



**SEFTON**

Safeguarding Children  
Partnership

# Sefton Safeguarding Children Partnership Annual Report 2023–2024



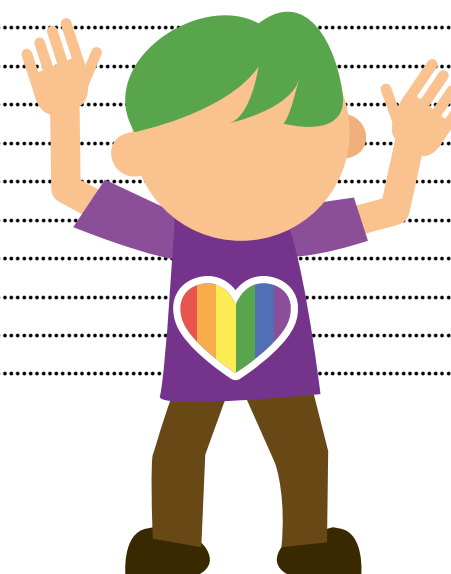


**Every child and young person in Sefton should be able to grow up free from abuse and neglect and the fear of being abused or neglected.**

**We are committed to improve the safety of all children and young people in Sefton so they can be healthy, happy, achieve and reach their full potential.**

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## Foreword from Sefton Statutory Partners

We are pleased to present the second annual report written under our leadership as the Delegated Strategic Leaders for the Children Safeguarding Partnership. As leaders we meet monthly to progress and be assured that the priorities in the strategic plan are being progressed. The strategic meeting for period 2023 -2024 was chaired by Kerrie France (Associate Director of Quality and Safety Improvement- NHS Cheshire & Merseyside). The three priorities set out in the strategic plan which we are working hard to meet are leadership and culture, core safeguarding and harm outside the home.

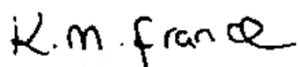
We are pleased to present the 2023-2024 Annual Report on behalf of all the agencies represented on the Safeguarding Children Partnership. The report covers the period 1 April 2023 to 31 March 2024.

This report sets out our collective achievements and areas for development against a backdrop of unprecedented challenges for children and families, communities and the safeguarding services working to support and protect them. The lasting effects of the pandemic on mental health; the cost-of-living crisis and impact of poverty, and challenges of staff recruitment and retention at a time when demand is increasing have combined to make this a particularly difficult period. However, our partners and dedicated frontline staff have shown remarkable resilience in rising to these challenges and for that we are very grateful.

Throughout this report, you will see evidence of the collaborative efforts of the partnership which have enabled us to progress our priorities and create a safer environment, both within homes and communities, for our children and young people and we remain steadfastly committed to continuing that work.



**Risthardh Hare**  
Director of Children Services  
Sefton Council



**Kerrie France**  
Associate Director of Quality and Safety Improvement  
NHS Cheshire & Merseyside



**Paul Holden**  
Superintendent  
Merseyside Police

## Role of Sefton Safeguarding Children Partnership

In line with 'Working Together to Safeguard Children (2023)' each area is required to have multi-agency arrangements in place that enable partners to work together to ensure that children are effectively safeguarded. The three safeguarding partners who are responsible for the local Multi-Agency Safeguarding Arrangements (MASA) in Sefton Council, Cheshire and Merseyside Integrated Care Board and Merseyside Police. Further information about the Multi-Agency Safeguarding Arrangements in Sefton is outlined in our Multi-Agency Safeguarding Arrangements available on our website [www.seftonscp.org.uk](http://www.seftonscp.org.uk). The (MASA) arrangements are in the process of being updated to include the changes in Working Together to safeguard Children (2023) and they will be published by 31 December 2024 and will be found on the Sefton SCP website.

## Sefton at a Glance

Sefton is a metropolitan borough of Merseyside; England and its local authority is Sefton Council. The borough consists of a coastal strip of land on the Irish Sea and extends from the primarily industrial area of Bootle in the south to the traditional seaside resort of Southport in the north. In the south-east it extends inland to Maghull. Sefton has an approximate area of 155km<sup>2</sup>. Sefton has a population of approximately 275,899 with 24% of Sefton's population being 65 years old or over (65,463) and one in five being aged under 18 (54,098).



There are 75 state funded primary schools (this includes infants, junior and primary settings) in Sefton. 68 of these are maintained by Sefton with 7 being academies. 49 primary schools have nursery settings, 45 of which are maintained with 4 being academies.

There are 18 secondary schools within Sefton, 6 of these are maintained, 11 are academies and 1 is a free school. 10 secondary schools across Sefton have further education settings / 6th forms. Of these, 4 are maintained schools with 6 being academies.

The Team Around The School was introduced 2 October 2023 and has 5 cluster groups areas covering Bootle/Hillside, Formby, Maghull, Crosby and Southport. Each Cluster has a high school and several primary schools. All have a multi-agency team that provides advice, support, signposting and direct work with a focus on practical support, improved school attendance and attainment. The teams have received positive feedback from schools, children and families. This is being expanded to include all Southport schools in the coming months.

Within Sefton, there are 5 maintained special schools. 3 nursery schools are maintained by Sefton. Sefton also maintains 2 pupil referral units (one for Key Stage 2 and 3, the other for Key Stage 4).

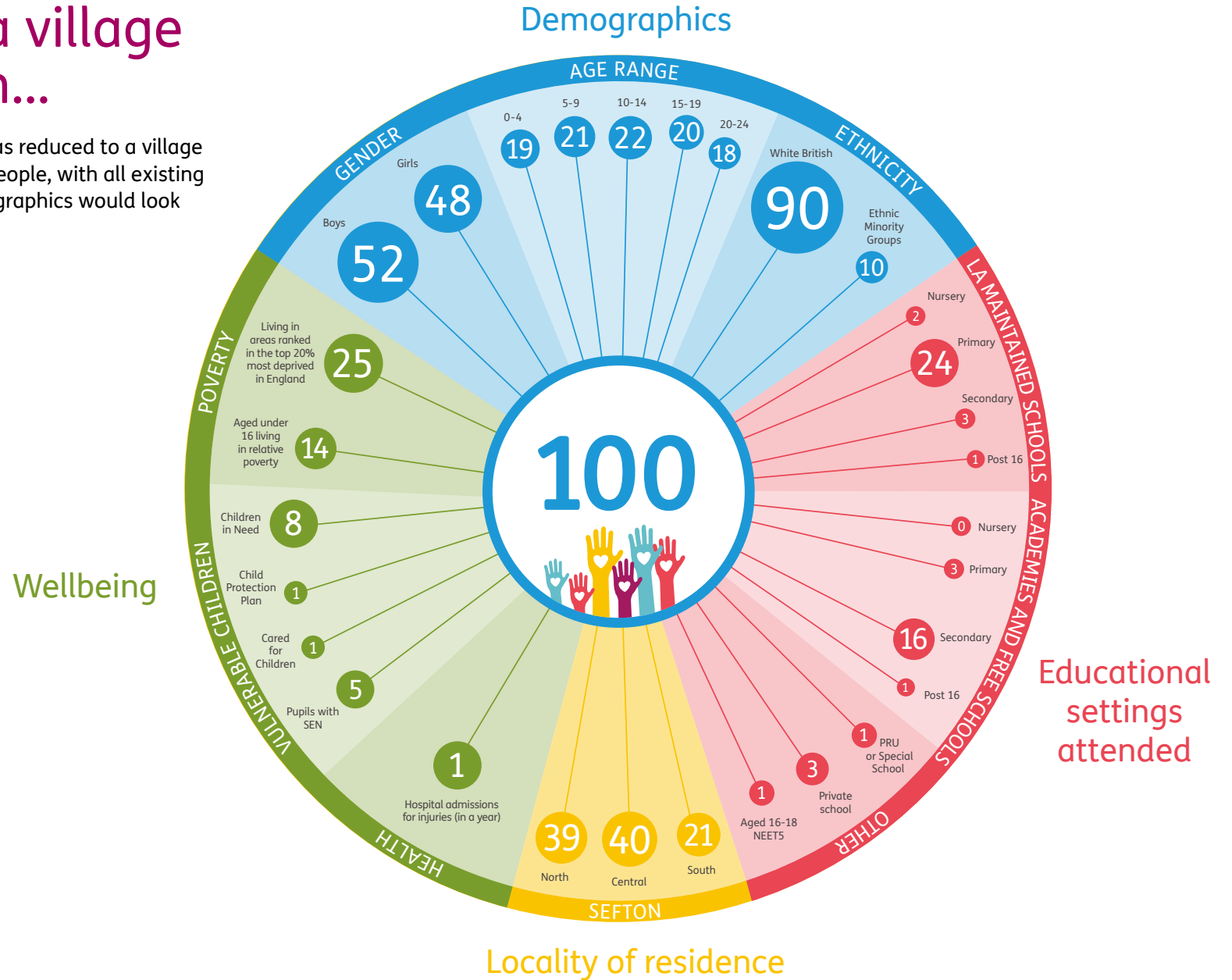
There are 3 main Family Hubs within Sefton covering North, Central and South and smaller satellite hubs serving several communities. They deliver early help and early intervention services to families as well as acting as a safe, welcoming space for families to go to find support across a range of areas from pre birth right the way through to adolescence and beyond.

Sefton is home to three further education colleges (not maintained by Sefton MBC) - Hugh Baird College in the south, Southport College, and King George the V in the north.

*Reference: Sefton Joint Needs Strategic Assessment (2021)*

# If Sefton was a village of 100 children...

If Sefton's population of under 25s was reduced to a village of precisely 100 children and young people, with all existing ratios remaining the same, the demographics would look something like this:



## Sefton Lead Safeguarding Partners (LSPs)

Under Sefton’s Safeguarding Children’s Partnership, the Lead Safeguarding Partner’s (LSPs) are the head of each statutory safeguarding partner agency, the LSPs are:

### **Phil Porter**

Chief Executive of  
Sefton Local Authority

### **Serena Kennedy**

KPM, Chief Constable  
of Merseyside Police

### **Graham Urwin**

Chief Executive (NHS Cheshire  
& Merseyside, ICB)

The LSPs have joint and equal responsibility for multi-agency safeguarding arrangements in Sefton. They are required to show strong leadership in overseeing the arrangements to help and protect children. Their focus is on multi-agency activity.

**The key task of the LSPs is to act as a team, as opposed to a voice for their agency alone.**

LSPs can delegate their function to a senior officer in their authority. In Sefton, the decision has been taken by the LSPs to delegate these functions (with full responsibility and authority for ensuring participation with these arrangements) to Delegated Safeguarding Partners (DSPs). In Sefton DSPs are referred to as Key Statutory Leads (KSLs). The KSLs in Sefton are the Director of Children’s Services, Risthardh Hare, Superintendent Merseyside Police, Paul Holden and Associate Director of Quality and Safety Improvement of NHS Cheshire and Merseyside, Kerrie France. The KSLs are sufficiently senior and able to speak with authority, take decisions on behalf of the LSPs and hold their sectors to account. Although the functions are delegated, ultimate responsibility for them remains with the LSPs.

# Sefton 3 Key Safeguarding Partners

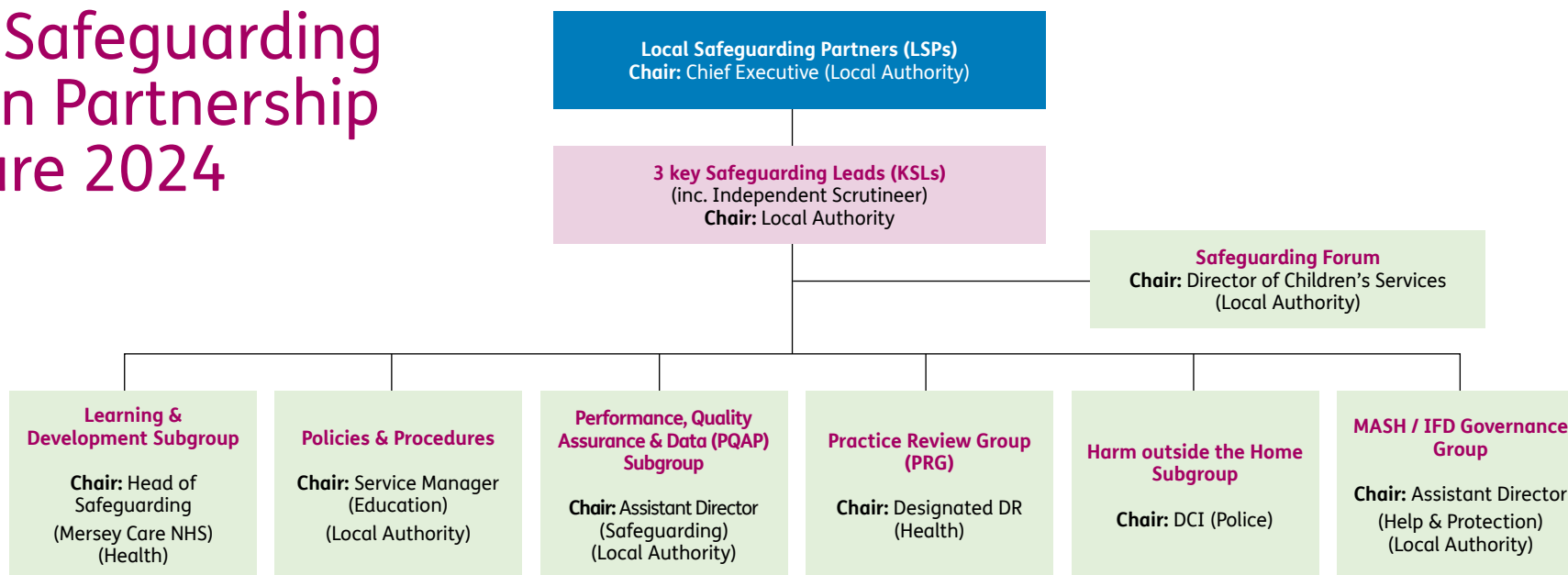
The following representatives form tripartite leadership of Sefton Safeguarding Children Partnership (SSCP).

- Sefton Council
- NHS Cheshire & Merseyside Integrated Care Board
- Merseyside Police

The Sefton SCP Safeguarding Forum includes representatives from the following organisations and sectors:

- Sefton Council
- NHS Cheshire & Merseyside ICB
- Merseyside Police
- Education – (Primary, Secondary, Special)
- Sefton Public Health
- Alder Hey NHS Hospital
- Liverpool University Hospitals Foundation Trust
- Liverpool Women’s NHS Foundation Trust
- Mersey West Lancashire Hospital Trust
- Mersey Care NHS Trust
- Sefton Council for Voluntary Services (CVS)
- Probation Service
- Merseyside Fire & Rescue Service
- Change Grow Live (CGL)

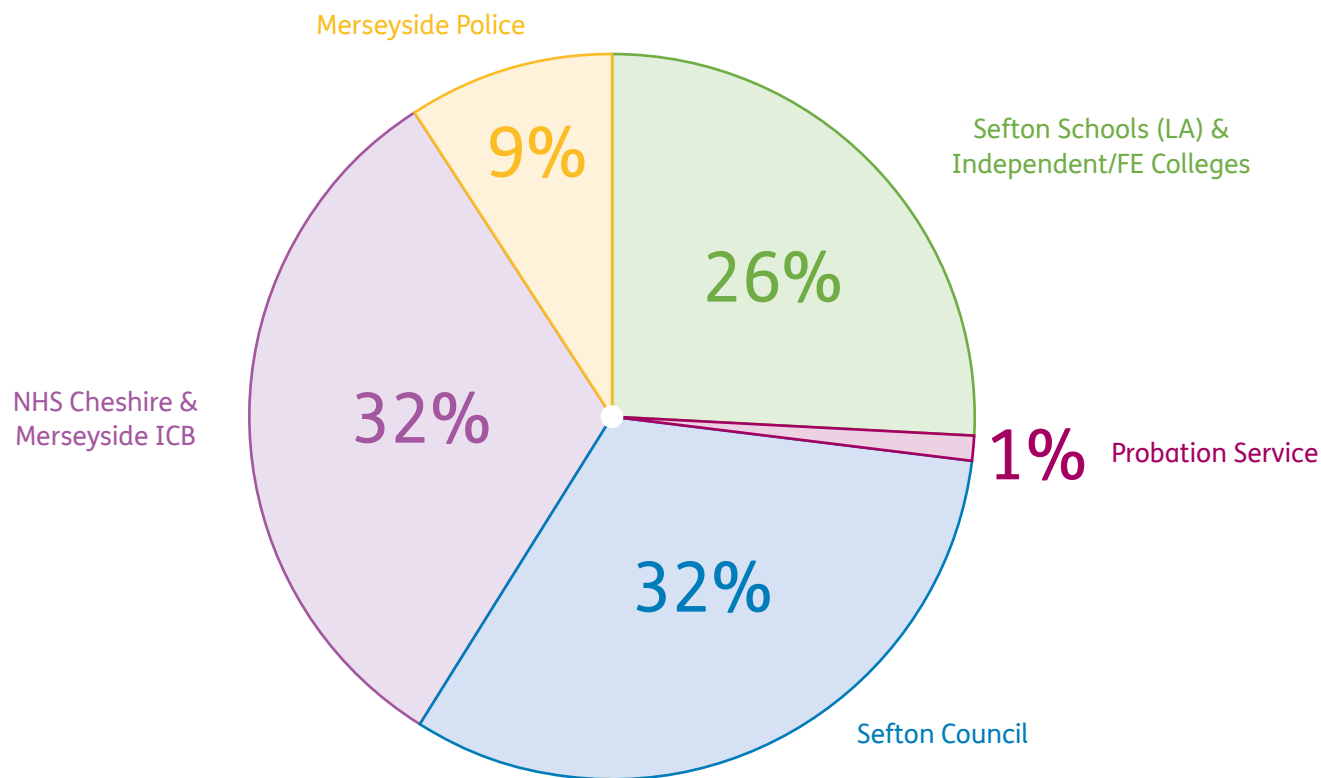
# Sefton Safeguarding Children Partnership Structure 2024



# Sefton’s Partnership’s Financial Arrangements

Contributions from our partners have remained static for some years. The Business Unit is now fully staffed which will result in staffing costs marginally outstripping contributions. Fortunately, the partnership has a reserve budget due to previous underspends because of staffing vacancies, and this enabled the partnership to draw down from reserve.

Partnership Financial Contributions are set out below:





## Partnership Priorities 2023-2024 and our response to areas of work

The Selected Priorities were:



All the priorities were chosen based on a range of evidence presented to the Sefton SCP, highlighted through both internal and external audits, key performance indicators, feedback from professionals and families and external reviews including the OFSTED inspection of Sefton Children Services.

Our focus across the three priorities will be the early identification of potential safeguarding requirements, the right intervention by the right agency at the earliest opportunity and delivery of effective performance and implementation of learning.

# 1 PRIORITY 1 - LEADERSHIP & CULTURE

## Our efforts to address Leadership and Culture

1. The Sefton SCP Strategic Priorities continue to be Leadership and Culture, Harm outside the Home and Core Safeguarding as outlined in last year's annual report 2022-23.
2. The KSLs have developed a strong, collaborative working arrangement along with the Independent Scrutineer to identify risks and more importantly to put in existing controls to reduce any risk to the partnership not achieving its priorities. Collectively they problem solve and work together to agree solutions to improve core safeguarding practice and leadership and culture across the partnership, i.e. they have commissioned external support when required.
3. Key Strategic Leads (KSLs) (Local Authority, Health, and Police) meet monthly to support the partnerships priorities as outlined in the strategic plan, collectively with the scrutineer.
4. Arrangements have been put in place for all subgroup chairs to report directly to 3 KSLs their progress against the strategic plan.
5. The Sefton SCP training offer to ensure that it was reflective of key learning from local and national reviews.
6. Developed the multi-agency auditing programme with a focus on cross partnership learning and ownership of outcomes.
7. A risk register for the partnership was developed and is reviewed monthly by the Key Statutory Leads to avoid drift and delay in meeting the strategic priorities.
8. Sefton SCP structure and terms of reference have been refreshed.



## 2 PRIORITY 2 - CORE SAFEGUARDING

### Our efforts to address Core Safeguarding

1. Developed key performance indicators to support our understanding of risk towards children and core safeguarding function.
2. The data is tracked via the performance quality assurance data subgroup.
3. The Partnership delivered Multi-agency briefings from the National Panel concerning the deaths of Arthur and Star alongside learning from Sefton case review activity, this supported staff developing Core Safeguarding skills and analysis.
4. Completed a multi-agency audit focused on neglect which underpinned the Sefton SCP workplan for 2023/2024.
5. The Independent Scrutineer reviewed referrals to Sefton SCP Practice Review Subgroup (PRG) and Strategy Meetings in Multi-Agency Safeguarding Hub (MASH) and presented the findings to the KSLs on 12 September.
6. Developed a Sefton SCP training plan that considers National Reviews and equips staff across the partnership with the knowledge and skills to safeguard child in Sefton.
7. Reviewed our Threshold of need document to strengthen identification of neglect, safeguarding infants and contextual safeguarding and to ensure children receive the right support at the right time.
8. Reviewed the Integrated Front door, and agreed an implementation plan for the planned Launch of the Conversational Model May 2024, to ensure all children in Sefton receive support and protection in a timely way.



## 3 PRIORITY 3 – HARM OUTSIDE THE HOME

### Our efforts to address Harm outside the Home

1. My Space, (Sefton’s response to child exploitation and children who go missing) is now in its second year and continues to support children at risk of harm outside the home. A My Space Procedural Manual was drafted, shared, agreed, and finalised.
2. The Harm outside the Home subgroup developed a 12-month work plan to address and to respond to children at risk outside the Home.
3. Sefton SCP issued a survey aimed at school children themed on ‘harm outside the home’ asking questions about how safe children and young people feel in Sefton. Children reported they felt most safe in the family home. The survey was presented to the Harm outside of the Home Subgroup and Sefton Stronger Together Board, for actions to be taken so children in Sefton feel safer outside of the home.
4. The Harm outside the Home Sefton SCP Subgroup with the Children’s Society contributed to the planning and disruption of exploitation with a focus in Southport and the nighttime economy. This transpired into a successful operation and work is ongoing.
5. Revised the online safety strategy and it is on the Sefton SCP website.



## Learning from Serious Child Safeguarding Cases/Rapid Reviews and response from the National Panel

Sefton Council have a duty to notify the National Child Safeguarding Practice Review Panel if it knows or suspects a child has died or is seriously harmed, and abuse and neglect is known or suspected. The Safeguarding Children’s Partnership Rapid Review Group carries out reviews in these circumstances.

Not all incidents that are reviewed will meet the definition of a ‘serious child safeguarding incident’ but may still raise issues of importance and opportunities for learning. This might include cases where there has been good practice, poor practice or where there have been near misses. In these circumstances the Safeguarding Children Partnership Practice Improvement Group will decide whether to conduct a Practice Learning Review or audit to ensure that learning is captured and shared with the workforce.

For each Local Child Safeguarding Practice Review (LSCPR) and Practice Learning Review (PLR), detailed action plans have been created and actions progressed to address the identified issue. This is monitored by the Practice Improvement Group who report regularly to the Partnership Executive.

The table below highlights how many Rapid Reviews, and notifications have been made or undertaken in Sefton from 1 April 2023 to 31 March 2024.

Number of Rapid Reviews held in 2023/24	3
Number of Notifications made to the National Panel 2023/24	3
Of Notifications made to the National Panel, Number that progressed to LSCPR	1
Number of LCSPRs published in this period	0
Number of LCSPRs currently in progress	1

Full details of the reviews and learning resources are now available on the Sefton SCP website [www.seftonscp.org.uk](http://www.seftonscp.org.uk).

Where Rapid Reviews have identified immediate learning, action plans have been developed and they tracked through the Partnerships Practice and Review Subgroup.

In addition, the learning from the Rapid Reviews has been disseminated via 7-minute briefings and the Sefton SCP Training plan has incorporated the relevant themes.

There were three Rapid Reviews undertaken during 2023/24. Of the three there were two that did not progress to a Local Child safeguarding Practice Review (LCSPR). The case that progressed to LCSPR is still subject to the ongoing review and it is expected for that the report will be published in November 2024.

All the children subject to Rapid Review were residents of Sefton the ages of the children ranged from newborn to 17 years of age. All the children identified as white British. The themes from the two cases that did-not progress to LCSPR are co-sleeping and harm outside of the home. 7-minute briefings named Alfie and Bella can be found on the Sefton SCP website. The case that progressed to LCSPR, the theme was also Harm outside of the home.

In terms of safe sleeping health partners took a lead on the development of a partnership pathway to support professionals when the offer to view a child’s nighttime sleeping arrangements is declined by parents.

The pathway reflected learning from the Child Safeguarding Practice Review Panel: Out of Routine publication. The pathway was agreed as a partnership approach and accompanied a partnership pledge in respect of safe sleep advice. A safe sleep App was also launched involving Merseycare and Merseyside police to prevent serious harm to babies as a result of co-sleeping.

## Learning From Multi-Agency Audit

To support the Partnership in maintaining a line of sight to frontline practice, the Safeguarding Children Partnership undertook a range of different audits:

- Neglect– Conducted with multi-agency partners. Agencies completed audit tools in advance and then came together virtually with multi-agency auditors to discuss the children’s experiences. The audit is graded in line with Ofsted Judgements. A facilitator feedback form is completed and shared with the professionals involved.
- Neglect audit – Completed in September 2023, commissioned by Sefton SCP as Neglect was a priority for the partnership. The audit reviewed overall effectiveness in the areas below:
  - Use of tools in assessment, especially the GCP2 tool.
  - Planning and intervention.
  - Integrating the child’s voice into the work.
  - Work with parents and carers.
  - Multi-agency working.
  - Management oversight, supervision and decision making.

Eight cases selected across different levels of intervention where there had been multi-agency involvement in neglect. Audit documents were sent to auditors in June 2023. Opportunities for support and advice offered/taken.

Plan: all auditors would meet to undertake the audit analysis and draw up findings and recommendations. Scheduled meeting was cancelled due to delays in receiving the audits.

A summary of the cases selected included:

- Drug use by one or both parents (100%).
- Domestic abuse in 50% of cases.
- Poor parental mental health in 6 cases (75%) - (all mother).
- Poor parental engagement with services in 6 cases (75%).

Overall findings from the neglect audit include:

- Systemic and intertwined issues raised: e.g. supervision, robust multiagency work, loss of focus on child, planning, challenges of working with resistance and complex cases.
- Multi-agency work – needs greater shared responsibilities.
- Grading issues.
- Children not receiving effective, proportionate, or timely interventions to improve their situation, practice is not improving outcomes or reducing risk, multi-agency work is inconsistent or problematic.

Sefton Safeguarding Children Partnership have revised and refreshed the multi-agency audit process in preparation for the 3 multi-agency audits planned for the year ahead. There is an audit guidance document, a new succinct audit tool and child and family feedback form included.

The audit schedule for the year ahead has been planned and themes include:

- Multi-agency working at Child Protection (CP) and Child in Need (CIN) at step up and step down.
- Sexual abuse including child on child abuse.
- Pre-birth assessment and planning.

All learning from audits is compiled into individual reports and shared with the Performance Quality Assurance & Data Subgroup for scrutiny.

The Sefton SCP Newsletter also shares the findings of our quality assurance activity.

## Learning and Development (including workforce engagement and attendance at training)

The Partnership continues to offer a diverse Learning and Development offer consisting of Face to Face and virtual learning training courses. Further opportunities are communicated across the partnership which are available from National and local initiatives and organisations.

During the period April 2023-March 2024 76 courses offered (virtual and face to face model) with 1987 professionals attending. This is a significant increase in the SSCP Learning Development offer in comparison with the previous reporting year.

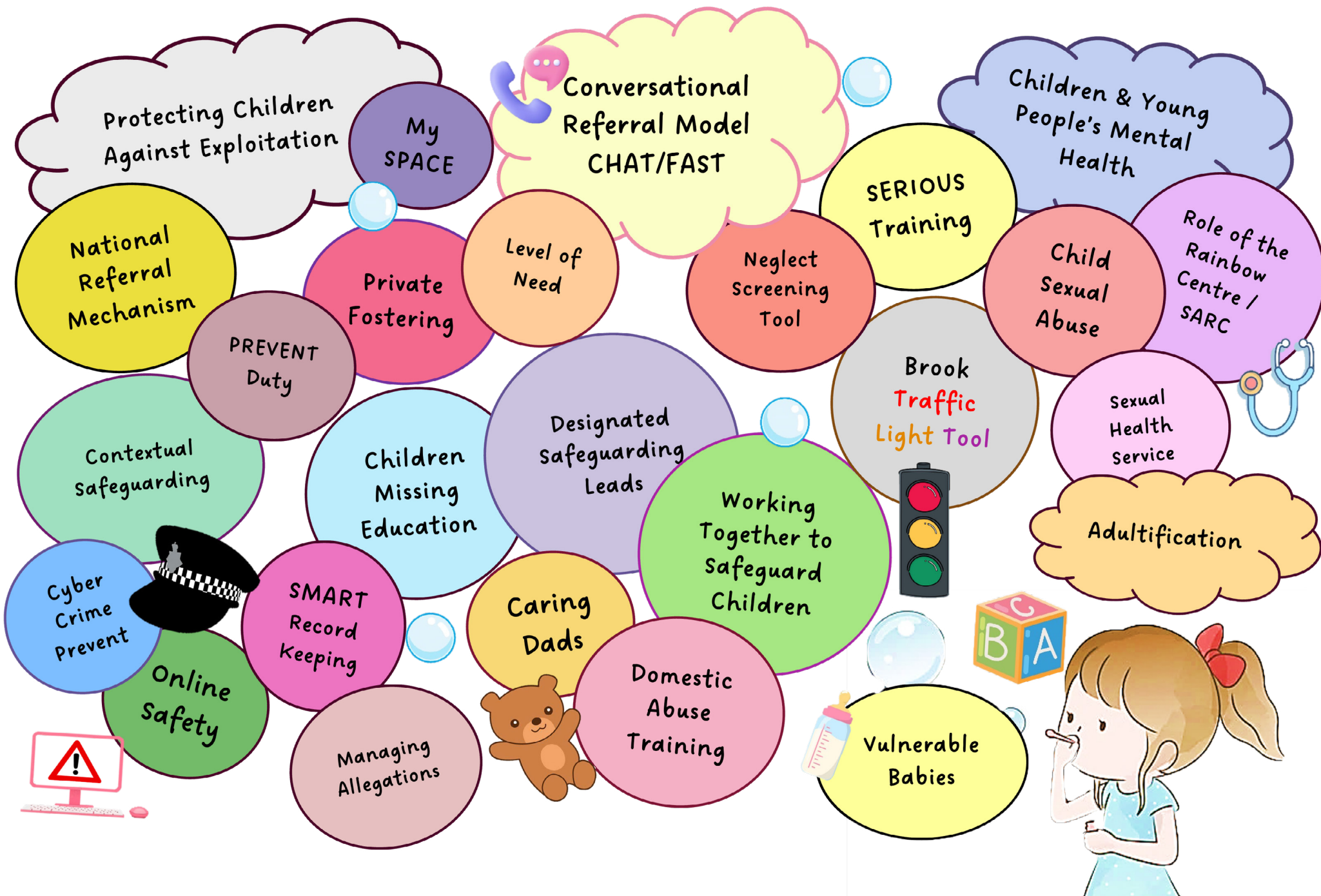
- ✓ Following the launch of Sefton Harmful Sexual Behaviour Policy & Procedure work was completed to improve understanding of Harmful Sexual Behaviour in Children, its links to experience of abuse & neglect; The need for tools and resources to support effective identification & response to HSB. This included the commissioning of Brook HSB Traffic Light Tool and train-the-trainer course to ensure necessary availability of agency HSB Leads to support staff working across partnership agencies. Additionally, SSCP Commissioned Specialist/National Leader in the field of HSB to deliver a series of multi-agency partnership events focusing of improving identification & response to HSB and Childhood Sexual Abuse.
- ✓ Awareness raising & uptake of the ICON campaign to support parents to cope with crying babies and reduce the prevalence of shaken-baby syndrome. An ICON Train-the-Trainer resource was made available to all partnership agencies. ICON Resources shared across the partnership including 7 Minute Briefing: Supporting Parents Coping with Crying Babies.

- ✓ Promotion of the ‘Safe Sleep’ agenda to support the reduction of child death through co-sleeping. Pan-Mersey Guidance on Safer Sleeping cascaded across partnership agencies. Safer Sleep for Multiple Births Guidance introduced. Promotion of Lullaby Trust Safer Sleeping Training to partners, including a specialist training for Midwives. Safeguarding Newsletter dedicated to Safe Sleep shared across the partnership network.
- ✓ Safe Sleep Resources in multiple languages sourced and cascaded.

### During 2023-2024 Sefton SCP delivered the following multi-agency training: (x) = number of sessions delivered

Face to Face	Virtual Briefings
Working Together to Safeguard Children (11)	Neglect Screening Tool (3)
Designated Safeguarding Leads (9)	Managing Allegations (3)
Brook Traffic Light Tool (7)	Coercive Control (3)
Domestic Abuse Training / Awareness (5)	Private Fostering (3)
Children & Young People’s Mental Health (3)	National Referral Mechanism (2)
Contextual Safeguarding (2)	Protecting Children Against Exploitation (2)
Child Sexual Abuse (2)	Cyber Crime Prevent (2)
SERIOUS Training (2)	My SPACE (2)
Conversational Referral Model (2)	SMART Record Keeping (2)
	Caring Dads (2)
	Level of Need Briefing (1)
	Children Missing Education (1)
	Online Safety (1)
	PREVENT (1)
	Role of the Rainbow Centre (1)
	Vulnerable Babies (1)
	Adultification (1)
	Conversational Referral Model (1)
	Sexual Health Service (1)







## Performance & Data – what does it tell us?

During the period covered by this report, the Independent Scrutineer co-chaired 2 meetings with a Children’s Social Care colleague and chaired a subsequent meeting post the departure of the Children’s Social Care colleague. The Performance, Quality and Data (PQAD) subgroup had also met on 2 occasions prior to the Independent Scrutineer taking on the co-chair/chair role. The information provided below sets out the work overseen by the subgroup from August 2023 onwards; this is because the 2 meetings held prior to this date were used to re-establish the group as it had not met for a significant period.

### Subgroup functioning

Given the recognised gaps in the delivery of performance and quality assurance functions, the following are considered achievements made in 23-24:

- Appointing a vice chairperson and revising membership to be more reflective of the partnership.
- Devising an 18-month work plan (which was approved by 3KSLs); this included agreeing the themes for multi-agency audit for 24-25. The topics were selected to evaluate multi-agency practice and the impact of learning from Child Safeguarding Practice Reviews.
- Receiving quarterly performance data; albeit it is recognised that the quality of the submissions impedes the effectiveness of the group.

### Line of sight to safeguarding practice and the experiences of children and families

A significant limitation in respect of the effectiveness of the group has been the lack of multi-agency evaluation of safeguarding practice that took place in 23/24; this gap arose due to delays in completing the neglect audit which evaluated practice that took place in 2022; however, the audit findings were not reported until September 23. The Harm Outside the Home audit was also delayed and did not report until June 24 and so outside of the period covered by this annual report.

The neglect audit found some elements of good practice, plus a high return rate from partner agencies to the audit, however systemic issues were identified in respect of multi-agency working and a finding that practice is not improving outcomes or reducing risk.

Multi-agency working was found to be inconsistent or problematic. Rather than create a bespoke audit action plan, and in recognition of the scale of the issues identified, a decision was made that the findings would inform the delivery plan for the ‘core safeguarding’ priority that was formally agreed by statutory partners in 23-24.

From September 2023 onwards, PQAD has received a performance report which has enabled discussion of some key issues in respect of safeguarding practice and the experiences of children and families; the quality of the data/narrative provided has however impeded on the ability of the group to exercise the line of sight required in respect of front line practice and often the information provided raises more questions than it can answer.

In respect of the Multi Agency Safeguarding Hub (MASH), and line of sight to practice at the ‘front door’, it was reported that MASH operational group was re-establishing a programme of multi-agency auditing which would be reported to the MASH/Integrated Front Door strategic group. A pragmatic decision was made that these reports should be shared with PQAD for line of sight, however, governance and responsibility for celebrating good practice and addressing any issues/deficits would be the responsibility of MASH/Integrated Front Door strategic group. It is understood an audit of children were there had been repeat referrals in last 6 months took place in March 2024. For this audit, partner agencies evaluated Children’s Social Care (CSC) records. Learning was identified both in terms of MASH processes, CSC practice and partnership working. At the year end, the audit had yet to be formally reported to the MASH/Integrated Front Door strategic group. The gaps in some partner agency involvement in the audit process was noted and it was reported they were being addressed by the chair of MASH operational group; PQAD recommended that to support multi-agency working/practice, all agency records should be audited as part of the front door audits rather than just CSC.

Through either single agency, thematic reports or performance data, the following improvements were noted:

- A decrease in the number of referrals made to Children’s Social Care
- A decrease in the number of child and family assessments
- A decrease in the number of s47 enquiries
- A decline in the number of cared for children

*Police provided verbal assurance in March 24 that there is no longer a backlog of Vulnerable Person’s Referral Forms (VPRFS) as identified during PEEL inspection and that the 24 hour performance standard is being consistently met.*

Through either single agency, thematic reports or performance data, the following issues were noted:

- High number of strategy meetings with no further action as an outcome and a low Section 47 enquiry to Initial Child Protection Conference conversion rate.
- Low numbers of privately fostered children and lack of assurance about the timeliness of service provided to this group of children.
- Ongoing issue in respect of understanding whether invitation or attendance is the key issue in respect of multi-agency presence in statutory meetings, plus gaps in the distribution of child and family assessments, children’s plans, and the minutes of some statutory meetings e.g. child in need meetings.
- Discrepancies between Police and CSC data in respect of children who are ‘missing’.

### Voice of practitioners

Positively, a session was held with a group of multi-agency practitioners to explore the key findings from the neglect audit in respect of inter-agency working. Through engaging with front line practitioners, PQAD was able to identify multi-agency workforce development needs in respect of:

- Child focused meetings

- Planning and review
- Courageous conversations
- Chairing skills

### Voice of children and families

Obtaining and using the experiences of children and families is a recognised gap in respect of PQAD’s work plan. Securing parental feedback has been included in the revised audit methodology which commenced in 2024-25.

Securing the voice of children and families is a component of the PQAD workplan and it is considered the activity should be determined as part of the wider SSCP approach to capturing and using the voice of children and families in its work.

As a safeguarding partnership, we are committed to seeking and incorporating feedback from children and families, this is something we are actively trying to improve.

Sefton SCP undertook a children’s survey during January/February 2024 themed on Harm outside the Home. 22 schools took part in the survey (14 primary and 8 secondary) and 435 surveys were completed. The survey contained 8 questions asking children and young people where they do and don’t feel safe in their communities. The most common place where children do not feel safe is local parks where children feel anxious around strangers, fear of being kidnapped and fear of teenage gangs. Children also expressed a fear on the streets during darkness. Children were also asked about whether they feel safe online and 64% stated they do feel safe with an awareness of privacy settings and blocking strangers when they become concerned. 72% of children stated they know where to get help if needed. The survey findings were used by Sefton Communities to support a successful bid for funds from the Merseyside Violence Reduction Partnership to undertake open access outreach work in Sefton north.



### **Matters escalated by Sefton SCP Performance, Quality Assurance & Data (PQAD) Subgroup to 3 Key Safeguarding Leads (KSLs)**

Examples of matters that were formally reported to 3 KSLs by PQAD Chairperson include:

1. In support of the need to embed behaviours that promote a child focused approach and collaborative working, a recommendation was made to review the effectiveness of their response to one of scrutineer's recommendation made in October 22, following an evaluation of Sefton SCP partnership arrangements (Recommendation made in October 22 was to: Deliver a programme of activities over a sustained period to develop the culture of partnership working at an operational and strategic level. Areas to address include common purpose, individual responsibilities, behavior's, accountabilities and celebrating successes.)
2. The need to reduce drift/delay in completion of activity agreed under the auspices of PQAD as well as improve the quality of individual agency submissions to the Sefton SCP dataset to enable PQAD to have the required line of sight on multi-agency practice.
3. Collecting and scrutinising data about agency attendance at statutory meetings.
4. Clarity about the evidence-based assessment tool to be used in cases of neglect and its implementation on a multi-agency basis.
5. The status and profile of Sefton SCP multi-agency working agreement which can be found at [Sefton Safeguarding Children Partnership - \(seftonscp.org.uk\)](https://seftonscp.org.uk). This agreement sets out the role and responsibility of partner agencies at an operational level.



## Sefton SCP Communications 2023–24



**Sefton SCP SWAY  
Briefings**

**4**

SWAY briefings  
published themed  
on Harmful Practice



**Sefton SCP SWAY  
Briefings**

**810**

@seftonscp followers  
on X (formerly twitter)



**Sefton SCP website  
[www.seftonscp.org.uk](http://www.seftonscp.org.uk)**

**94,506**

views were received on  
the Sefton SCP website.  
Most viewed pages:  
Managing Allegations  
SWAY Briefings



**Sefton SCP  
Briefings**

**8**

briefings  
published/updated



**Sefton SCP  
Newsletter**

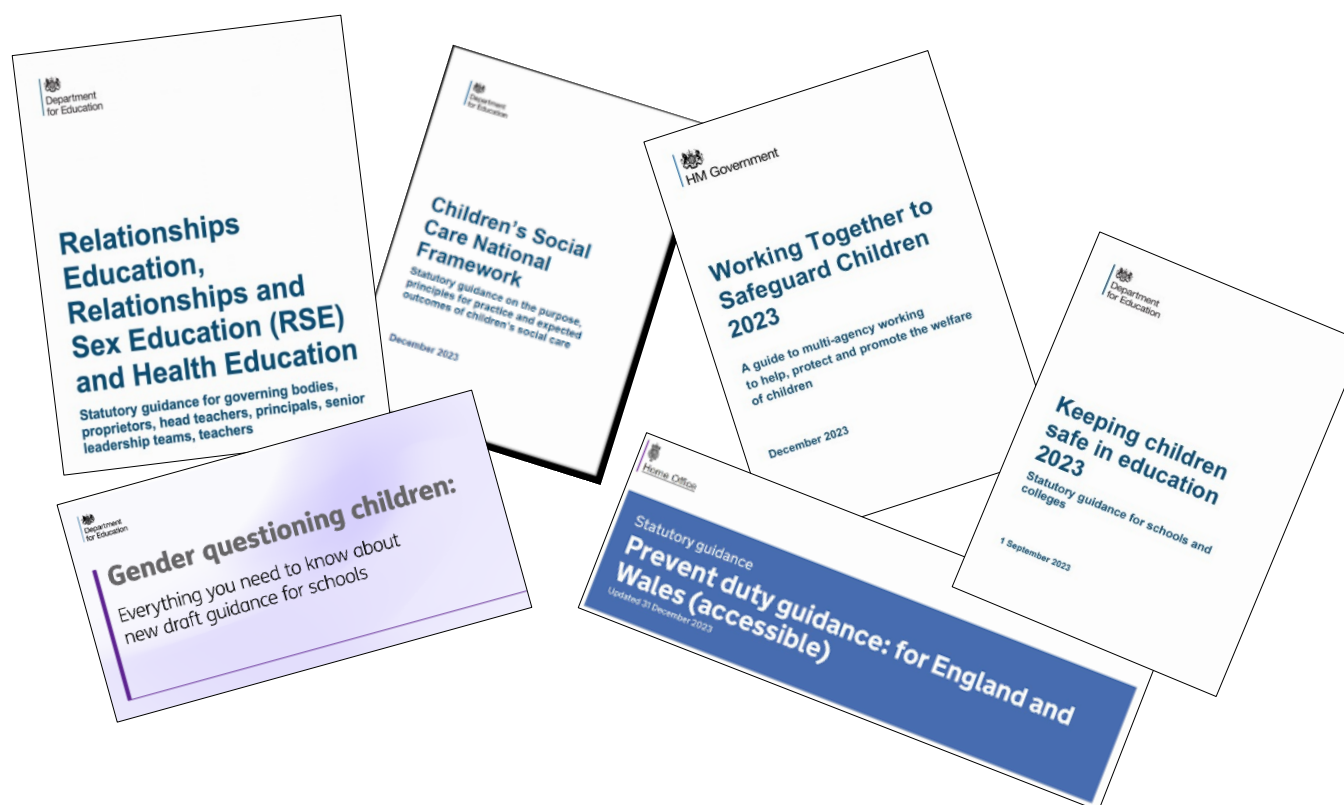
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# Sefton SCP Communications

Legislative/Guidance shared across the children's workforce in Sefton 2023-24:

- Working Together to Safeguard Children (2023)
- Keeping Children Safe in Education (2023)
- Children's Social Care National Framework (2023)
- Prevent Duty Guidance (2023)
- Relationships Education, Relationships and Sex Education (RSE) and Health Education (2023)
- Gender questioning children



# The Effectiveness of our Safeguarding Arrangements – Perspective from Sefton SCP Independent Scrutineer

During the period covered by this yearly report, revised statutory guidance: 'Working Together 2023' was published in December 2023. That guidance details the requirements for the content of yearly reports and sets expectations about the future requirements of the leadership provided by statutory partners through local safeguarding partnership arrangements. On the basis that the revised guidance was introduced in December 2023, National Safeguarding Partner Facilitator advice is that it is recognised that the yearly report for 23-24 may need to be considered as an intermediary report in respect of meeting the requirements of revised statutory guidance. It is in this context that I provide my independent scrutineer reflections albeit despite the revision to statutory guidance, the core requirements of safeguarding partners yearly reports remain unchanged.

I took up the role of Independent Scrutineer in early 2022 and in the period covered by this report and following my report to the Improvement Board in April 2023, there has been a change in the way statutory partners utilise independent scrutiny. One of the changes made was to invite the independent scrutineer to join the membership of the 3KSL meeting which creates the opportunity to offer support and challenge to the leadership provided by the delegated safeguarding partners. For some of the reporting period, I undertook the co-chair or chair role of the performance, quality and data subgroup and I have provided at page 19, a summary of the issues identified under my tenure including matters escalated to the 3KSLs. One of the matters escalated is the limitations with the quality of the data/narrative provided which has impeded the ability of the group to exercise the line of sight required in respect of front-line practice. That said, the group has made progress in the reporting period and has an agreed workplan.

I undertook two discrete pieces of scrutiny activity which both reported in September 2023. One of which was a review of the cases that had been referred to the practice review group which found significant learning in respect of the identification and timely learning in respect of serious child safeguarding cases. In response to the findings, I facilitated a workshop on the statutory requirements to identify and learn from serious child safeguarding cases.

The other piece of scrutiny undertaken was in respect of decision making and effectiveness of multi-agency contribution to strategy meetings held in Multi-Agency Safeguarding Hub. The findings included:

- Assurance of appropriate decision making to hold a strategy meeting in the majority of cases.
- Gathering information from partner agencies to inform decision making could reduce the need for a strategy meeting.
- Consistent evidence of partner agency attendance and contribution to strategy meeting; albeit it there was a gap in the contribution from schools during school holidays.
- Partner agencies should individually and collectively analyse the meaning/ impact of information shared in strategy meetings and articulate the evidence base for statutory thresholds being met.
- The contribution of partner agencies to assessments and delivery of support should be clearly defined in strategy meetings.

Both pieces of work also provided a line of sight to the experiences of children who are at risk of or have been sexually abused and identified that child sexual abuse should be an area of focus for safeguarding partners to deliver a child focused safeguarding response.



I met with Lead Safeguarding Partners on two occasions during the period covered by this report and in response to the requirements of Working Together 2023, arrangements for Lead Partners to come together on a Sefton and Pan-Merseyside footprint have been further developed in 2024. Further, I have continued to attend the Children’s Services Improvement Board and have met with the Government appointed Commissioner.

This report outlines activity that has been undertaken under the auspices of Sefton SCP and in respect of statutory functions and locally agreed priorities. A significant amount of work supported by external consultancy, was undertaken in evaluating and subsequently re-designing the multi-agency front door, and is an achievement to be celebrated, in terms of both, collaborative working and driving the strategic ambition to provide early help and support to children and families. Furthermore, delegated partners collaborated with a range of partners to produce a high-level one-year delivery plan to support the implementation of SSCP strategic priorities 24-27. Reporting against its implementation in this yearly report would promote greater accountability including detailing what elements of the delivery plan have been achieved and the areas where there has been little or no evidence of progress at the point of publication of this report.

Like many safeguarding partnerships, future yearly reports should have a stronger focus on describing the actions taken to embed learning from serious child safeguarding cases and evaluation of its impact upon practice. A reliable indicator of the effectiveness of Sefton’s multi-agency safeguarding partnership arrangements will be when its yearly report shifts from listing activity undertaken, and instead, describes how safe children are in Sefton, the evidence base for that judgement and critically how their safety has increased because of the leadership provided through the safeguarding arrangements. Statutory partners should also report on how they have responded to the findings of independent scrutiny, including inspection.

**Liz Murphy**

Sefton SCP Independent Scrutineer



# What requires more focus to improve the effectiveness of our arrangements?

## The voice of children and families

Is an area of activity that requires strengthening to become an essential ingredient within all areas of our work at both an operational and strategic level. We aim to seek and utilise feedback from children and families to inform our strategic planning and delivery. This means that children and young people will be consulted and influence the development and implementation of our work. We would aim to have accessible and understandable descriptions of the work of the SCP to achieve equality and inclusivity.

## Measuring sustainability of improved practice

Whilst there is a significant amount of work undertaken by the partnership, it is recognised that we need to be stronger in our approach to closing the loop by scheduling in a review of work completed. This is in reference to learning from audit and learning from case reviews where findings from these activities are systemic in nature.

## Evidencing impact

Concerted efforts are required to consistently seek the answer to “what difference has this made?”. This question will be added to all quality assurance activity including training and development.

## Practitioner Feedback

As part of the Leadership and Culture priority for the Sefton SCP a key development for the next year is to strengthen the links between the SCCP and front line practitioners in order to achieve this, a model of engagement will be adopted and implemented.





## Closing Summary

The Partnership's Three-Year Strategic Plan extends into 2027. Whilst the overarching priorities will not change, some key actions have been added to the plan based on learning from this period. They include:

- Signing off the Multi Agency Safeguarding Arrangements in December 2024.
- Strengthening governance and communication with other relevant boards and partnerships to develop a culture of learning and strategic collaboration.
- Support transitional arrangements for those children and young people who approach a new phase of their lives and require appropriate services and resources to do this safely and effectively.
- Evaluating the impact of the progress made for the next annual report.
- Support our children and families to be the best that they can be. Give them the right service at the right time. Help and protect them in a proportionate way.
- Develop the role of the Lead Practitioner across the Partnership for Child in Need Cases
- Increase opportunities for the Sefton SCP to work collaboratively with Children and Families
- Strengthen connections between the SCCP and frontline practice by facilitating more engagement opportunities with practitioners across the Partnership.

**Author: Tracey Overs**  
Sefton SCP Manager



# APPENDIX 1

## Managing Allegations – Local Authority Designated Officer (LADO) Overview

A total of 313 referrals were received from 1st April 2023 to 31st March 2024, this is a decrease of just under 4% on the previous year. Looking at the quarterly referral rates, each quarter showed an increase in referrals on the previous year until Q4 where there was a significant reduction on the previous year by 46%.

Of those referrals 48 were closed as contacts and 265 were given further consideration. The data below relates to those referrals which were given further consideration.

	2020-21	2021-22	2022-23	2023-24
<b>Referrals</b>	118	203	271	265
<b>Contacts</b>	44	27	54	48
<b>Total Activity</b>	162	230	325	313

Referring Agency	Percentage of Referrals
Education	38%
Social Care	17%
Residential	13%
Other	32%

Employment Sector	Percentage of Referrals
Education	42%
Residential	21%
Early Years	9%

Category of Allegation	Percentage of Allegations
Physical	45%
Neglect	17%
Emotional	10%
Sexual	6.5%
Other	21%
Total	

## Outcome of Cases Concluded During 2023-24:

This data includes cases referred in previous years which were concluded in 2023-24. This may be because the referral came towards the end of the previous year, or for those cases taking 12 months or more to conclude, due to ongoing criminal investigations and court cases. All cases which took over 12 months to conclude were subject to criminal proceedings.

Outcome of Cases	Percentage of Allegations
Threshold Not Met	22%
Substantiated	21%
Unsubstantiated	24%
Unfounded	24%
Malicious	3%
False (this outcome is only used in education settings)	5%

## Timescale for Conclusion:

It is the role of the LADO to ensure that the allegations management process is concluded without undue delay. 90% of allegations were dealt with in less than three months. This continues the significant improvement shown last year on previous years. This is positive to see as there have been several cases going through police investigation and the criminal justice process which conclude 12 months or more from the initial referral to LADO.

Timescale	2020-21	2021-22	2022-23 cases only	2023-24
Less than one month	62%	58%	84%	76%
Less than three months	11%	26%	8%	14%
Less than 12 months	19%	16%	8%	9%
More than 12 months	8%	0.5%	0.4%	0.8%

## Ofsted

The LADO met with Ofsted inspectors on 15th and 16th November; this was the second time that Ofsted had met with the LADO as part of their monitoring visits to the Local Authority. On this occasion Ofsted randomly selected a number of cases from the LADO tracker. Ofsted gave positive feedback in relation to the recording system enabling the LADO to monitor and track the progress of allegations. Initial strategy meetings under the allegation management process were deemed to be timely and well attended, effectively identifying risk and appropriate actions. Ofsted stated that: *“The safeguarding of children is a core priority for the designated officer and strategic regional collaborations are strengthening the response in Sefton.”*

## Managing Allegations Training

In 2023-24 the LADO delivered 3 online briefings on managing allegations to multi-agency staff on behalf of Sefton Safeguarding Children Partnership and three briefings to Sefton Local Authority Foster Carers as part of the Allegations and Safer Care training.

The LADO is an accredited trainer delivering the Safer Recruitment Consortium’s courses. The LADO has delivered 2 single agency Safer Recruitment in Education courses on behalf of Sefton Governor Services. These were delivered virtually over two half day sessions. The LADO also delivered a Safer Recruitment in Education course to staff at Hugh Baird College; this was delivered as two face to face half day sessions. The LADO is also a member of the National LADO Network Training Group. This group arranged the annual LADO conference which was delivered as a virtual event on 15th November 2023.

## APPENDIX 2

### Children's Social Care

This narrative covers key activity into Children's Social Care for the reporting period 23/24, where available data is compared to statistical or regional averages.

During the period a total of 16930 contacts were received by the integrated front door, an average of 1411 per month. This is an increase of 25% compared to the previous year. Similar to the year before, the rate was not consistent throughout the period with the first 6 months seeing an average of 1294 contacts per month compared to an average of 1528 for the second half of the period.

The main sources of contacts were:

- Police 40%
- Schools 14%
- Health 9%

Of these 16,930 contacts, 3,357 of them were converted into referrals into Children's Social Care, a conversion rate of 20%. This means that roughly one in every five contacts to the Front Door resulted in an intervention by Social Care. This number is significant and provides a clear illustration of one of the key features of the intervention offered to families during the period, namely that there was a significant chance of a contact resulting in a high tariff intervention. Regional conversion rates for the period are not available, but it is of note for the period 23/24 they are approx. 19% in the Northwest.

The source of referrals roughly reflected the source of contacts:

- Police 36%
- Schools 19%
- Health 11%

These figures suggest that the conversion rate for all sources of contact was roughly similar. A slightly higher proportion of referrals were sourced from schools despite having fewer proportion of contacts, the opposite is seen for referrals and contacts from police.

For the period covered by the report the average rate of referral into social care was 628 per 10k, a 20% drop compared to last year. The interventions with families at the 'social care' level with Sefton families were in line with statistical neighbours (rate 630 per 10k in 22/23).

This pattern in continued in the rate of S47 enquiries carried out during the period, a rate per 10k which decreased by 32% from 258 at the start of the period to 378 by its end. For comparison the average rate for the period across statistical neighbours was 311 per 10k.

These high rates of s47 enquiries are reflected somewhat in the high rates of Social Care assessments undertaken with families in respect of children. Over the period this figure averaged 843 assessments per 10K, a figure considerably higher (35%) than the statistical neighbour figure of 622.

A notable feature of this high rate of assessment completion is the number of them that conclude with 'No further action'. Throughout the reporting period approximately 40% of assessments concluded with No further action, supporting a hypothesis that a number of them need not have commenced, or possibly could have been shut down at an earlier stage.

This high level of assessments that did not lead to ongoing social care intervention is perhaps one explanation for the relative lack of impact the high level of activity at the 'front end' of the service had on the cohort of children subject to Child in Need and Child protection Plans.

Open Child in Need plans fell from 763 at the start of the period to its lowest figure of 672 in Sep 23. The numbers have since increased and back to a similar position seen in Apr 23 at the end of period (753). Child protection plans have dropped from 334 in Apr 23 to 278 at the end of the period. During the period categories of child protection registration were as follows:

- Emotional Harm 48%
- Neglect 39%
- Physical harm 7%
- Sexual abuse 4%
- Multiple 2%

Cared for children numbers increased from 606 in April 2023 to 625 in August 2023 (highest in the period). The numbers then fall to 581 at the end of a period, a figure that translates to 108.7 per 10,000 and a drop of 7% from August 2023. This figure exceeds the statistical neighbour rate of 89 per 10,000 by 22%.

It is clear from the data illustrated above that ongoing exploration of the key challenges within the safeguarding system to ensure that there is a proportionate and timely response to safeguarding concerns remains. In place to achieve this, there are robust actions plans to address areas of practice that raises questions or concerns that are closely monitored by the Sefton SCP and the Local Authority's Children Improvement Board.



## APPENDIX 3

### Sefton Youth Justice Service (YJS) Offences and Incidents 2023/24

YJS Statutory – Offences 2023/24	
Total number of offences	108
Total number of children	45

Offence Type	%
Breach of Bail	4.6%
Breach of Statutory Order	5.6%
Criminal Damage	1.9%
Death or Injury by Dangerous Driving	0.9%
Domestic Burglary	2.8%
Drugs	25.9%
Fraud and Forgery	2.8%
Motoring Offences	11.1%
Other	4.6%
Public Order	3.7%
Racially Aggravated	0.9%
Robbery	1.9%
Theft and Handling Stolen Goods	4.6%
Vehicle Theft / Unauthorised Taking	4.6%
Violence against the Person	24.1%

Offence by Gender	%
Male	86.7%
Female	13.3%

Offence by Age	%
13	2.2%
14	6.7%
15	17.8%
16	48.9%
17	33.3%
18	2.2%

YJS OOCB – Anti Social Behaviour (ASB) Incidents 2023/24	
Total number of incidents	14
Total number of children	14

Incident Type	%
ASB – Knives Involved	35.7%
ASB – Violent Behaviour	35.7%
ASB – Drugs Involved	14.3%
ASB – Varied	14.3%

Offence by Gender	%
Male	86.7%
Female	13.3%

Incidents by Age	%
13	14.3%
14	14.3%
15	7.1%
16	21.4%
17	35.7%
18	7.1%

### **Sefton Youth Justice Service (YJS) Offences and Incidents 2023/24**

During 2023/24 there were a total of 108 offences carried out by 45 children that resulted in involvement from Sefton YJS for specific interventions to address their offending behaviour. Most offences were for Drugs 25.9%. Of the cohort 86.7% were male and 13.3% were female. Most of the cohort were 16 and 17 year old males with 75.6%.

During 2023/24 there were a total of 14 incidents carried out by 14 children that resulted in involvement from Sefton YJS for specific interventions to address their offending behaviour. Most incidents were for anti-social behaviour with knives and violent behaviour involved 71.4%. Of the cohort 57.1% were male and 42.9% were female. Most of the cohort were 17 and 18 year old males with 62.5%.

There were 122 offences and incidents during 2023/24 committed by 45 children, most offences and incidents committed were for drugs and violence.

The latest cohort profile (July 24) highlights that drugs is the top offence followed by violence against the person. 33.8% of children were involved with Children Social Care, 29.8% of the children live in the top 10% of the most deprived areas nationally. 37.8% of children had issues with their mental health.



**SEFTON**

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