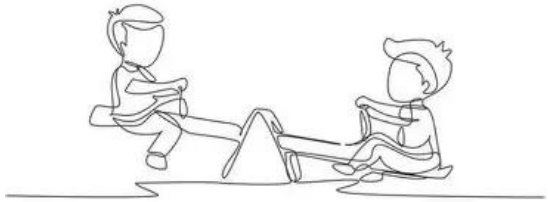


7.1 Children and Young People Plan 2024-2030

In 2024 the Partnership commissioned the creation of the **Halton Children and Young People Plan**. Central to the Plan are the following 3 questions we must ask:

- What is life like for this child or young person?
- What can I do to make it better?
- Would this be good enough for my child?

In writing this plan we have spoken to many: children, young people, professionals, carers, parents, leaders and politicians and there is one striking point upon which everyone agrees and that is:



'HALTON'S CHILDREN, YOUNG PEOPLE & FAMILIES ARE OUR PRIDE & OUR FUTURE'

The 3 top priorities in the Plan are focused around:

- **Prevention and Early Intervention**
- **Increasing Education Attendance**
- **Improving Professional Practice**

This plan therefore aligns closely with the One Halton Health and Wellbeing Strategy 2022-2027 and the HSCP Business Plan 2024-27.

7.2 Diagnostic Report on Participation in Halton

During 2024/25, the HSCP worked with **Participation People** in establishing how well the Lundy Model principles are embedded in partner practice. The diagnostic report captured Halton's progress and potential in embedding participation across its Multi-Agency Safeguarding Arrangements (MASA). The report draws on consultations with key stakeholders, reflective workshops, and region-wide training, offering a current picture of Halton's participation landscape and practical recommendations for achieving excellence.

The analysis of Halton's Multi-Agency Safeguarding Arrangements (MASA) underscores the importance of genuine, structured, and accountable youth participation. While established frameworks are in place, the report highlighted the need for greater inclusivity, diversity, and transparent decision-making processes. To bridge the gap between strategic intent and operational execution, we recognise that MASA partners must embed participation as a core principle, driven by robust accountability and continuous feedback.

Our **Expanded Roadmap to Success** provides a structured path forward, prioritising immediate improvements in accessibility and engagement, followed by the integration of digital methods, enhanced oversight, and systematic feedback loops. Over the long term, we recognise that Halton's MASA must institutionalise these improvements, ensuring that babies, children, young people, and families are not only heard but actively shape the safeguarding policies that impact their lives.

Achieving this vision will require commitment across all MASA partners, shared ownership of outcomes, and a collective drive towards safeguarding system where youth voice is central, impactful, and transformative.

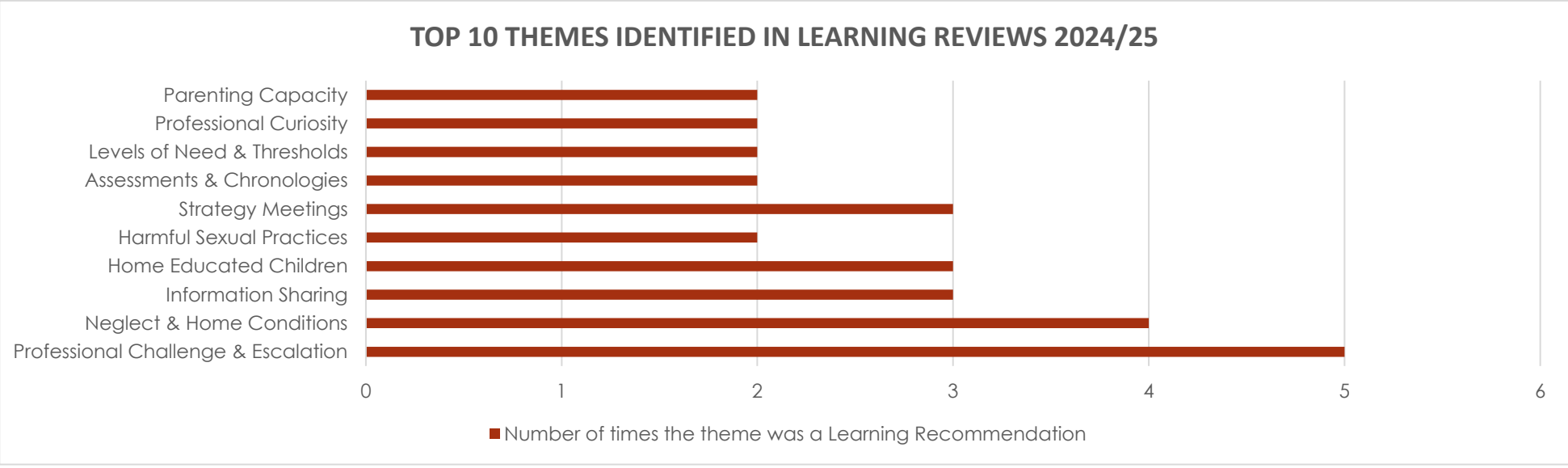
8. Learning from Case Reviews

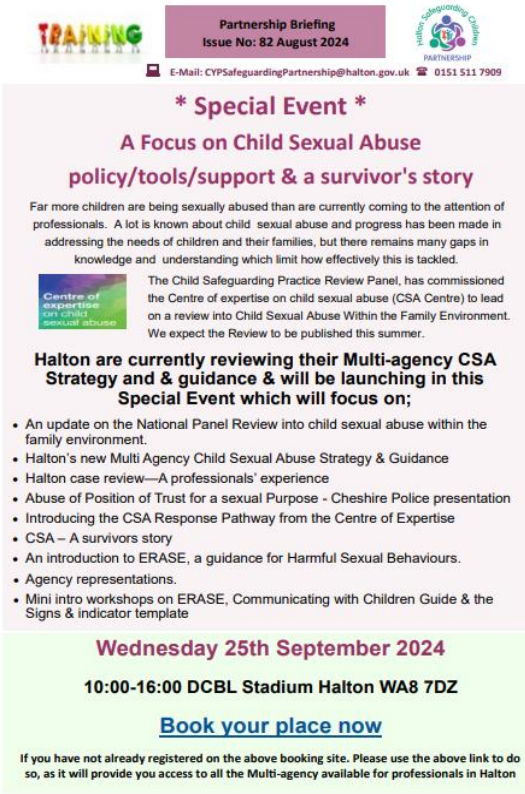
There were no Child Safeguarding Practice Reviews in 2024/25 in Halton. However, during the reporting period the Safeguarding Children Partnership conducted 6 learning reviews:

- ✓ **Learning Circle for Sibling Group L**
- ✓ **Learning Circle for Child M**
- ✓ **Rapid Review for Child N**
- ✓ **Learning Circle for Child O**
- ✓ **Thematic Audit for Sibling Group P**
- ✓ **Local Reflective Review for Sibling Group Q**

8.1 Learning Reviews

The following chart shows the themes that were evident in more than one learning event in this reporting period. The themes that occurred most frequently centred on Professional Challenge and Escalation and Home Conditions (Neglect).





What happened after our learning circles and local reflective reviews?

I. Following all the learning reviews, reports were presented to the Quality and Impact Group with recommended actions. These actions were then documented on the HSCP learning Improvement tracker and assigned workstreams.
II. Training events were facilitated and advertised across the HSCP (see examples above)
III. Professional pages were added to the HSCP web site to guide and support practitioners on protocols, support services and the use of toolkits.
IV. When necessary, Task and Finish Groups initiated, as with the review of the Neglect toolkits.
V. The digital learning offer was enhanced with multi-agency partners collaborating on the creation of learning resources.
VI. The HSCP Scorecard was enhanced with additional indicators, e.g. ketamine indicators.
VII. Multi-agency audits were conducted, for example in relation to strategy meetings and the SCP's response to neglect.
VIII. The HSCP consulted with other partnerships to ensure they were abreast of key findings, e.g. Public Health and Safer Community Partnership re ketamine.

8.2 Key learning that resulted from the Rapid Review for Child N

The Child Safeguarding Practice Review Panel discussed our rapid review for Child N on 3 September 2024 and, following careful consideration of the information provided, agreed with our decision not to undertake a Local Child Safeguarding Practice Review (LCSPR). The panel noted the wider public health work we are doing with the Cheshire Child Death Overview Panel regarding updating guidance on water safety for professionals and parents for the safe use of hot tubs when there are young children present. At the time of writing this annual report, there have been no further incidents in our region in relation to water safety in the home environment.

Halton Safeguarding Children PARTNERSHIP

Partnership Briefing
Issue No: 70 May 2024

E-Mail: CYPSafeguardingPartnership@halton.gov.uk ☎ 0151 511 7909

Please share this briefing and poster within all your agencies ahead of the imminent school holidays

Pan Cheshire Child Death Overview Panel

Following a very sad, tragic and preventable incident last weekend when children had got into difficulty in open water: Northumberland Fire and Rescue Service issued this message to remind the public that:

"The water may look calm on the surface, but there can be strong undercurrents that could pull even a strong swimmer under the water.

"And even when the weather feels very hot, the water may feel warm on the surface, but just a few feet below the surface it can be icy cold – affecting the stamina and strength of even strong swimmers.

"If you are with someone who gets into difficulty, call emergency services for help. If you can, use an object to try and reach for them, but don't put yourself in danger by entering the water."

Summer water safety

Accidents are mostly preventable with the correct knowledge and judgment and here are our tips to staying safe in the water during the summer:

To enjoy the water safely and make the right call...

- Enter slowly and carefully
  Think carefully about your ability to splash or swim in cold outdoor water. 49% of those who lost their life were classified as swimmers*. Are you really a good swimmer?
- Stay within reach
  Don't go too far and stay within a standing depth.
- Always be supervised
  Over 70% of fatal accidents occur in the absence of professional supervision. Seek life guarded areas and always make sure some one is available to raise the alarm.

Summer is an amazing time to enjoy our beautiful waterways but we must be mindful that warmer weather is directly linked to an increase in fatal drowning incidents.

Rivers and Lakes/Lochs pose the greatest statistical risk as there are often hazards that the average person is equipped to handle and there is a lack of professional supervision.

In an emergency...

- Call 999
  Ask for the Fire and Rescue Service when inland and the Coastguard if at the coast. Don't enter the water to rescue.
- If you're in trouble FLOAT and call for help
  Fall in or become tired – stay calm, float on your back and call for help. Throw something that floats to somebody that has fallen in.

STOP AND THINK · STAY TOGETHER · CALL 999 · FLOAT

WATER SAFETY ADVICE FOR THE HOME

Halton Safeguarding Children PARTNERSHIP

Drowning happens silently. A drowning child can't speak or control their arms. It's only in the movies they splash about and cry for help.

Baths - At home, younger children are most likely to drown in the bath or garden pond. There may be no warning that something is wrong, as babies drown silently in as little as 5 cm of water.

- A baby should never be left alone even for a moment
- Bath seats are not float aids
- Get everything you need ready before bath time so you're not tempted to nip to grab anything
- Don't rely on your toddler to keep an eye on the baby as they're still too young to understand danger.

Paddling Pools and Ponds - Drain paddling pools when not in use and cover garden ponds securely if fencing isn't an option.

- Empty the paddling pool out after you've used it
- Turn a pond into a sandpit, or fence it in or cover it while your children are little
- Make sure your child can't get to the neighbour's pond
- Be alert to ponds or pools when visiting other people's homes
- Ensuring fencing is used around residential swimming pools

Hot Tubs:

Many families have hot tubs in their gardens or visit friends who have. one. **Never leave a hot tub lid off** and always replace the cover even if you are going inside for just a short amount of time. Babies and young children ae naturally inquisitive and can easily climb in to explore..

What do we need to do next?

Partner attendance and engagement at HSCP learning events is consistently excellent and several cogent recommendations are made and upheld by strategic leaders and Executive. After this, training is enhanced, protocols are often revised, dashboards are improved, and sometimes thematic audits are undertaken. However, we need to get better at periodically revisiting our learning priorities and assessing in a more granular, evidence-based fashion the impact of our actions. This should include a review of whether more work is needed to embed such changes or whether activity needs to be modified and/or further adapted for optimum gains.

9. Quality Assurance

One of the core functions of the Safeguarding Partnership is to seek assurance about practice in Halton. To this aim we have undertaken a wide range of auditing activity in the last year. Each audit has been completed with the support and expertise of representatives across the multiagency group, with methodology adjusted according to the nature and matter under review. Methods used include self-assessment, file audits, roundtable discussions and the development of bespoke review tools.

The findings, analysis and recommendations of each review have been communicated to the relevant subgroup, with a standalone report produced for each audit. The engagement of safeguarding partners with the review process has been generally positive.

9.1 Learning from the s175 audit

Auditing activity commissioned during this reporting period included the s175 audit. This is a biennial mandatory process which takes place across all schools in Halton. The audit helps to identify strengths, learning opportunities, areas requiring support and individual actions for schools.

Summary of Key Findings:

• We had a particularly good response from schools and colleges with 96% completing their s175 audit and the remaining 4% partially completing the audit. This compares to a completion rate of 97% in 2023 and 93% in 2021.

• We broadly agreed with the majority of schools who judged that they had met or exceeded standards and felt that, overall, schools accurately recognised gaps or areas for improvement.

• Schools completing the audit felt that for 92.5% of the questions they were meeting or exceeding standards which is almost identical to the previous s175 audit in 2023 when this figure was 92.6%. Respondents noted that standards were being partially met in 5.4% of the questions and in only 2.1% of the responses did settings feel they had not met the standard at all.

• Standards around Voice of the Child had the highest proportion of Exceeds grades (24.24%) followed by Designated Safeguarding Lead (22.22%) and Safeguarding Culture (20.63%). Conversely, the standard arounds Escalation (4.76%), Online Safety (8.06%) and Managing Concerns (9.52%) had the lowest. These areas were similar to the returns in 2023 when Voice of the Child, Safeguarding Culture and Designated Governor were the standards receiving the strongest responses while the Designated Teacher, Online Safety and Escalation attracted the lower self-assessment grades.

• 89.06% schools reported that they had completed all actions from the previous audit (compared to 89.23% in 2023).

A review panel conducted a deep dive to consider the responses of 10% of the schools in each of the 12 areas documented on their audit. Audits were selected based on the Ofsted grades awarded to schools, and the time that has elapsed since their last Ofsted inspection. One setting was also identified as it is a new provision in Halton. The review panel broadly agreed with the majority of grades and shared individual s175 audit feedback with each of the settings that identified areas of strength and areas for the school to further develop. Some of the common areas identified from the deep dive analysis for further development included:

• Quality Assurance Framework: the need for settings to monitor the effectiveness of their safeguarding training to identify safeguarding gaps and issues.

• Child-focused: to ask that future audit submissions provide some examples to illustrate impact from the perspective of the child, i.e. what this means for the child.

• Greater clarity around how the Designated Teacher ensures that Pupil Premium funding is allocated to the individual child and particularly how such impact is monitored.

• Greater clarity on how the setting ensures staff are aware of the School's Unauthorised Absence and Children Missing in Education Procedures.

• Clearer reference to all the ways in which young people are briefed on the safe use of electronic media, including mobile phones.

The review panel noted that schools were broadly successful at completing the gaps or areas for improvement they had referenced on their previous s175 submission. Moreover, some schools in the deep dive provided a lot of relevant information in their audit submission, but a small number lacked sufficient detail to confidently understand the quality and impact of safeguarding arrangements.

S175 Arrangements for 2025-27

The Halton Safeguarding Children Partnership encourages schools to return to their 2025 s175 audit submission in the 2025/26 academic year and continue to make updates where necessary so it remains a live and up-to-date safeguarding document.

Thus, schools can continue to login and make changes accordingly until such time as the next s175 audit is re-launched in conjunction with PHEW in the 2026/27 academic year.

The gaps identified by schools themselves, through deep dive analysis and by a wider desk top scrutiny have been very helpful in informing the future training offers of Halton's Education Team and the Halton Safeguarding Children Partnership.

The key themes to emerge from the 2025 s175 audit where focus will be directed in 2025/26 are captured below:

- ❖ Front Door/Early Help access arrangements
- ❖ Private Fostering
- ❖ Use of screening tools
- ❖ Unauthorised absence and children missing education
- ❖ Understanding Harmful Sexual Behaviour
- ❖ Operation Encompass

9.2 Learning from the s11 audit

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and those of any services that they contract out to others or license, are discharged having regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its functions.

During this reporting period, the HSCP undertook an audit of compliance with section 11 across relevant partnership member organisations. The findings provided assurance that the organisations that completed the self-assessment are discharging their duties with regards to the welfare of children and are therefore compliant with the duties set out in Section 11 Children Act 2004 and Working Together to Safeguard Children 2023.

The areas that we assessed on the s11 were as follows:

1. Senior Management Commitment to the importance of Safeguarding and promoting children's welfare
2. Leadership & Accountability
3. Listening to Children and Young People
4. Complaints, Allegations and Whistleblowing
5. Professional Challenge and Escalation
6. Information Sharing, Communication and Confidentiality
7. Safer Recruitment

8. Supervision and Support
9. Equality, Safety and Protection
10. Staff Induction
11. Programme of Internal Audit and Review

A rating system was applied with organisations grading themselves against each of the 11 areas. After aggregating the responses from partners, areas of strength for the partnership are:

- ✓ Leadership and accountability
- ✓ Safer recruitment
- ✓ Staff induction.

The key opportunities for development are around listening to the voice of the child and equality, safety, and protection. There is also an opportunity to enhance the programme of internal audit and review.

Next Steps:

For most of the applicable standards that were marked as 'partially met,' organisations documented their proposed actions. This provides a useful framework for organisations to monitor and develop their own compliance in the next 12 months.

Furthermore, in 2025/26, the Pan Cheshire Partnerships want to adopt a scrutiny process whereby organisations that work across Cheshire, e.g. Police, ICB, Youth Justice Service, Cheshire Fire, Probation etc come together on a biennial basis to peer challenge themselves against the s11 standards. At the same time, individual partnerships will facilitate similar peer challenge opportunities for organisations specific to their local authority, e.g. some housing associations, Children's Social Care, Early Years settings.

Finally, a more detailed scrutiny of the s11 submissions, rather than the current desktop analysis that is reliant on self-reporting is proposed for 2025/26. This detailed scrutiny would involve safeguarding leads from the statutory organisations coming together to scrutinise and moderate the audits of their partner agencies. Moreover, it would allow partners the opportunity to ask questions and seek further assurance in respect of any standards not suitably documented by an organisation on their s11 submission. If upheld as safeguarding gaps, these would help inform single agency action plans.

9.3 Multi-Agency Audits

Multi-agency audit activity during the reporting period focused on the following themes:

1. The quality and effectiveness of strategy meetings and discussions (July 2024)
2. Compliance in relation to the new Practice Standard and Guidance for Strategy meetings and discussions (Oct 2024)
3. Children as Victims of Domestic Abuse (Dec 2024)
4. The Quality and Timeliness of our responses in relation to Neglect (March 2025)

9.4 Multi-agency audit on Strategy Meetings

What did we learn from the multi-agency audits focusing on strategy meetings?

- Auditors are satisfied that the right agencies were at the meetings. There is a shared view by auditors that attempting to involve all agencies who may hold information about the family, such as housing providers, could cause considerable delay.
- There are at times several meetings in one day, and the timings of these may conflict, thereby compromising attendance occasionally. However, Safeguarding Nurses contributed to all strategy meetings and provided written reports when there was a conflict of time.
- There are mixed responses about the quality of the safety plans developed during the strategy meeting. The focus appears to be on sharing information and deciding on outcome, rather than on what needs to happen next.
- An emerging theme that required further exploration in the audit discussion was information sharing. Indeed, the timeliness of written records after the meeting was variable and appeared wholly dependent on individual social workers within CSC.
- The ownership of information and duty to share also required further exploration.
- When we do not meet standards around timeliness, the rationale for this is not always recorded clearly in each organisations electronic recording system, nor is there any evidence of formal challenge/escalation readily available.

- We are transparent in our decision making around informing parents. and auditors are confident that we are making the right decisions in this area.

What did we do to improve strategy meetings as a result of audit activity?

- ✓ The Multi Agency Best Practice Standards and Guidance was revised using the content of the multi-agency audit and discussions and approved by Executive.
- ✓ A second multi-agency audit three months later scrutinised how closely the new Multi-Agency Best Practice Standards and Guidance were being followed.
- ✓ Monthly reports have been compiled to record the timeliness of strategy meetings and the attendance of the 3 core partners and Education.
- ✓ A multi-agency digital resource was created and disseminated across the HSCP to ensure all front-line practitioners understand the protocols vis-à-vis strategy meetings.
- ✓ A multi-agency training event took place focusing on strategy meetings and s47 enquiries.
- ✓ Monthly reporting to partners ensures the timeliness and engagement of the core partners and Education is shared at all Improvement Board meetings.

What difference has this made?

- ❖ At the time of writing the annual report, attendance at strategy meetings is now typically at 100% for Health, CSC and Police and 90%+ for Education., as documented in the monthly strategy reports.
- ❖ Timeliness is now recorded as 83% within 24 hours; 10% within 48 hours; 5% within 72 hours and 2% exceed 72 hours.

9.5 Multi-agency audit focusing on children as victims of domestic abuse.

What did we learn from the multi-agency audit focusing on children as victims of domestic abuse?

➢ **Domestic Abuse (DA) awareness training** is an integral element of training for all new staff in the majority of organisations, irrespective of position within organisation.
➢ Some partners offer dedicated **Voice of the Child Training** (VoC) which explores the importance of capturing VoC, the legislation, methods, and options for recording the VoC and using this in practice and service improvement. However, this was not referenced in all responses.
➢ Some providers offered support to the research which shows the experience of **early childhood victimisation** (predominantly DV) is highly prevalent in the lives of children who perpetrate violence themselves (violence breeds violence albeit not necessarily DV breeds DV). Many children who have experienced DV in childhood do express negative emotions through aggression and violence but towards peers and/or authority, not necessarily to intimate partners.

➢ Some professionals are trained in the importance of **active listening to children and families** so wishes and feelings are explicitly asked for as part of an assessment and prior to professionals attending multi-agency meetings about their risk and needs.
➢ Several partner agencies provide **therapeutic support to children** who have experienced DV, either direct 'talking therapy' from seconded CAMHs workers or through nationally recognised social prescribing models. This may involve a socially prescribed mindfulness activity (such as fishing) or other therapeutic outlet (lyric writing/rapping).
➢ All **pregnant women** who have or are experiencing domestic abuse have a delivery plan in place which shares appropriate information and safety plans for the mum and unborn during and post-delivery.
➢ Dedicated Victim Liaison Officers and Domestic Abuse Support Officers provide support to the victims of domestic abuse throughout a **perpetrators'** sentence. They share information on a timely basis with probation practitioners so action can be taken swiftly when risks escalate/change.
➢ Partner agencies report that for all domestic abuse referrals they enquire about children and unborn babies. Details are obtained accordingly, and appropriate referrals are made. Responders to this self-assessment feel a **Think Family approach** is becoming widely adopted across the region.
➢ Routine Enquiry is encouraged within maternity services and midwives are encouraged to provide 1-1 confidential time with all **expectant mothers**. This is the 2024/25 focus for the safeguarding slot on the midwifery study day.
➢ Partner agencies consistently noted how they engage fully in **MARAC meetings** and have dedicated reps who attend the meeting to share information, collate actions, and ensure actions are completed.
➢ Information sharing arrangements within Halton ensure that a police vulnerable person assessment (VPA) is shared with the Bridgewater safeguarding team for all domestic abuse incidents where there is a **pre-school child present** or either the victim or perpetrator has a child under 5 years of age (education are notified and respond about school age children).
➢ Partners feel the **Police response to domestic violence and abuse** has improved, e.g. regarding how they respond to victims, understanding what they have experienced, believing victims, understanding coercive control and how it impacts on victims' responses to the Police and putting into place domestic abuse prevention orders (DVPO) to protect victims.
➢ Partners feel it is working with perpetrators where the difference will be made. Historically the responsibility was said to be placed on the victim to make changes which did not work on its own. My Cheshire Without Abuse (My CWA) and the CHOICES Programme are said to be addressing a whole family approach and direct perpetrator work within custody is seen by partners as a good starting point.

Where did we need to improve as a result of audit activity?

1. Organisations report that they are aware of the services in Halton in relation to supporting victims of domestic abuse, but they have concerns that capacity in these services does not meet demand.
2. Some partners feel there are occasions where children are not seen as victims, and that myths such as they "*weren't present in the house during the incident*" "*the relationship has ended*" and "*it was an isolated incident*" can influence an assessment outcome. It is said the experience of the child can be overlooked and statements like "*school have no concerns*" or "*there are no health issues*" reflect this.
3. From a hospital perspective, it is said that there are occasions when discharges are delayed due to the lack of a safe discharge address. Access to refuge and local safe accommodation is not always available.

4. Working with perpetrators is seen by partners as a crucially important pro-active measure. However, the availability of such services is not readily understood by all.

What have we done to make a difference?

- ❖ Increased the capacity of services supporting victims of domestic abuse.
- ❖ Commenced a pilot 12-month project called: 'Breaking the Cycle of Domestic Abuse in Halton'. This has meant that a higher number of young people can access support programmes related to domestic abuse.
- ❖ Relaunched Operation Encompass so schools are receiving information about domestic abuse in a timelier manner and thus able to provide the appropriate nurture, counselling, and support for their pupils.
- ❖ Increased safe discharge capacity.
- ❖ Launched the Lundy Model for which the voice of the child is paramount.

9.6 Multi-agency audit on Neglect

What did we learn from the multi-agency audit focusing on the Quality and Timeliness of our responses in relation to Neglect?

- ✓ Audit responses consistently highlighted effective communication & information sharing between agencies.
- ✓ Audit returns reference good multi-agency working to support families.
- ✓ Numerous responses noted practitioners having good relationships with families; a number of these audit responses also referenced agencies exploring diverse ways to work with children and families to best support them.
- ✓ Several audit returns refer to timely interventions to support children and their families.
- ✓ Some audit returns evidenced a clever use of assessment tools to support decision making and monitor progress.
- ✓ Some audit responses noted there is evidence of voice of the child within assessments and case recordings.
- ✓ A small number of audit responses referenced both professionals and families feeling listened to.
- ✓ A small number of audit returns highlighted specific training being provided to practitioners to enable them to best support a child to manage their health needs.

Where did we need to improve as a result of audit activity?

- To have a recognised definition of poverty for Halton Children's Services, across all agencies.

- Clear exploration around causal factors of neglect built into screening and assessment tools and addressing these to be part of a plan for every child. Multi-Agency Practice Standards for Neglect would all need to include reference to causal factors, and what is being done to support parents.
- Neglect Multi-Agency Practice Standards to be shared with the Quality & Impact Group for review, and agreement around Task & Finish Group to review and update the Practice Standards, before being shared with Strategic Group for sign off.
- Assurance activity to be built into new Practice Standards to help ensure these standards become embedded and to monitor compliance, for example, periodic dip sampling to look at number of referrals accepted or rejected, and how many were submitted with / without a tool.
- Identify and link in with other adult, child and community focussed partnerships and boards to support the development of a whole community response to Poverty in Halton, e.g. the Poverty Alliance.

What have we done to make a difference?

- We are using research from the University of Plymouth to help establish a common framework that documents what our partner organisations should do to help tackle poverty, alongside what is currently being provided to address this in Halton. Our work will include an analysis of what approaches are most efficacious.
- We are consulting with other boards including the Well-Being Board and the Poverty Alliance to help tackle this collegiately.
- We now have an agreed definition for poverty.

10. How data is being used to inform practice

Partners submit data and narrative to the HSCP to form the multi-agency data dashboard. During the reporting period, the Partnership's scorecard was enhanced. The scorecard now evidences the indicators that are specific to each organisation and the key concerns they have. The scorecard also includes data specific to ad hoc initiatives, including ketamine. In addition, 'Storyboards' continue to be used. These storyboards are used by agencies to provide a narrative to the following:

- What is working well?
- What are you worried about?
- What are you doing about it?
- Updates from previous actions.

Within HSCP meetings each partner discusses their data, and the narrative storyboards are interrogated by partners to provide an indication of potential flaws in provision. Key trends and issues are then picked up and escalated to the Strategic Partnership Group for action. However, the HSCP should tighten up the processes, ensuring it is available every quarter from all partners and allocating more time for data scrutiny. All data is completely anonymised.

What we need to do with our data next year:

- Contribute to the NW RIPP dataset so we have a comparison with our north-west partners on a more varied and informative range of indicators than is currently available.
- Ensure the newer subgroups (Young people Voice & Influence Group and the Voice of the Child Operational Group) both have scorecards that can be interrogated every quarter.
- Ensure the HSCP Strategic Leadership Group gain assurance from each of the subgroups that they have a clear oversight of their subgroup's data and that they use it in a timely way to improve enhance safeguarding provision.
- Ensure the data collected by other Boards and Partnerships is shard with the HSCP so we have a complete, up-to-date, and holistic picture of safeguarding across our region.

11. Workforce Development

The HSCP delivered an extensive training programme between April 2024 - March 2025, supported through the shared expertise of the safeguarding partners. The HSCP delivered briefing and training on a range of safeguarding topics, including:

- Intra-Familial Child Sexual Abuse
- Honour Based Abuse
- Responding to Sexual Assault & Violence
- Mental Health Disorder and Parenting Capacity
- Intra-Familial Child Sexual Abuse
- Non-Fatal Strangulation and Suffocation
- Educational Neglect
- Missing From Home
- Abuse of Position of Trust for Sexual Purposes
- Understanding Neglect and Local Procedures
- Child Sexual Abuse Tools and Survivor's Story
- Working Together to Safeguard Children (Refresher)
- Child Exploitation Awareness
- Understanding Harmful Sexual Behaviour-Erase Tool
- DASH (2009-2024) Risk Identification, Assessment and Management Model and how to use it.
- Prevent
- Trauma Informed Awareness

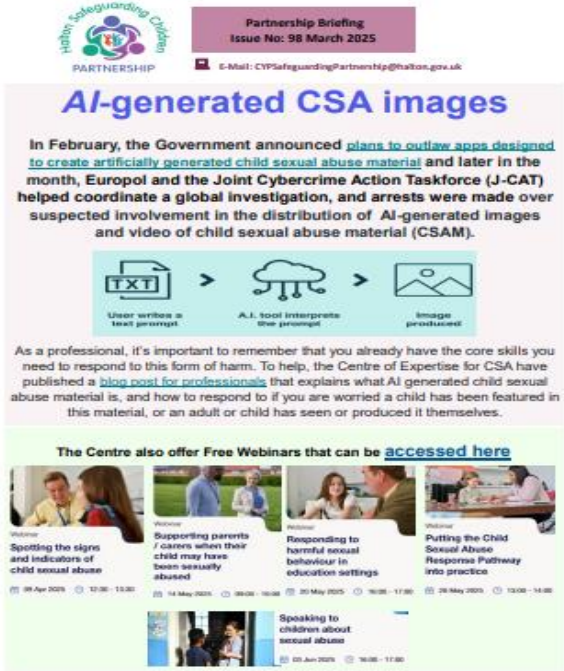
- Ketamine Awareness
- Neurodevelopmental Conditions Professionals Awareness Raising
- Working Together to Safeguard Children Level 3
- Reducing Parental Conflict
- Mental Health Disorder - parenting capacity
- Managing Allegations Against People who work or volunteer with children.
- Sexual Violence Awareness
- Domestic Abuse Awareness

11.1 Training Analysis:

Attendance at multi-agency training showed a dramatic improvement for this reporting period. This has largely culminated from the reduction in professionals failing to attend a training event onto which they were booked. In the period April-September 2024, 936 multiagency partners booked onto training events but only 543 attended the event (393 no shows). This equated to an attendance record of only 58%. However, in the period October 2024-March 2025, the attendance percentage improved to 87% with 708 professionals attending the training events they booked onto (only 107 no shows). This has partly been a result of the Charging Policy the Business Unit now applies to practitioners who fail to attend or provide late notice of their inability to attend.

This year, the Executive identified the difficulties in releasing staff for training events when the capacity on the ground for operational duties is often compromised. Therefore, the Partnership is now supplementing its face to face and online courses with multi-agency virtual materials. These have been created by multi-agency partners but with the understanding that single agencies will use their training calendars to ensure these key messages are disseminated. These shared multi-agency training resources have been enhanced with the creation of a Strategy Meeting SWAY and a Section 47 SWAY. These two resources compliment an ever-increasing suite of multi-agency materials that include areas such as the Voice of the Child, Professional Resolution, and ICON.

The difficulties in attracting multi-agency partners to support the HSCP Training Pool resulted in training being identified as



a risk on the HSCP Risk Register. However, in the last 6 months of the reporting period, we have seen a significant increase in multi-agency partners contributing to the delivery of training courses. This is evident from the HSCP training calendar that now documents the organisation/s supporting the delivery of every learning event. In addition, the suite of virtual materials has also meant organisations have more autonomy in when multi-agency training is delivered.

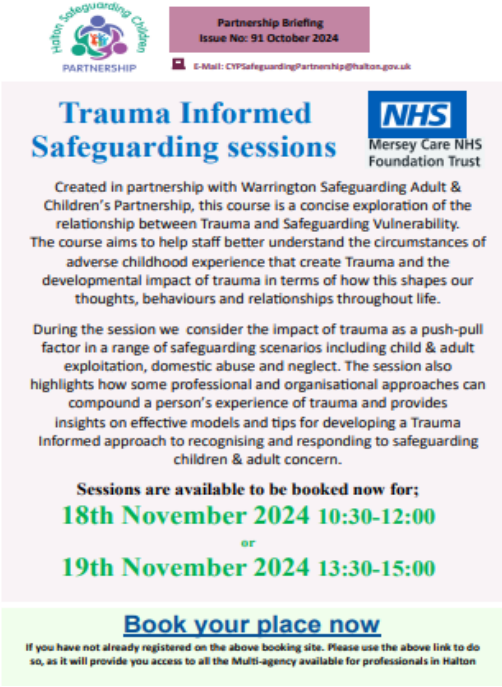
Numerous Partnership Briefings have been shared to help raise awareness of other training events offered by local agencies, and to update all stakeholders on key safeguarding messages, a small selection is contained within this report. Each briefing currently reaches approximately 700 partners from across the region and continues to increase as our distribution lists are updated.

Following a review of the 2024/25 training offer, 2 additional training events are now being facilitated with the support of the HSCP Business Unt. These focus on two areas identified in recent inspection reports, namely MAPs and Private Fostering. MAP training has typically attracted low numbers of attendees, and the training has not culminated in significant increases in the numbers of MAPs being led by the wider partnership. In addition, the HSCP has not promoted learning events centred on Private Fostering in recent years. Hence, several training events have been identified for 2025/26 that will enhance practitioner knowledge and seek to address barriers in these two domains.

11.2 Trauma Informed Halton

Halton recognises the evidence base that is emerging day by day, across both national and international communities, which identifies the impact of trauma and the consequences of exposure to adversity as a profound health, wellbeing, and social care issue of our time. During 2024/25, the HSCP has therefore sought to ensure that we adopt a trauma informed practice across our region. Trauma-informed practice is achieved when we:

- Realise what trauma is and how it can have widespread impact for children, young people, families, and communities.
- Recognise the signs and effects of trauma in individual children, young people, families, groups, and communities.
- Respond by integrating knowledge regarding trauma-informed approaches into safeguarding policies, procedures, and practice.
- Resist re-traumatising children, young people, families, and communities by actively seeking to avoid situations where traumatic memories might be retriggered and seeking to deescalate and diffuse potentially traumatic interactions when they occur.
- Resilience is promoted in supporting children, young people, families, and communities to cope with and adapt to adversity and have the strength to challenge situations where it might occur.



Consequently, over 150 practitioners and managers were trained in Trauma Informed Practice, and nine trainers were trained to roll out further training programmes in the future. In addition, strategic leads have ensured that a trauma informed approach is intrinsic to new strategies launched across the region in the reporting period, including the Pan Cheshire All Age Exploitation strategy and the revision of Halton's Neglect Strategy.

12. Communication Strategy

A key area of work for the HSCP is the effective delivery of information to professionals working with children, senior leaders, community partners, and parents/ carers, so that children and young people are safeguarded, and their wellbeing supported.

Our approach to communication-as documented in our Communication Strategy- is based on the following principles:

- Information is a service in its own right.
- Information should be accessible to everyone.
- Communication should be clear and open using plain English (e.g., avoiding jargon and explaining acronyms) or giving clear explanations where this is not possible.
- Promoting equality and valuing diversity is central to the provision of information.
- A commitment to keeping information up to date and relevant.
- Information may need to be delivered in the spoken word to be effective.
- Consultation and engagement are central to the Partnership's continuous improvement.

Therefore, during the reporting period we have used a wealth of methods to communicate to our audiences:

- Annual Report and Strategic Plans
- Subgroups/Task and Finish Groups/Local Reflective Reviews/Local CSPRs
- Quarterly newsletters
- 7-minute Guides
- Partnership Briefings
- Induction presentations, e.g. Social Worker Academy
- Emails and email briefings

- Training/briefing sessions/ workshops
- Conferences/ media statements
- Leaflets/Posters/ Factsheets
- Press releases.
- Lunch and Learn sessions.
- Public Events/ roadshows
- Service User and Practitioner feedback (Surveys /forums)
- Social media i.e. LinkedIn
- Staff supervision
- Visual media sources
- Participation in Community Group events

How will we know we have made a difference?

Our Communication Strategy endeavours to make a difference in the following ways:

- ✓ All stakeholders will know what safeguarding is, how to protect themselves and how to report abuse.
- ✓ Our audiences will understand the role, remit, and work of the HSCP and will be able to access information about it.
- ✓ People's experiences of safeguarding will inform future communications and improvements to safeguarding practice.
- ✓ The workforce will understand their respective roles and responsibilities in safeguarding, leading to improvements in multi-agency working and outcomes for service users.
- ✓ Better outcomes for children and young people involved in safeguarding.
- ✓ Increase in positive media coverage.

The Communication Strategy and the Implementation Plan that supports the strategy can be accessed on the HSCP web site: Home - Halton Safeguarding Children Partnership

During the reporting period, the HSCP also continued to develop its web site. The web site contains numerous pieces of safeguarding information including:

- ✓ Governance & Reporting Arrangements
- ✓ Helpful resources for children and young people
- ✓ Policy, Procedures, and toolkit guidance for professionals
- ✓ The ability to book onto HSCP training events.
- ✓ Latest news, including Partnership briefings.
- ✓ Avenues of support for parents and carers
- ✓ Key learning recommendations

- ✓ Links to partner agencies.

This evidences the effectiveness of the HSCP's communication strategy in reaching a variety of frontline workers and community members. The website is regularly updated with latest news and information and is a useful resource in advertising training events across the region.

Our website remains a useful repository for our policies, guidance, and leaflets. We have invested in Search Engine Optimisation technology to ensure that searches for documents on our website are easily accessible. Web analytics also enable us to analyse the most viewed pages and respond in a timely manner to pages where enhancements are needed to increase footfall.

13. Independent Scrutiny

The three safeguarding partners are responsible for determining local arrangements including the provision of independent scrutiny. The independent scrutiny function is described on pages 36-38 of *Working Together 2023*. Independent scrutiny provides the critical challenge and appraisal of Halton's multi-agency safeguarding partnership arrangements in relation to children and young people by doing the following:

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

The independent scrutineer works independently of the three safeguarding partners and Education, in liaison with the HSCP Business Unit.

Anna Berry became Halton's independent scrutineer in January 2024. A description of the key role of the independent scrutineer in Halton can be found on the partnership's website.

13.1 Feedback from Anna Berry, Independent Scrutineer

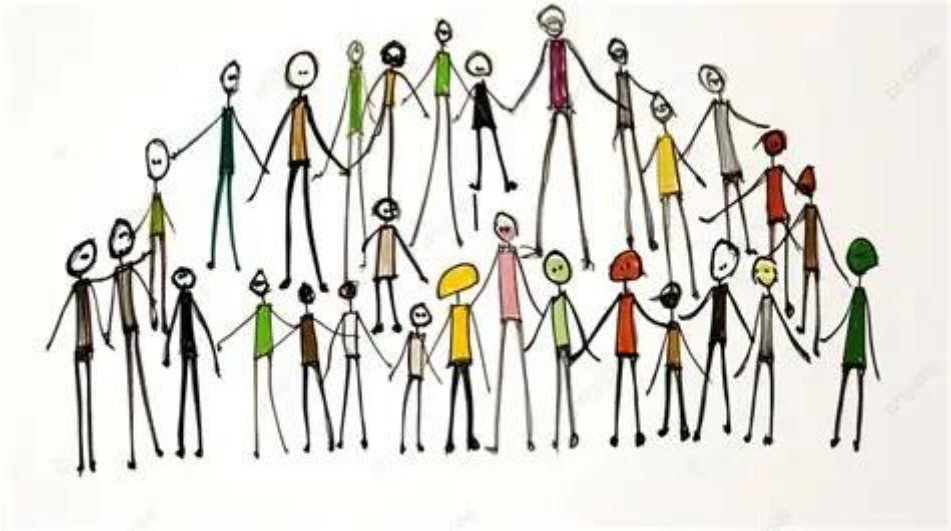
The Independent Scrutineer for the Halton Safeguarding Children Partnership (HSCP) presented quarterly reports, and an end of year scrutiny report to the Delegated Safeguarding Partners in the reporting period of this annual report. These reports outlined the key developments of the partnership over the year and made some recommendations for the year ahead.

The role of the scrutineer is to ask questions about how well services are safeguarding and promoting the welfare of children and young people in Halton. Whilst there is no set list of things for a scrutineer to do or how to do them, activity was agreed with the SCP Executive throughout the year in alignment with their arrangements. This included a review of the arrangements under WT23 implementation, a self-assessment and scrutiny response exercise culminating in recommendations, participation in the Regional Improvement Programme (RIP), and overall effectiveness of the subgroups. This activity was supplemented by regular participation in strategic meetings, review of relevant SCP documents, engagement with partner agencies, business manager, chairs of the subgroups, information obtained from the Halton Strategic partnership meeting, observations of the work of some of the subgroups, review of meeting minutes and action logs, and ongoing observations of overall SCP processes and systems.

Overall, there is observation of good partner engagement, positive relationships, and an appetite for the success of joint children's arrangements. The amount of work undertaken within HSCP to develop, strengthen and function is vast and provides a solid foundation for the HSCP, in particular and not exhaustive:

- Under the neglect priority, the revision of the Neglect Assessment Framework, and a focus on Multi Agency Plans (MAPS) which has demonstrated an increase of MAPs across the partnership.
- Under the exploitation priority, the development and strengthening of the contextual safeguarding arrangements and a Ketamine task and finish group.
- Under the domestic abuse priority, the SCP has undertaken a mock JTAI and made recommendations which sit within the Halton Domestic Abuse Board
- The development of the Young People's Voice and Influence Group
- A full review of the training offer
- Dissemination of learning identified through multi agency audits e.g. S47 SWAY package.

The independent scrutineer has worked closely with the business manager and the strategic partnership meeting in its work throughout the year, and the scrutiny work plan is intended to add value and run alongside the functions and mechanisms of the SCP. There are a number of key points identified throughout the scrutiny report as areas for development, and areas for further scrutiny which can be broadly summarised into the thematic areas of impact and outcomes, engagement, resource, and leadership. This will influence the scrutiny work for 2025/2026.



14.The Future

14.1 HSCP Priorities for 2025-26

The HSCP's current Business Plan 2025-27 will continue in the next reporting period with the workstreams, and programmes further developed.

Hence, our 3 key priorities will continue to be:

1. **Improving the quality and timeliness of our practice in relation to neglect.**

2. **Safeguarding Children from Violence and Exploitation**

3. **Protecting children as victims of domestic abuse**

In addition, cross-cutting themes will continue to be a key feature in Partnership working. Progress against these cross-cutting themes will be discussed in partnership meetings, scrutinised by the Independent Scrutineer, and reported on in next year's annual report. The cross-cutting themes are as follows:

Theme 1: Strengthening the Partnership's relationships with all relevant children, adult and community focussed boards and partnerships across Cheshire. This is particularly relevant in relation to the Halton Safeguarding Adults Board as we strive to ensure transitional arrangements are robust, effective, and widely understood.

Theme 2: Measuring the effectiveness and impact of the Children's Partnership. (see 14.2 and work with Northwest Multi-Agency Safeguarding Learning and Support Hub).

Theme 3: Co-production: ensuring the voices of children and families are consistently heard and their voices influence service planning and delivery (see 14.2).

The finer detail on how the HSCP will deliver on these priority areas and the cross-cutting themes is documented within the following key delivery plans:

- ✓ The Contextual Safeguarding Strategic Group Delivery Plan 2025-26
- ✓ The Health Subgroup Delivery Plan 2025-26
- ✓ The Young People Voice & Influence Group Delivery Plan 2025-26
- ✓ The Education Subgroup Delivery Plan 2025-26
- ✓ The Quality & Impact Group Delivery Plan 2025-26

14.2 North West Multi-Agency Safeguarding Learning and Support Hub

Furthermore, the HSCP will be working closely in 2025/26 with the Northwest Multi–Agency Safeguarding Learning and Support Hub to strengthen and support our Multi-Agency Safeguarding Partnership Arrangements (MASAs). The Learning and Support Hub endeavours to:

"Collaborate better to improve child centred, multi-agency practice; nurturing a culture of trust, accountability, and support for our children."

The key opportunities provided by such collaboration include:

- To **share** and embed multi-agency practice that is improving outcomes for children and families.
- To **enable** the system to demonstrate the impact and effectiveness of multi-agency practice
- To **collaborate** better together by facilitating spaces for collaboration at a sub-regional and regional level.

The desired Impact of our Collaboration with the Northwest Multi-Agency Safeguarding Learning and Support Hub:

An improved understanding of safeguarding effectiveness and performance of Halton's Safeguarding Children Partnership. Data will be used more meaningfully to understand our local safeguarding effectiveness, and to target activity to understand local need and priorities. This will ensure that identified priorities for our partnership are evidence- based and proportionate for local children and their families. There will also be an improved understanding of "what works" across our local MASA to enhance local safeguarding effectiveness, insights, performance, scrutiny, and assurance.

The Halton Safeguarding Children Partnership will also have a robust safeguarding effectiveness and quality assurance framework, which is evidence based and used to target multi agency activity to improve outcomes for children and families. There will be an improved shared understanding of local issues that affect children and their families in Halton and commitment from partners in addressing key challenges. The partnership will also be able to demonstrate the impact of partnership activity and strategic direction and decision making for the partnership will be evidence based.

Finally, Halton's SCP will be robust, efficient, and effective. Partners will work together effectively to protect children. There will be a co-ordinated and effective local response to safeguarding concerns, with agencies working collaboratively to assess risks and to provide support.

How this will be delivered in collaboration with the Northwest Multi-Agency Safeguarding Learning and Support Hub is documented in Halton's Bespoke Offer 2025-26

14.3 Annual reporting arrangements

Both the HSCP Strategic Leadership Group and the Executive will review a final draft of the annual report for 2024/25 in September 2025. The report will then be submitted to the Department for Education by 30 September 2025.

This annual report will be available on the partnership's website here: Home - Halton Safeguarding Children Partnership

15. Glossary

A & E	Accident and Emergency
ACE	Adverse Childhood Experience
CAMHS	Child and Adolescent Mental Health Services
CE	Child Exploitation
CIC	Children in Care
CP	Child Protection
CSA	Child Sexual Abuse
CSC	Children's Social Care
CSSG	Contextual Safeguarding Strategic Group
CSOG	Contextual Safeguarding Operational Group
CSPR	Child Safeguarding Practice Review
CSSG	Child Safeguarding Subgroup
CYP	Children and Young People
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment
DFE	Department for Education
DSL	Delegated Safeguarding Lead
DSP	Delegated Safeguarding Partners
EAL	English as an Additional Language
EHCP	Education Health Care Plan
FE	Further Education
FGM	Female Genital Mutilation
GRT	Gypsy, Roma, and Traveller people
HBC	Halton Borough Council
HSCP	Halton Safeguarding Children Partnership
ICART	Integrated Contact and Referral Team
ICB	Integrated Care Board
IDVA	Independent Domestic Abuse Advisor

JTAI	Joint Targeted Area Inspection
LADO	Local Authority Designated Officer
LMS	Learning Management System
LSCB	Local Safeguarding Children Board
LSP	Lead Safeguarding Partner
MAP	Multi Agency Plan
MASA	Multi-agency safeguarding arrangements
NEET	Not in Education, Employment or Training
PEP	Personal Education Plan
PRU	Pupil Referral Unit
QIG	Quality and Impact Group
RIPP	Research into Pilot Practice
SCP	Safeguarding Children Partnership
SEND	Special Educational Needs and Disabilities
SGO	Special Guardianship Order
SPOC	Specific Point of Contact
VOC	Voice of the Child