23 August 2019

Mil Vasic, Director of Children's Services
David Parr, Local Authority Chief Executive
Andrew Davies, Executive lead of the CCG with responsibility for Halton
Michelle Creed, Executive lead of the CCG for Safeguarding Children
Darren Martland, Chief Constable, Cheshire Constabulary
David Keane, Police and Crime Commissioner Cheshire
Gareth Jones, Head of Youth Justice Services
John Davidson, Director of the National Probation Service
Chris Edwards, CEO, Community Rehabilitation Company

Dear local partnership

Joint targeted area inspection of the multi-agency response to child exploitation in Halton

Between 8 and 12 July 2019, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMIP) carried out a joint inspection of the multi-agency response to children experiencing or at risk of exploitation, including sexual and criminal exploitation, in Halton.

This letter to all the service leaders in the local area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Halton.

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door' for child protection, including a focus on children experiencing or at risk of child exploitation. Also included was a 'deep dive' focus on this vulnerable group of children who are known to be in this situation of concern. Inspectors also considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the Halton safeguarding children board (HSCB), now known as the Halton children and young people safeguarding partnership (HCYPSP).

Senior leaders in the Halton local area partnership have a clear vision and strong commitment to working together to meet the needs of vulnerable children. During this inspection, the HCYPSP was launched. Effective strategic planning is in place to address child exploitation. The partnership has a clear understanding of the needs of its vulnerable children and has established a model of practice called 'contextual safeguarding'. This model is embryonic and has not yet been fully implemented by

the workforce across the partnership. Therefore, it is too soon to assess the impact of these new safeguarding arrangements for children.

Local authority leaders have addressed the findings from previous inspections, particularly the inspection of local authority children's services (ILACS) focused visit in July 2018. For example, improved reporting and data analysis of return home interviews (RHIs) mean that the partnership has a clearer understanding of the push and pull factors when children go missing. This crucial information is shared with partners at the contextual safeguarding strategic group (CSSG), and informs the overall understanding of the prevalence and impact of child exploitation in the Halton area.

The local authority identifies and responds to concerns relating to children. However, strategy meetings are not always convened when potential child protection concerns arise. This means that not all agencies can hear and share information to make informed decisions for future interventions.

Professionals do not always escalate their concerns when they do not agree with the local authority's decisions.

Key Strengths

- Early help is a strength in Halton. When children do not require a statutory service, they are signposted to and provided with an effective response from a range of early help services. Regular 'working together' meetings involving a range of partners ensure that intervention is at the right level for the child's needs. If risks are deemed too high or the child's plan is not supporting positive progress, then a swift step-up to statutory services is agreed.

- The initial contact and referral team (iCART) is well structured and includes partners from police, health, CAMHS and education. Partners understand thresholds and make appropriate referrals. Information-sharing is prompt, and, for most children, appropriate decisions are made in line with their identified needs. The engagement of the community rehabilitation company (CRC), national probation service (NPS) and the youth justice service (YJS) is underdeveloped, which reduces the opportunity for more effective joint working at the front door.

- Child protection information-sharing (CPIS) checks and paediatric liaison teams provide a structure to effectively share information between hospital emergency departments and community health teams. This means that staff are aware of any known risks to children who may present at Whiston or Warrington hospitals for emergency treatment.

- A strong emphasis on engaging families, in the context of a strengths-based practice model, supports assessments and decision-making. Children's views are captured by professionals, including school, college and health staff. These influence the assessments, analysis and future care planning.

- Weekly multi-agency 'missing' meetings use knowledge of wider exploitation and potential risks to consider children who are going missing. The collated intelligence from RHIs and 'missing' meetings can then be used to support the partnership in maintaining a well-developed understanding of the prevalence of child exploitation in the area.

- Partners work well together, led by the local authority chief executive. Strong strategic partnerships across not only the local Halton area but also the combined Liverpool, pan-Cheshire and north-west consortium effectively share information to aid agencies' understanding of the impact and prevalence of child exploitation in the area. This includes the establishment of the local and regional serious and organised crime partnership boards focusing on reducing vulnerability. Key information about themes, disruption activity and individual vulnerable people are shared in the local area strategic and operational groups. For example, partners worked well together raising awareness for children and practitioners about violent youth behaviour and the risks of carrying knives.

- CAMHS includes a broad offer to children, and there is access to the service from a number of points of contact. It also responds well to children's needs. Staff, who are commissioned by the local authority to provide services for child exploitation and missing children, are knowledgeable and receive ongoing training about child exploitation. They provide tailored specialist services for children experiencing or at risk of exploitation. The partnership has supported the development of a complex youths team in the Community Safety Partnership. This team supports a holistic partnership and whole-family approach to reducing the risk of exploitation. The youth justice team's focus on understanding the impact of trauma and adverse childhood experiences on behaviour is improving long-term outcomes for children and families. For children transitioning to adulthood, the 'navigate youth cohort' (within the youth justice service) ensures that there is a direct and seamless transition to multi-agency services and integrated offender management.

- NPS, YJS and the school nursing service provide regular supervision for their staff and demonstrate effective use of management oversight. This means that staff are able to reflect on their practice and to structure their interventions with families in order to promote positive experiences and progress for children.

- Strong political and senior leadership support enables the local authority to focus on recruitment and retention. A focus on employee benefits has seen vacancies

and the use of agency social work reduce. This means that social workers' workloads are manageable. Social workers have the time to see children in accordance with their needs and build trusting relationships with them, and this supports children to share their worries and experiences. A structured learning and development programme, using the local authority's chosen model of practice, is starting to have an impact on children's experiences. For example, specialist family therapy is beginning to improve parent/child relationships.

- The HSCB receives performance data reports that include a rationale for the performance. This enables the board to offer challenge to partners and supports it to determine themes for multi-agency auditing. Findings from the board's audit of missing children and RHIs supported the local authority to revise its contractual agreement with its commissioned service addressing child exploitation, resulting in clearer performance reporting to the local authority. Additional challenge from the HSCB related to the lack of training and learning opportunities for practitioners within the partnership about contextual safeguarding. It is recognised by all partners that training for contextual safeguarding needs to be jointly delivered in order to maximise partnership learning opportunities.

- Children's voices are actively sought and heard in Halton, both individually and in a group forum. Local authority children's records clearly record the child's voice, and, for some children, this work assists their social worker to gain an understanding of their lived experience. However, the vulnerable person assessment submissions (VPASs) completed by the police do not always incorporate the child's voice. A children's 'question time' event was an opportunity for children to ask senior leaders across the partnership questions. This resulted in children's views being incorporated, for example, into the plans for the new safeguarding partnership arrangements.

Case study: highly effective practice

A very sad incident occurred in Halton approximately one year ago involving knife crime. One young person lost their life and two young people received lengthy custodial sentences as a result of their actions.

The prompt response of the partnership in Halton demonstrates their commitment to reducing risks and improving safety for children in Halton. A wider and varied range of partners and local politicians came together less than one week after the incident to plan how they could provide education, prevention support and a cohesive response to knife crime and other serious youth violence. This group has continued to meet regularly and has successfully implemented a significant range of resources to reduce risks for children in Halton communities. Many school staff and pupils fully engage with a 'Healthitude' programme that increases awareness and highlights the risks of carrying knives. Headteachers have shared the positive impact this has had on children and staff with their colleagues. Other initiatives like 'live your life – drop the knife' and 'Everton in the community' are well attended by children and support them to be safer through a greater understanding of risks.

Through working together effectively, the partnership is raising awareness of serious youth crime for practitioners, senior leaders and importantly children and young people. This is building a clearer understanding of the prevalence of knife crime in Halton and is supporting young people to be and feel safer in their communities.

Areas for improvement

- Assessment of risk and threshold for intervention are not consistently applied. Children receive a prompt service when needs are identified, although, for some children, this has been through the provision of early help services. Where risks identify potential significant harm, this has not always resulted in multi-agency child protection strategy discussions. This results in delays to effective multi-agency information-sharing and plans being put in place to reduce risks for children. Furthermore, when children already have an allocated social worker, strategy meetings are not always convened in a timely way in order to respond to changing and ongoing risks. When they are, the right professionals are not always invited or attend.

- The agreed Pan-Cheshire child exploitation screening tool is not being used effectively by all partners. Some agencies report that the tool takes too long to complete when they have limited contact with a child. When used well, for

example by the YJS and social workers, it is a helpful tool to support wider assessments and identification of need for children who may be exploited. The partnership was already aware of this issue and has undertaken to consider this further at the HCYPSP meetings.

- When there is a disagreement between agencies, such as the police and children's social care, about the assessed and graded level of risk to children, there is no formal challenge raised. Children's social care services do not always record a clear rationale for the risk reducing, which means that agencies do not know what has changed for the family.

- Children are discussed at several different meetings, for example the 'missing' meeting, the contact challenge meetings, child in need/core group meetings, strategy meetings and the contextual safeguarding operational group (CSOG). The relevant professionals are not always represented at each meeting, and children's records are not routinely updated across the partnership. An example of the impact of this is that the health professional attending the CSOG does not share information about children at risk of exploitation with all relevant agencies, for example GPs. For some children, this means that there is no coherent single plan which addresses their needs and risks and which is shared with all agencies.

- For some children experiencing or at risk of child exploitation, planning for their educational needs is not robust enough. Too many children do not receive full-time education. Some children experience too long a period without any education provision. However, more recently this has begun to improve, and there has been positive progress for some of the children who were considered during this inspection.

- The quality and regularity of supervision and management oversight in children's social care, police and CAMHS mean that practitioners are not always provided with the opportunity to reflect on their practice and areas of potential safeguarding. When children's cases have become 'stuck' or records are not up to date, managers do not always provide sufficient challenge to improve practice. Management oversight and well-structured regular and reflective supervision is key to monitoring children's plans in order to improve their experiences and progress.

- A comprehensive and robust auditing framework demonstrates the local authority's commitment to continuous improvement. However, the quality of individual case audits is not analytical or appropriately self-critical, and this does not support continued learning. This is also reflected in the multi-agency auditing of individual cases.

- The partnership recognised that staff knowledge and understanding of the new safeguarding arrangements and the approach to 'contextual safeguarding' for vulnerable children is not yet where it should be. Most partner agencies address child sexual exploitation in their training offer. However, there is a significant gap in the training offered by single agencies and the HSCB (now HCYPSP). This means that practitioners and managers are not being provided with the knowledge and expertise to understand and confidently assess all forms of child exploitation.

- The new safeguarding partnership arrangements (HCYPSP) has clear guidance for key lead safeguarding partners. However, these arrangements are not yet embedded. The role of relevant partners is not clear (for example CRC/NPS), and this could be a missed opportunity to ensure that all agencies in Halton can contribute to the safeguarding arrangements effectively.

Case study: area for improvement

For one child, numerous concerns were raised by police and education staff about absence from school, weight loss, associations with unsuitable adults, inappropriate housing and criminal behaviour.

The action taken to protect and meet the needs of this child was too slow. The child has been subject of a child in need plan when there are clear indications that a child protection plan should have been considered. As a result, the risks to and unmet needs of this child have not been adequately reduced, and they rarely attend school.

The local authority took immediate action when inspectors identified concerns for this child and reassessed the level of risks and interventions planned.

Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response, involving NPS, CRC, YJS, the police, the clinical commissioning

group and health providers in Halton. The response should set out the actions for the partnership and, where appropriate, individual agencies.[1]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 2 December 2019, 70 working days from pre-publication. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Yvette Stanley National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary and Fire & Rescue Services	**HMI Probation**
 Wendy Williams HMI Constabulary and Fire & Rescue Services	 Helen Davies Assistant Chief Inspector

1The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.