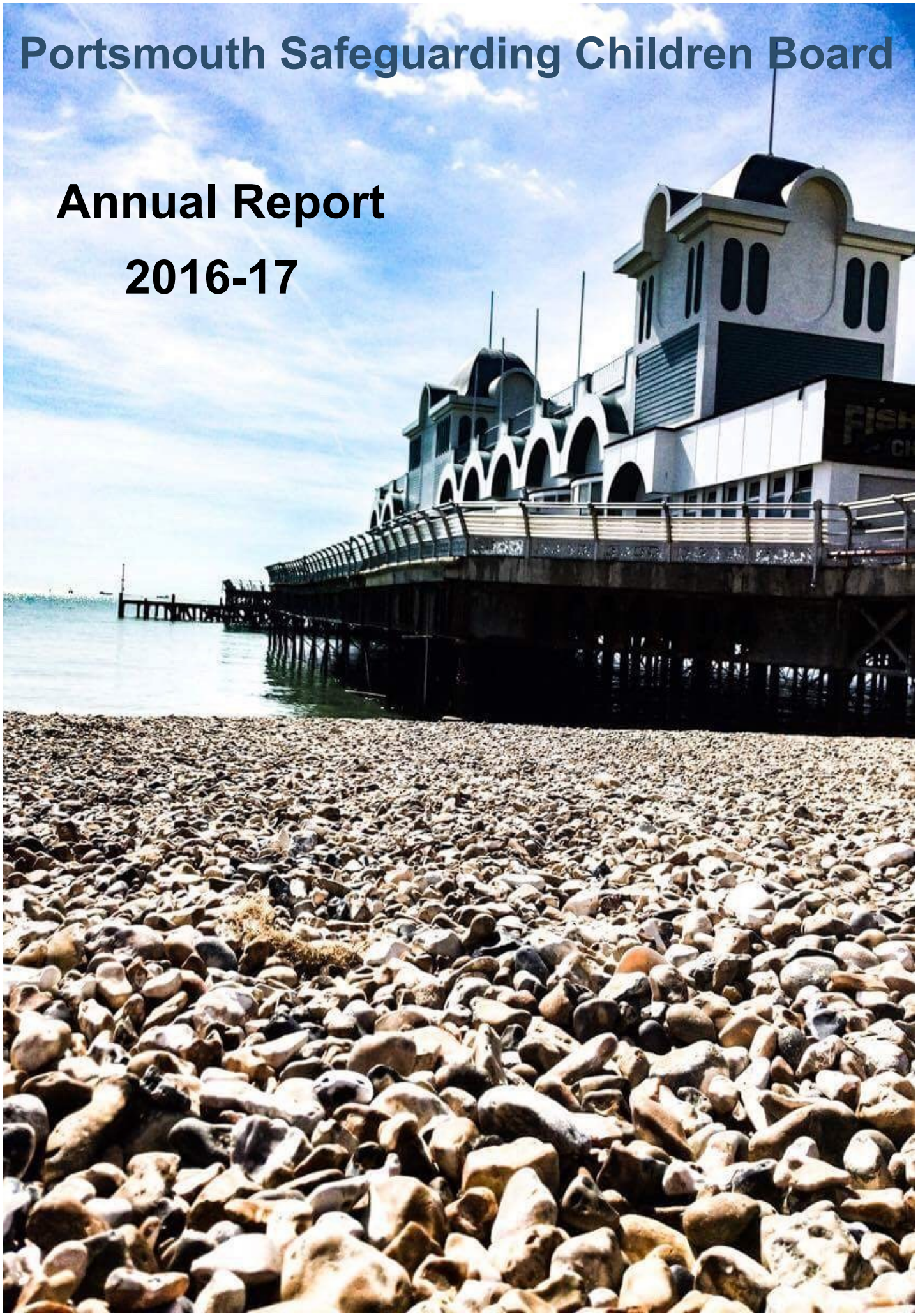
Portsmouth Safeguarding Children Board

Annual Report 2016-17



Foreword by the Chair, Reg Hooke

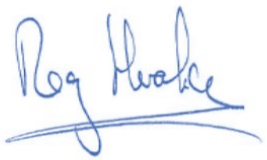
This is the fourth annual report of the Portsmouth Safeguarding Children Board (PSCB) that I have presented. I will be standing down as Chair during 2017/18 and so it is also my last. In the time I have been Chair I have been impressed by the energy and skill of people across many agencies whose work affects the lives of children and young people and their commitment to work together to safeguard them. I believe we have been able to extend the impact the PSCB has for the most vulnerable and to prepare and respond to other emerging challenges in spite of reducing budgets across the public sector. Our work to sharpen the impact that multi-agency working is having on those children most at risk will continue and this is the main focus of our new priorities for 2017-2019.

The PSCB is a statutory partnership that works to safeguard and promote the welfare of children in Portsmouth by working with, and scrutinising, the work of agencies with key responsibilities for keeping children safe in the city. These include staff working in health, social care, police, probation and education settings as well as voluntary sector organisations. This statutory arrangement has existed for over 10 years as set out in the Children Act 2004. New legislation in the Children and Social Care Act 2017 now permits local areas to vary these arrangements and so there may be some organisational changes to the independent scrutiny of child safeguarding over the next year or so but the clear responsibility to build effective partnerships and to have independent scrutiny of those arrangements remains a legal requirement.

This report summarises the year's work and highlights specific risks and priorities. Quality training has been delivered to many schools and to all school safeguarding leads. Our routine audit of a wide range of city organisations in the public and voluntary sectors has provided the basis for constructive discussions from a platform of good shared understanding.

Challenges remain of course and current priorities are designed to improve work to protect children who go missing (including missing education), are suffering neglect in all its forms and are exposed to domestic abuse.

It has been a privilege and pleasure to have been Portsmouth Safeguarding Children Board Chair since 2013. I wish my successor and all of you success for the future but reserve my greatest wish for the success and wellbeing of the children of the city, especially those who face the greatest challenges in their lives.



Safeguarding is everybody's responsibility

This report gives an overview of the work of the Portsmouth Safeguarding Children Board (PSCB) from April 2016 to March 2017; showing what our plans were, what we achieved and what further work needs to be done to strengthen safeguarding arrangements and promote the welfare of the children of Portsmouth.

The PSCB Independent Chair is required to produce an Annual Report which evaluates the partner progress against the Business Plan and to demonstrate that the statutory requirements of the Board have been met. You can read more about the PSCB and the business unit at our website: **www.portsmouthscb.org.uk/.**

PSCB
Portsmouth Safeguarding Children Board
Protecting Portsmouth's Children

Portsmouth Safeguarding Children Board
Annual Report 2016-17

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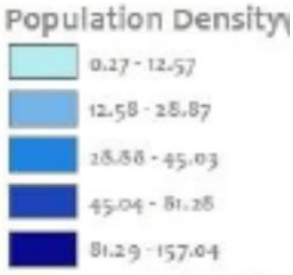
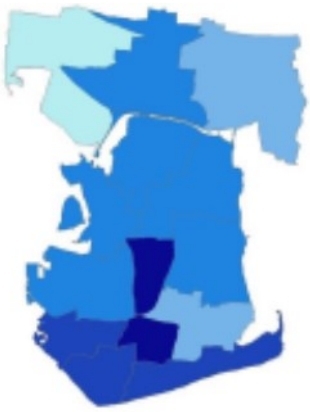
Section One

The City of Portsmouth



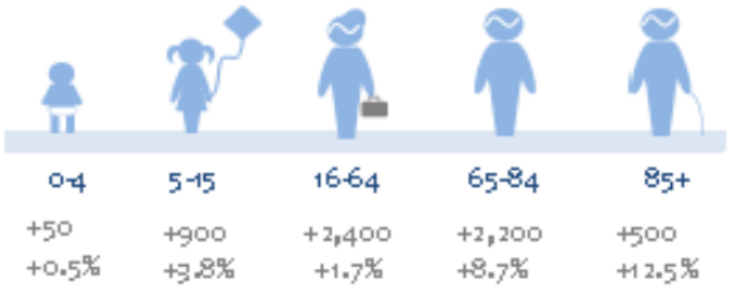


Portsmouth is a port city situated on the southern coast of Hampshire. The city area spans just 15.5 square miles, with a population of approximately 208,400[1] it is recognised as being the most densely populated area in the United Kingdom outside of London. The population of Portsmouth is forecast to increase to 214,600 by 2023.

The Children of Portsmouth

Approximately 48,500 children and young people under the age of 18 years live in Portsmouth. This is 20.6% of the total population in the area.

Expected Increase in Population by Age Group



There are 24,759 children on roll at schools in Portsmouth (from Reception to Year 11) of a total of 28,581 pupils living in Portsmouth[2]. Of these:

- on roll at a Portsmouth school 4,340, 17.53% are registered as being eligible for free school meals compared to the national average of 14.3%.
- 940 Portsmouth pupils, representing 3.3% of the total, have a statement or Education, Health and Care Plan. This compares to a national average of 2.8% and an average of 3% across the south east region.
- 16.4% of pupils in Portsmouth do not have English as their first language. After English, Bengali and Polish are the most common languages spoken in Portsmouth schools.

Children get off to a good start in Portsmouth with development levels at age 5 slightly above the national level. Standards in schools have shown a good rate of progress in Ofsted ratings with the vast majority of inspected schools now Good or Outstanding; however, despite recent improvements, GCSE results in Portsmouth remain below national and the city ranks low in its group of statistical neighbours. The proportion of 16-18 year olds who are NEET has significantly improved and the gap to national has reduced. Portsmouth is now in line with its statistical neighbours' average.

[1] Hampshire County Council: Small Area Population Forecast
[2] Dept. for Education Statistics: SEN and SEND 2017

The Children of Portsmouth

Children and young people from ethnic groups other than white British account for 24.7% of the total population compared to the national average of 31.4% in primary schools and 27.9% in secondary schools.

Portsmouth is one of the 20 most deprived districts/unitary authorities in England and about 23% (8,200) of children live in low income families. The city's child poverty rate (compared to the national average of 20.1%) masks significant differences at ward level, with rates ranging from 6.3% to 48.1%. Portsmouth has an employment rate of 71.9% and an average of 18.7% households that are workless, compared to an average of 77.7% and 11.6% respectively across the south east region.

Ethnicity	%
White British	76.33%
White Other	5.98%
Asian Bangladeshi	3.48%
Black African	2.51%
Any Other Ethnic Origin	1.85%

According to Portsmouth's 2017-10 Children's Trust Needs Assessment the rate of Children in Need has fallen and is lower than the average for England. However contacts into the Multi-Agency Safeguarding Hub (MASH) have increased over a three year period but are stabilising. The rate of Child Protection Plans per 10,000 has increased and is above the national and statistical neighbour averages

The rate of A&E attendances for children age 0-4 years has increased over recent years and is significantly higher than the national rate. However, emergency hospital admissions due to injury have reduced and are lower than those nationally.

There has generally been an improving trend in levels of obesity in Year 6 which are now in line with national. However approx.1 in 3 Year 6 pupils are overweight or obese. Portsmouth's infant mortality rate is similar to the England average. The overall trend is decreasing trend over time. The percentage of low birthweight babies has overall been reducing gradually, remaining in line with the national average.

Portsmouth has a relatively high proportion of Armed Forces personnel resident in the city with 2.3% of the adult population compared to the England average of 0.3%.

What our dataset tells us

Indicator	Number	Increase from 2015/16	Reduction from 2015/16
Number of Looked After Children	358	11%	
Number of children on a Child Protection Plan	242		12%
Number of children who were Children in Need (rate per 10,000)	185.8	13%	
Number of referrals to Children's Social Care	2,479	19%	
Number of children missing 3 times in 90 days	201	data from last year not available	
Number of new referrals of CSE investigated by Police	92	106%	
Number of victims of trafficking	12	data from last year not available	
Number of children linked to high risk domestic incidents	729	59%	
Number of child deaths	11	same	

There have been no reported incidents of FGM or forced marriage during 2016/17

Over the year the Board's Monitoring, Evaluation and Scrutiny Committee (MESC) review this data that is provided on a quarterly basis and provide regular reports to the Board. These reports identify parts of the system that appear to be working well and those we want to keep an eye on. The report also identifies parts of the system that the Board needs to consider what improvements activity is required as they appear to indicate possible areas of concern.

When reviewing the data for 2016-17 the Board received the following messages:

Significant positives -

- The child protection system is broadly timely and effective
- Processes and systems to keep Looked After Children safe are good
- Allegation management continues to function well and appears to be a robust system
- Stable workforce and good workforce development in place for all agencies
- Developing multi-agency dataset for children at risk of exploitation, trafficking and going missing
- Good take-up of PSCB training

Potential areas of concern -

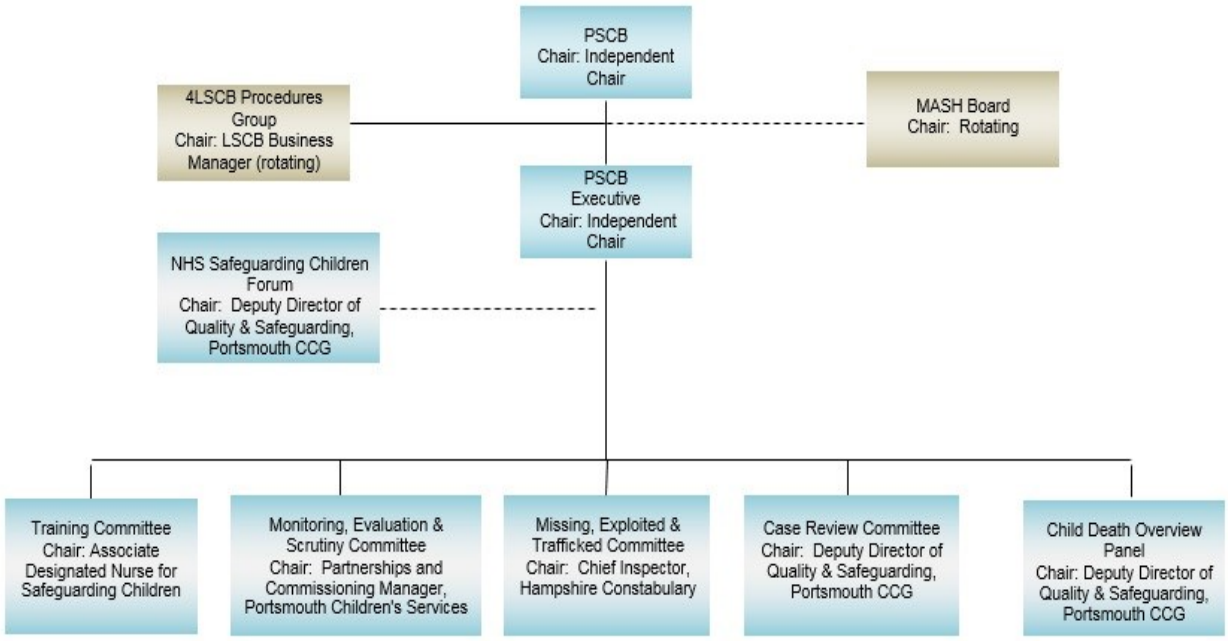
- Continued high pressure on the safeguarding system in terms of increased referral to children's social care
- Consistent use of the Early Help Assessment needs to be improved
- Child Protection Conference quoracy is a continuing issue at review conferences
- Reports into Child Protection Conferences has improved slightly and could be better still
- More in depth analysis of police data on children as victims of crime needs to take place
- Midwifery are not routinely screening women for domestic abuse concerns

The Board

Statutory Duties and Functions

The functions undertaken by the PSCB are set out in Chapter 3 of Working Together to Safeguard Children issued in March 2015. Regulation 5 of the LSCB Regulations 2006 sets out in detail the functions of an LSCB, the core objectives are set out as:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
- to ensure the effectiveness of what is done by each such person or body for that purpose.



What is the Portsmouth Safeguarding Children Board?

The Board is made up of representatives from local statutory and voluntary sector agencies that work with children and their parents or carers and three long-standing Lay Members. The Board is led by an Independent Chair whose role is to hold agencies to account.

It is the responsibility of the Local Authority Chief Executive to appoint the Independent Chairperson (with the agreement of a panel including PSCB partners) and to hold the Chairperson to account for the effective working of the PSCB. In order to provide effective scrutiny the PSCB should not be subordinate to, nor subsumed within, other local structures.

The Board agrees a Business Plan each year which ensures its functions are fully carried out and improvements can be progressed which arise from local and national learning. The main Board meets 4 times during the year with an additional development day in March to review the progress of the Business Plan over the previous year, and to agree the priorities for the forthcoming year. The Board's structure and membership and terms of reference for the committees were reviewed in March 2017.

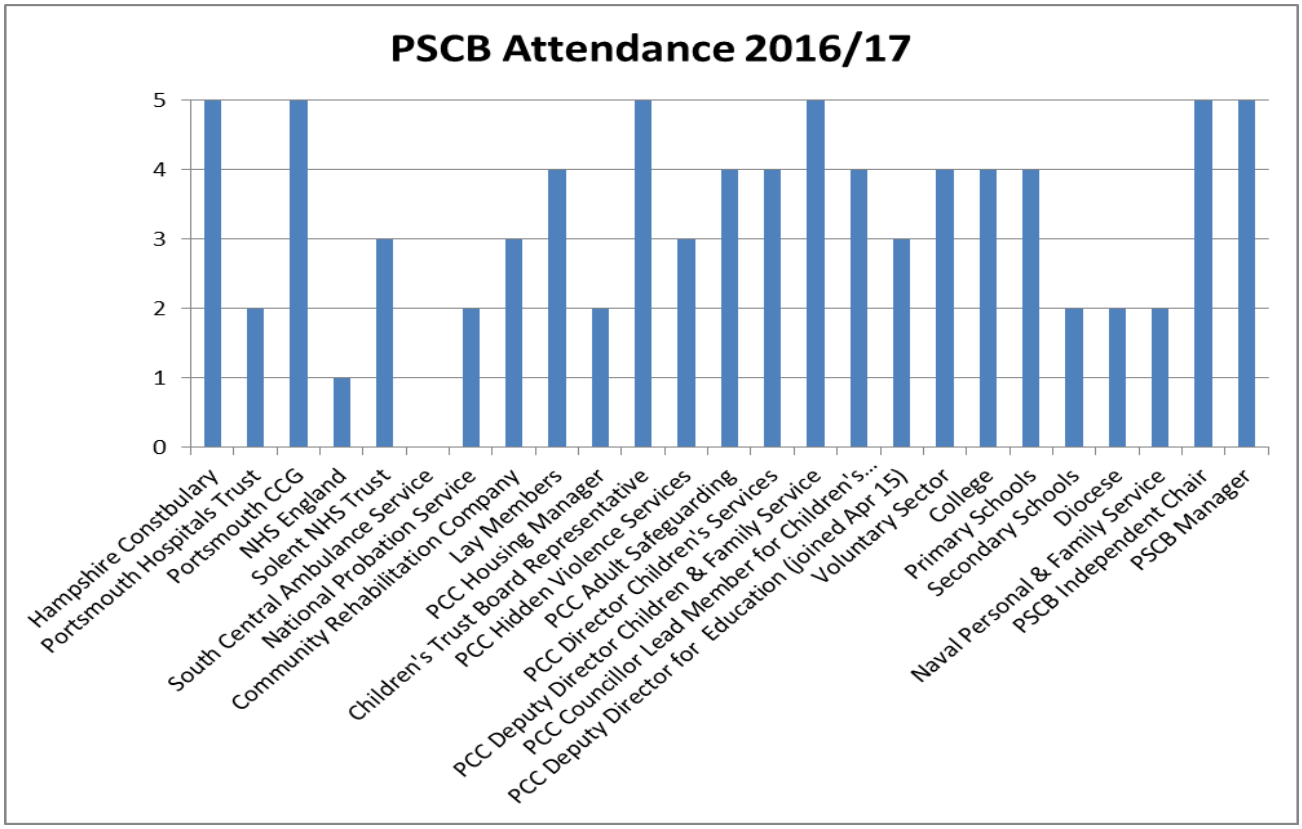
A significant amount of the PSCB's work is undertaken by the Executive Group and Committees. These help to progress many of the detailed actions in the PSCB Business Plan

The Executive Group and the Committees are accountable to the Board and this is reflected in the terms of reference of each group. The Committee's Chairs are all Executive Committee members and report routinely at the main Board

The Board

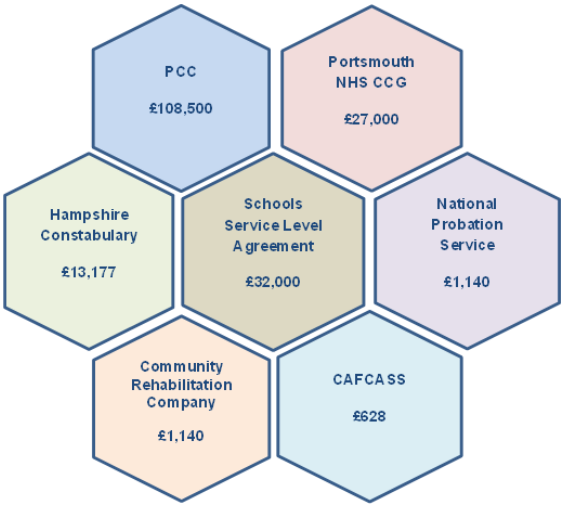
Membership and Attendance

A list of the statutory and non-statutory Board members as at 31 March 2017 and their attendance is shown below. We are confident the Board is represented by the right local statutory and voluntary agencies who are engaged appropriately in the Committees.

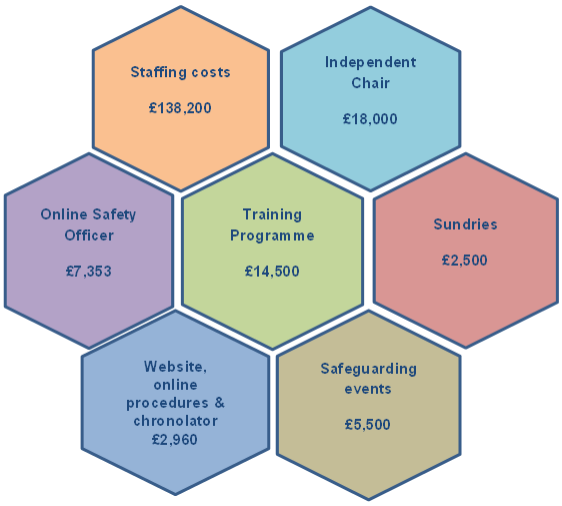


Financial Arrangements

Income



Expenditure



The Business Plan

Priorities for 2016-17 and how we delivered against them

Neglect - *Improve the effectiveness of agencies and the community in addressing neglect*

During this year the PSCB Business Unit worked with members of partner agencies to update the Thresholds Document for Portsmouth. An 'Indicators of Need' section was introduced to enable front-line practitioners to clearly identify the signs of abuse across the domains of the My World Triangle and to demonstrate an appropriate response in line with the tiers of need. An essential element of this was to support those working with children to understand what the impact of neglect might look like and when additional support and/or a statutory response would be required.

The Multi Agency Safeguarding Hub (MASH) has reported that since the introduction of the revised Thresholds Document the outcomes of contacts highlights an increase in the number which result in being referred to the Children and Families Service for a statutory assessment by children's social care and a reduction in tasks remaining for the Universal Services.

In the Board's ongoing Safeguarding Training Programme neglect and it's effect on children is covered in all courses offered to practitioners and managers. The Neglect Identification and Measurement Tool (NIMT) and Neglect Practice Guidance is regularly referred to. The Board is working with the Local Authority's Learning and Development Team to co-commission a bespoke course to look specifically at neglect, to ensure training messages around the issue of neglect and practice are consistent across the workforce.

In September 2016 the Deputy Director Children's Services, Children & Family Services submitted a report to the Board reviewing the effectiveness of work undertaken to address neglect since April 2014. This report referred to the development of the Neglect Identification and Measurement Tool (NIMT) and accompanying practice guidance in 2014-15. The report noted that the number of children on a Child Protection Plan under the category of neglect had remained unchanged and that this raised questions about the impact of the guidance, particularly in terms of early help support.

In response to this report the Board commissioned the **Monitoring, Evaluation & Scrutiny Committee (MESC)** to undertake a re-run of the audit undertaken in 2014 and a survey of front-line practitioners to understand what, if any, impact the work completed thus far has had. The findings of this audit were that there was some level of awareness of the NIMT across the workforce as it had been used in half of the cases audited; in 5 of the 6 cases there was clear evidence of good communication and multi-agency working , which assisted in completing assessments and plans for the families. The use of the Early Help Assessment and Team Around the Child (TAC) meetings meant that cases appeared to be appropriately stepped up to children's social care and down. From the plans reviewed it was evident that they were more effective when they were developed **with** the parent, and when there was a professional that the parent had a good working relationship with.

The survey found that there is still work to do to improve the workforce's awareness of the NIMT and Neglect Practice Guidance. However, before this is done the NIMT should be reviewed to see if it can be shortened to make it more user friendly whilst still as robust, and that it covers all relevant issues including healthy weight.

Priorities for 2016-17 and how we delivered against them

The Board committed to keeping this priority for the next two years and the following work would be undertaken:

- A series of briefings would be delivered to the multi-agency workforce in June 2017 highlighting key messages and learning from Serious Case Reviews conducted across the country in the last 3 years that considered children who have died or been seriously harmed as a result of neglect.
- A multi-agency task and finish group of service and team leaders will be established to review and revise both the NIMT and the neglect practice guidance, taking into account the findings of both the audit and the workforce survey.
- Portsmouth's Children Safeguarding Week 13th-17th November 2017 would be dedicated to neglect. During this week the following activities will be happening:
    - partner agencies will be asked to hold awareness raising events with their workforce to consider how they identify and respond to children affected by neglect; and how they work with families to prevent neglect and to improve parenting where it has been identified that neglect is present;
    - three multi-agency briefing sessions will be held to raise awareness of and to disseminate the revised NIMT and Practice Guidance across the children's workforce;
    - A day's masterclass for those working with children and families to consider the role of the newly formed Early Help and Prevention Service in supporting families where neglect has been identified as an emerging issue; strategies for effectively working with resistant families and identifying and addressing disguised compliance; and the impact of diet and obesity on the welfare of children;

Communication and Participation Strategy - *Improve the effectiveness of safeguarding, including the work of the Board, amongst practitioners and the community, with a particular focus on at risk communities. Ensuring that the voice of children influences learning and best practice*

The PSCB Coordinator has ensured that the Board's website is regularly updated and new sections are added to make the website more informative and easy to use. The impact of this is demonstrated when looking at the number of visitors to the page; there has been over a 100% increase in the number of visitors to the page in just 5 months - from 736 in August 2016 to 1,556 in January 2017.

The PSCB Online Safety Officer also produces a termly newsletter, primarily aimed at schools, to provide useful information, links to helpful resources and to highlight new and emerging threats to the safety of children online.

The Board's multi-agency procedures are jointly commissioned with Hampshire, Isle of Wight and Southampton in a 4LSCB arrangement. During this year the four Business Managers worked with the website provider (Tri-x) to review and revise all of the procedures and safeguarding practice guidance. They have all been updated to ensure they are fully complaint with Working Together 2015 and that they better reflect current practice across the four areas. Tri-x has re-configured the platform to make it easier for practitioners accessing it to navigate. This includes the landing page asking the user to click on the relevant LSCB area according to the home address of the child and family they are working with. Where there are local differences in practice and services provided this is indicated in the new 'local information' section of each page.

The 4LSCB Business Managers will be completing a survey of practitioners during autumn 2017 to review the impact these changes have, had and to consider what further improvements need to be made. The 4LSCB group are also looking at ways to increase awareness of the procedures, when they should be referred to and how to access them. The first idea to be implemented will be developing a Procedures Newsletter every 2 months highlighting a key or new procedure.

Priorities for 2016-17 and how we delivered against them

The PSCB Business Team held the annual Portsmouth Children's Safeguarding week 14th-18th November. During this week briefing sessions were held across the city with the children's workforce to introduce the new Thresholds Document and case studies were used explain how and when to use the Indicators of Need. These sessions also provided an opportunity to explore when it is appropriate to complete an Early Help Assessment or when a contact into the MASH is required to consider a statutory response. Articles were written for both Flagship (the council's newsletter that is delivered to all households in Portsmouth) and Term Time (the council's newsletter that is distributed to all parents of children attending schools in Portsmouth) highlighting when and how to contact the MASH if they are concerned about the safety and well-being of a child.

In order to gain children's views on the Board's priorities, how they felt service's should implement them and their concerns for their safety and well-being, the Business Manager attended Children in Care Council; the Council of Portsmouth Schools primary and secondary forums; and wrote to all of the children who attended PSCB Development day in March 2016 to see if the actions agreed are in line with their concerns raised.

Tackling exploitation and abuse across young people in Portsmouth, including CSE - *to ensure robust partnership arrangements are in place to prevent and manage the risk of harm to young people, including Child Sexual Exploitation, Missing and Trafficked Children.*

During 2016-17 the PSCB Missing Exploited and Trafficked Committee worked to implement the MET Strategy developed in 2015-16. A scorecard of indicators relating to agencies work with missing, exploited and trafficked children has been developed throughout the year to monitor the impact of this strategy. The challenge for the Committee has been to understand what the data is telling us. The Committee will be working with Portsmouth's Operational MET Group during 2017-18 to provide some narrative analysis to better understand the trends underlying the figures.

The PSCB worked with Hampshire Constabulary, Barnardos and Children's Social Care to deliver Operation Make-Safe during September 2016. To support this event Hampshire Constabulary produced a short video based on a real-life scenario where a teenage girl was being groomed in a local hotel, and a member of the public who witnessed this had concerns and intervened to safeguard the girl. 250 taxi drivers, hoteliers, street pastors and others requiring licences attended these events. The campaign included a series of briefings about signs to look out for and what to do to keep children safe. During this week and again for a 4 week period between February and March 2017, key awareness messages about CSE were shown on the big screen in Portsmouth Guildhall Square to raise awareness with the public.

This campaign was followed up by a number of multi-agency community based events to raise awareness of CSE with the general public; to engage with potentially vulnerable children and to ensure they receive appropriate support; and to deliver the Operation Make Safe presentation to local businesses in the pedestrianised shopping areas in Portsmouth. Assemblies have been held in 4 secondary schools to provide pupils with key messages about CSE, what grooming is, the potential consequences and information on how to get advice and support.

The PSCB Case Review Committee facilitated two multi-agency reflective practice meetings in October 2016 to review contrasting cases where the risk of CSE had not been identified and a girl had been assaulted, and a case where it had been identified and the girl had been successfully safeguarded. The learning from these cases has been incorporated into the PSCBs Vulnerable Children course. It was identified that colleagues in health settings who had short, time-limited interventions with children were not routinely considering whether they were at risk of CSE. As a result Portsmouth CCG worked with colleagues from primary care services, Portsmouth Hospitals Trust and Solent NHS Trust to implement the shortened CSE risk assessment tool developed by NHS Wessex and delivered 'train the trainers' sessions to key managers across health settings in Portsmouth.

The Modern Slavery Act came into force in 2015 and introduced the duty to notify suspected victims of child trafficking via a National Referral Mechanism (NRM). The Act also makes clear that there is now a duty to not only refer via the NRM if indicators exist, but also for child victims to be referred into the newly developed Independent Child Trafficking Advocacy (ICTA) Service. Hampshire (including Portsmouth, Southampton and Isle of Wight) was chosen as one of the 3 early adopter sites by the Home Office for the ICTA Service as a statutory provider of this specialist support.

Priorities for 2016-17 and how we delivered against them

Tackling bullying in schools and online - *as this is what children and young people in Portsmouth tell us is their greatest concern*

At the Board's development day in March 2016 the Board heard from 16 children from secondary schools across Portsmouth that bullying was the greatest concern affecting their health and well-being. As a result, the Board committed to raising awareness of the impact of the issue and strategies for addressing it with services across Portsmouth.

The Board's Online Safety Officer worked with Barnardo's CSE Worker who has the lead for e-safety in their organisation to deliver 3 sessions to school staff to help them develop the necessary skills and knowledge to deliver online safety messages to pupils. These included having discussions about cyber-bullying, the impact of this and how to address its occurrence. These were followed up by a further session specifically for PSHE teachers to help them develop clear and consistent messages about online safety and cyber-bullying in their school's Personal, Social and Health Education curriculum.

To help understand the scale of bullying children are experiencing, the Public Health Service agreed to add an indicator to the 2016 You Say Survey which is completed by pupils in Years 8 and 10 attending school in Portsmouth. The following headline percentages are based on any response indicating that participants were bullied at least once in the past couple of months. The results show that for both Year 8 and Year 10 pupils, a higher percentage of girls (compared to boys) responded that they were bullied in the past couple of months. 79% of girls in Year 10 experience bullying and 75% of girls in Year 8 experienced bullying.

	Year 8		Year 10	
Experience of being bullied	**Boys**	**Girls**	**Boys**	**Girls**
Experienced bullying	196 - 67.8%	280 - 75.3%	183 - 54.3%	146 - 78.5%
Did not experience bullying	93 - 32.2%	92 - 24.7 %	154 - 45.7%	40 - 24.5%
No response	85	92	105	39
Total survey participants	374	464	442	225

The Board engaged with Beat the Bullies, a local anti-bullying charity to design and deliver a briefing session for schools across Portsmouth in March 2017. This briefing linked to Portsmouth's Strategy for Improving Well Being and Resilience in Education 2017-19 and to Portsmouth's Anti-Bullying Strategy, with the aim of helping schools in developing a restorative approach to bullying to help repair the harm and prevent future incident.

The PSCB Business Unit also developed pages for the Board's website on bullying for both children and those working with children. These pages include useful information, resources and contact details for support.

PSCB Business Plan 2017-19

At the Development Day in March 2017 the Board reviewed the progress against the priorities in the 2014-17 Business Plan, and considered what the future priorities should be based on our knowledge of the child's experience. In order to agree this the Board drew upon:

- data and audit to understand what causes the most harm to children.
- Current understanding of the quality of practice and interventions
- knowledge of what services are available, how they work together and where there are any gaps

When reviewing the previous Business Plan it became clear that the majority of the actions were assigned to the Committees or the Business Unit, so the Board was only holding itself to account for progress against the priorities. It was agreed that when developing the future Business Plan the Board should be considering each agency's role within the plan, that it should be seen as a multi-agency safeguarding plan for Portsmouth. In order to do this the Board and its partner agencies need to consider what are the interventions that will make the biggest difference and then monitor their implementation.

The Board agreed that for each of the future priority areas the activity should be considered under each of the following five principles:

a) What we will do, how we will do it and by when to provide **scrutiny & oversight** including through the S11 Compact Safeguarding & Early Help Audit; dataset; multi-agency audit and oversight of relevant single agency audit findings; SCRs and learning from reflective practice meetings etc.

b) What we will do, how we will do it and by when to **understand & identify** children affected by each of the issues

c) What we will do, how we will do it and by when to **prevent** future harm

d) What we will do, how we will do it and by when to **intervene & support** - both the parents to improve the family functioning and the child to address the harm already caused

e) What we will do, how we will do it and by when to **learn & improve** - The Board will support agencies with providing a multi-agency safeguarding programme that supports practice in these areas and strengthen the learning cycle to ensure the work is responsive to emerging issues and improving ways of working.

The Board agreed the following 3 priority areas that they considered are potentially causing children the most harm and having the biggest impact on their well-being:

1. **Children experiencing neglect**
2. **Children at risk of exploitation, going missing (including children missing education) &/or being trafficked**
3. **Children affected by domestic abuse**

Additionally it was agreed that it is important that the work of the Board is effectively communicated across our target audiences so that they feel informed about work we do to improve safeguarding in Portsmouth. So this **fourth priority** area was agreed as **Participation and Engagement**.

PSCB Safeguarding Training

Over 2016-17, PSCB offered more diversity in its training delivery to ensure that key safeguarding messages and emerging lessons from Board activity are disseminated quickly and effectively across the partnership. As such, the training programme consisted of both core courses (Basic Awareness Safeguarding Children, Early Help Module, Child Protection Module, Working with Vulnerable Children (CSE, Missing and Trafficked) Module, Supervision Module, Manager's Module and DSL Refresher Module), a series of lunchtime briefing sessions covering a range of topics including early help; restorative approaches to child protection conferences; and bullying in schools

During 2016-17 2,729 delegates have attended PSCB courses:

2217 spaces were filled on the **multi-agency and eLearning modules**

512 delegates were taught in **single agency settings**

The attendance figure shows an overall 28% increase from the previous year and reflects continued good attendance at core courses and also significant multi-agency take up of the new lunchtime briefing sessions. Attendance rates for all courses continue to be high, at over 95 percent. This reflects a high quality training administration system that includes a robust booking process and close monitoring of agency attendance.

As part of Hampshire Constabulary's Operation Make Safe campaign, PSCB offered sessions to over 250 people (including taxi drivers, security staff, hotel staff and sports groups) on Child Sexual Exploitation. Evaluation showed improvements in understanding of signs of CSE and knowing what to do about it.

Post evaluation processes continue to show that delegates increase their knowledge and confidence as a result of attendance with improvement in learning scores in terms of knowledge, skills and confidence. The evaluation processes show high satisfaction rates relating to the knowledge and skills of PSCB trainers.

Education providers remain the largest group of professionals accessing the programme followed by the Voluntary Sector and Early Years and Childcare settings. Schools have continued to sign up to the PSCB Traded Services Arrangements or use the Pay as You Use option to have their training provided by the PSCB. A charging policy was introduced in September 2016 for Early Years and Child Care Providers which has been taken up by local providers and attendance numbers from this sector have not reduced.

Despite economic and workload pressures on services, the PSCB training programme has continued to be delivered by a team of professionals from its partner agencies, supported by the PSCB Training Manager and Administrator. This has meant that PSCB has had the capacity to offer the amount of courses to meet demand with no one waiting longer than 3 months (with priority given when needed) and no cancellation of courses.

In a time of significant change to the offer of services to children and families in the city, it has also been important to draw on local and up-to-date knowledge from the multi-agency training team to design and tailor courses to meet the training needs of frontline professionals. This multi-agency approach needs to continue to ensure best use of resources and ensure the availability of enough courses delivered in an appropriate timescale to keep the knowledge and skills of the workforce up to date.

There will be some change to the PSCB courses over the coming year to ensure the content reflects the Restorative Approach adopted in Portsmouth by all services working with children and families in the city. PSCB fully supports the Children's Trust Board in promoting a restorative approach to working with children and their families that will more consistently result in 'the voice of the child' being included in all interventions and professionals will be moving away from doing things *to and for* families to doing things *with* them.

Learning from PSCB Audits

The PSCB oversees a range of audit activity to understand the effectiveness of early help and safeguarding in the city. During this year the Board's Monitoring, Evaluation and Scrutiny Committee (MESC) have introduced a quarterly programme of multi-agency themed audits. The theme for these is informed by emerging issues of concern identified either through the dataset, the Case Review Committee or by recently published reports or research that identify emerging threats. These audits are supplemented by information from single agency audits and 'deeps dives' into specific topics commissioned by the Board's other committees. During April 2016 to March 2017 the Board supported by its partner agencies completed 6 multi-agency audits, the findings of which were reported to the Board. Specific actions resulting from the recommendations in the audit reports were monitored by MESC.

Quality of Agency Reports submitted to Child Protection Conferences

The MESC Audit Team reviewed all reports submitted to half of all Initial Child Protection Conferences (ICPCs) and Review Child Protection Conferences (RCPCs) held in February 2016, which equated to a total of 101 reports submitted to 7 ICPCs and 13 RCPCs.

Findings:

√ In 63 of the 77 reports where it was felt applicable for the professional to comment, the analysis of the implications on the child's future safety, health and development was considered as either good or adequate.

√ The overall presentation of reports was rated as good or adequate in 89% of all cases.

√ Of the 10 reports from early years settings reviewed 7 were considered good, they were all noted to clearly record the child's progress and development

* The most significant weakness for all agencies was describing the child's views and wishes, only 12% of reports were graded as good in this area. The auditors considered that 36 of the 68 reports attempts to describe the child's views and wishes was inadequate

* Whereas all of the chronologies in Social Workers reports for ICPCs was scored as 'good', few of the chronologies for RCPCs were considered to be at the same standard.

* There was a low number of GP reports to the conferences, from a total of 20 conferences only six had reports from GP.

* Police reports were often considered difficult to read where they consisted of a long list of (often unrelated) offences from the Police National Computer (PNC) which would need 'interpreting' in a conference for those unfamiliar with PNC records

Recommendations:

- For the Board to consider developing guidance and examples of good practice to share with agencies to improve the quality of reports to child protection conferences
- All agencies need to explore how practitioners can identify and express the child's views and wishes better in their reports
- Work needs to be done to find a more consistent way of sharing reports with families prior to conference.
- For the Clinical Commissioning Group to monitor how many CP Conferences receive reports from GPs, to explore the barriers to GPs providing reports and provide some training to help them understand the importance of submitting a report
- To revise the format from review conference reports so that significant events are shared
- Maternity Services need to urgently provide their community midwives with training around writing of Conference reports. This should include what good looks like and the importance of sharing reports with families.
- For Hampshire Constabulary and GPs to consider how they might capture/comment of the child's views.

These recommendations have been delayed in their implementation due to Portsmouth Childrens Trust introducing a new approach to working with children and families. This Restorative Approach has significantly changed the Child Protection Conferences and as such the Board agreed to wait until the new system had been embedded before implementing the recommendations. The MESC will conduct the same audit on a smaller sample group of ICPCs during August 2017 to explore what impact the introduction of restorative child protection conferences has had on the quality of agency reports. The Board will then review whether the recommendations above are still relevant to improve practice.

Learning from PSCB Audits

Children who go Missing

The purpose of this audit was to look at the experiences of children who have gone missing to enable the PSCB to evaluate whether local agencies are accurately and reliably identifying and addressing the risks to these children.

Children's Social Care completed 11 audits using the PSCB audit tool and the Ofsted tracking tool. Barnardo's completed 7 audits using the PSCB audit tool; the police completed 4 audits using both the PSCB tool and the Ofsted tracker; and health completed 2 audits using the PSCB tool.

Findings:

- √ Good evidence of relationship building between young people and social workers in 81% of cases.
- √ Good evidence of impact with 91% of children reported to have made progress against identified outcomes
- √ Good management oversight was recorded for 81% of cases.
- √ Statutory visits were completed within timescale for 91% of young people.
- √ The referral for action was timely in all cases.
- * The chronology and genogram needed to be updated or improved in quality in every case audited
- * Key Information in only 3 of the cases audited was fully completed. Most needed to be improved often with religion and health contacts to be added
- * One social worker was reported to have worked well with the young person's family
- * The quality of supervision was not consistent

Recommendations:

- The missing toolkit to be re-distributed across the workforce
- A multi-agency missing audit to be rescheduled in 6 months to measure improvements
- Data cleansing exercise to understand what data is kept where and to ensure the relevant agencies are receiving the appropriate information
- Future thematic audits to be planned carefully, adapting audit tools with specific outcomes in mind so that they are fit for purpose
- Health and Police to develop a tool that assists them contributing relevant information to the multi-agency auditing process
- To agree regular reporting about the findings from return interviews

Survey to look at practitioner's awareness and use of the Early Help Assessment

In the dataset analysis report to the PSCB in November 2015 it was noted that the numbers of Early Help Assessments (formerly CAFs) reported to the Multi Agency Safeguarding Hub (MASH) remained low despite a recent redesign, simplification and re-launch.

A survey to establish if the workforce is aware of the Early Help Assessment and when to use it was agreed to try and understand what the problem is. There were 77 completed responses. Of those who attended PSCB training, 82% felt that they had the confidence to complete a Early Help Assessment with a family compared to 54% f those who hadn't received PSCB training.

Of the 37 people who had not attended a PSCB Early Help Assessment workshop or early help module, 11 said that they hadn't received any training at all, 10 had received training from colleagues, 6 felt training wasn't applicable as they would not expect to complete a Early Help Assessment and 10 did not answer this question.

In response to how they felt their agency supports, encourages and prioritises the Early Help Assessment process only 4 of those who answered this question said they didn't know how this was done. Most were able to identify that this was through supervision, team meetings and allowing time for them to attend training in this area.

By far the most common response to what barriers prevented a Early Help Assessment from being completed once it had been established it was needed, was parents not wanting to engage in the process which was cited 25 times. The second most common barrier was time constraints and this was mentioned 17 times. Lack of training was raised 5 times, there being no other agencies that could/would work with the family cited 3 times and the professional's role being in an acute setting and not appropriate for them to complete the Early Help Assessment with the family was noted 3 times.

The findings from this survey would correspond to what the recent Section 11 Compact Audit found. In that audit agencies self-reported a weakness in their early help processes. With 14 of the 86 agencies included not having an identified lead for completing and/or supporting Early Help Assessments and 14 agencies having not accessed training for their 'Early Help Champion'.

Recommendations:

- For the PSCB to continue to deliver the Early Help Module, which includes full training about the Early Help Assessment and related early help processes.
- For agencies to promote key professionals attendance on an Early Help Module and to make this a priority for all those professional groups engaged in early help.
- Produce some clear instructions as to what to do with completed Early Help Assessments and who to record them with and ask agencies to promote this with all professionals who may complete a Early Help Assessment. .
- Each agency to be required to report quarterly to the PSCB during 2016-17 on the number and quality of Early Help SAFs completed by their workforce. This data will be used against the early help profile to ensure that the workforce is confident and competent in this area of work.

Learning from PSCB Audits

Review of Multi-Agency Safeguarding Hub (MASH) Process/Thresholds

This audit was completed 9 months after the introduction of the Multi Agency Safeguarding Hub (MASH) in Portsmouth. The purpose was to seek assurance that systems and processes were working effectively and in particular to ensure there was evidence that the MASH were checking consent, applying thresholds and evidencing decision making that is proportionate.

In order to do so random sample of 21 MASH Case Analysis Forms between 01.06.16 and 30.06.16 were reviewed by both health and children's social care leads

Findings

- √ MASH decisions were clearly evidenced and well recorded
- √ Information shared by each agency was appropriate and contributed effectively to proportionate decision making
- √ There was evidence of good multi-agency working.
- √ All of the cases reviewed had relevant consent documented.
- √ All of the cases reviewed had consistent application of thresholds and evidenced decision making that was proportionate.
- √ The MASH process was straight forward, logical and easy to follow.
- * The letter sent to referrers from the MASH was inadequate and confusing.
- * 19 of the 21 forms reviewed had clear evidence of MASH processes. There were two that indicated they needed to go through MASH but for some reason did not. These have been followed up separately to help understanding.
- * On review of the two cases it was found that in one case the information was recorded on the three siblings records that went onto be assessed. In the other case the information was recorded upon another sibling's record but not copied across - this has now been rectified.

Recommendations:

- All cases where there are challenges about threshold following a MASH outcome should be highlighted to a senior manager.
- Health colleagues to ensure the 'right' practitioner is part of the MASH, particularly with the upcoming aim to join up the MASH and MARAC processes.
- The letter sent to referrers from the MASH advising the outcome should be clear and sent out consistently.
- Staff to be reminded that records of outcomes need to be copied across all the siblings' records.

Children Living with Domestic Abuse

A multi-agency review of cases where children are living in households affected by domestic abuse. The topic was selected because Portsmouth is currently undertaking a strategic review of the domestic abuse provision it commissions; and the triennial analysis of Serious Case Reviews concluded that of the many risk factors identified in the parents' backgrounds, the most prominent was domestic abuse.

Findings:

√ In all cases audited, as soon as the concern was raised either via the Police or School, then contact was made to the MASH, who made a timely decision as to whether the child should be assessed by a Social Worker; a recommendation made for an early help assessment to be completed; or that the family could continue to be supported by universal services.

√ Good evidence of timely referrals to domestic abuse services such as Aurora New Dawn and the Early Intervention Project.

√ The Police reflected that it is not easy for them to consider previous incidents when an officer attends domestic incident in an emergency

* The audit highlighted that if families refuse an Early Help Assessment there is currently no clear pathway for following this up and ensuring other professionals are aware.

* Even in this small sample group there was a wide variety of evidence as to how professionals were involving/engaging children and families in their assessment and planning. There was evidence in half of the cases of good practice and no evidence of this in the other half of cases. What was unclear was whether there was no evidence because it hadn't happened or because it hadn't been recorded

Recommendations

- That Portsmouth CCG issues advice to GPs that any symptoms a child is demonstrating that reflect the impact of the DA occurring in their household (e.g. the child is frightened to go to bed due to domestic abuse between parents) must be noted on their record.
- The PSCB Training Committee to oversee a review of the domestic abuse training given to staff in all partner agencies to ensure that it sufficiently covers sexual abuse/rape within a relationship.
- The PSCB Training Committee to write to all partner agencies asking for them to ensure that their training on domestic abuse explains the increased risk posed when a couple separates.
- For the PSCB Training Committee to ask agencies to report on what training is given to their workforce on how to ensure the child's views, wishes and feelings are recorded and taken account of in any assessments.
- The NHS Safeguarding Forum Health to consider and report back as to how relevant information is shared with all appropriate health professionals following a MARAC
- For Hampshire Constabulary to report to PSCB Executive Committee as to how they consider the cumulative effect of a number of low risk incidents when considering the risk posed to a child when responding to a further incident
- For Children's Social Care to review a number of cases that have been stepped down form Child Protection to Child in Need, and to report back the PSCB Executive Committee on whether all risks are adequately translated in to the CiN plan
- That the Domestic Abuse Strategic Review Group considers the appropriate response to families whose need for services changes and move tier/category of need and often require a flexible level of intervention that most services find difficult to meet
- The Portsmouth Children's Trust - in their current work at reviewing the role of Lead Professionals - should ensure that individuals taking on this role have the leadership skills and competencies to ensure progress against plans is made and sustained. It will also include reviewing the supervision arrangements for this role as part of the new Team Around the Worker model of practice support.
- The Portsmouth Children's Trust - in their current work at strengthening early help pathways - have a clear process to address family non-engagement in early help Single Assessments.
- The NHS Safeguarding Forum to consider the appropriateness and feasibility of having an alert system in place so that if a previous victim of domestic abuse attends the Accident & Emergency Department with an injury they are aware there has been a history of domestic abuse.
- PSCB MESC to secure a representative for the Audit Team from the education sector
- In the Early Help audit scheduled for 2017-18 the Board will ask the MESC multi-agency audit team to review and report back on how well early help assessments are considering the risks, needs and strengths relating to the presenting issue
- Maternity service to re-audit cases so as to check all women are asked about domestic abuse

Learning from PSCB Audits

Children Living with Neglect

To review the progress of agencies interventions for children living with neglect to try and determine what impact the activity since the introduction of this as a Board priority in 2014. To evaluate the impact this work has had on the quality of assessments; whether there appears to be evidence of robust multi-agency working; and whether there was greater clarity around thresholds for escalation and use of a neglect tool to help clarify the appropriate pathway for the cases.

Alongside the audit it was agreed to complete a further survey of the children's workforce to review what impact the introduction of the NIMT had on practitioners' confidence in understanding neglect, spotting the early signs and knowing what support is available.

Findings:

* In 3 of the 6 cases it was evident that the NIMT had been used to help assess the impact of neglect on the child, and was recommended for use in the fourth which demonstrates some level awareness of the tool within the workforce.
* As in 2014, the quality of assessments and plans is variable in quality
* In 5 of the cases there was clear evidence of multi-agency working and communication, which assisted in completing assessments and plans for the families. However, whilst records showed that within health - school nurse, health visitors, paediatricians etc. were aware of the concerns regarding the impact of neglect on the child this was not evident in the GP records
* The use of the Early Help Assessment and TAC meetings meant that cases appeared to be appropriately stepped up and down.
* The audit team noted that in all of the cases there was evidence of a good level of support and oversight of the issues from staff at the Primary Schools the children attended.
* That plans were more effective when they were developed with the parent, there was a professional that the parent had a good working relationship with and that often when the case became closed to Children Social Care the parent's engagement lessened.

Recommendations:

* The PSCB Business Unit should establish a short-term Task and Finish Group to:
  - ⇒ review and shorten the indicators currently in the NIMT and redesign the tool as appropriate
  - ⇒ update the multi-agency guidance for practitioners supporting children living with neglect to aid the description of neglect and impact
  - ⇒ refresh the Thresholds Document to help aid assessment of the impact of neglect so that it can be clearly expressed in a contact to the MASH
* The PSCB Training Committee should plan a range of activities for Safeguarding Week in November 2017 to:
  - ⇒ relaunch the NIMT and guidance
  - ⇒ deliver workshops for the children's workforce on evidence based interventions to address neglect
* MESC to consider if there is more learning to do on effective safeguarding of children who are obese where there is concern that this is linked to neglect.

Partner Compliance with Statutory Safeguarding Requirements

Effective practice to safeguard children and young people is dependent on partners having appropriate policies, procedures and arrangements in place to support their staff. Section 11 of the Children Act 2004 and sections 175 and 157 of the Education Act 2002 set out the requirements for agencies and form the basis for regular self-auditing of compliance. A full self-assessment of statutory partners' compliance with S11 responsibilities was undertaken between December 2016 and February 2017.

This is the 5th year that Portsmouth Safeguarding Children Board chose to combine various duties to test agencies compliance with safeguarding legislation, along with the Section 11 process. This Compact Audit allows us to make comparisons between health, education, early years and voluntary settings alongside those listed as statutory agencies in Working Together 2015. The enables our Board to consider the quality of the whole system in Portsmouth that children and families will engage with at all tiers of need, from universal services through early help settings and into those providing statutory child protection services.

Partner Compliance with Statutory Safeguarding Requirements

In Portsmouth we also have a history of visiting at least 12 providers from a range of settings each year, and this has proved invaluable in relationship building. It also gives the MESC confidence that, whilst using a self-assessment tool, with those organisations visited there has been no evidence of over-inflated grades or that the evidence referred to was not available upon request.

Therefore, despite the process adopted in Portsmouth appearing to be a more time consuming and labour intensive process than adopted in other areas; the MESC would still recommend this approach be continued as the benefits of being able to have an overview of the whole system is worthwhile.

This year, in recognition of the organisations that provide services in Hampshire, Southampton and the Isle of Wight as well as Portsmouth; the PSCB Business Manager worked with the LSCB Managers in these areas to agree a standardised tool. It was agreed that these agencies (such as Hampshire Constabulary, HIOW Community Rehabilitation Company etc.) would supply one audit return that would be shared with all the relevant LSCBs. These returns aren't analysed in this report as a 4LSCB evaluation group is meeting in June 2017 established to review these returns and oversee any improvement activity.

134 agencies (*including schools, GP surgeries, nurseries, teams within Portsmouth City Council etc.)* were sent the self-assessment tool to complete this year and we received 125 completed returns. The 9 agencies that didn't respond will be sent the S11 Compact Audit to complete in 2017-18 (Should they still refuse to or not respond to the request, the matter will be escalated to the Independent Chair of the Board to challenge)

The key finding was that the child protection system in Portsmouth is effective. A range of measures demonstrate a timely and effective system despite increased numbers, and that processes and systems to keep children safe are good.

Recommendations:

1. The Board should consider how it can raise awareness of the 4LSCB Procedures, how they can be accessed and why they are of importance to the workforce
2. The Training Committee should review whether the current online course for Safeguarding Children with Disabilities sufficiently references safeguarding those children with communication difficulties; and scope what training is available from other sources.
3. The Monitoring, Evaluation & Scrutiny Committee should consider how it encourages settings to share the findings of their internal audits of safeguarding practice with the Board so that the learning (where applicable) can be shared across Portsmouth
4. In the 2015-16 Safeguarding Compact Audit report it was recommended that the Board should '*continue to closely monitor early help activity and processes. The next S11 audit will occur 4 months after the launch of the Multi-Agency Teams and close attention will need to be given to whether this shows the hoped for improvement in agencies practice in this area'.* There is no evidence that this has changed and so the MESC Multi-Agency Audit Team will be auditing the early help processes and use of the Early Help Assessment in quarter 3 of 2017-18 and reporting to the Board on their findings in January 2018.
5. The Strategic Missing, Exploited and Trafficked Committee should consider what training would be appropriate on CSE for those working with pre-school children and their families, and ensure this is available in Portsmouth.
6. The PSCB MESC and PSCB Training Committee should consider developing a strategic response to developing the capacity and skills in the workforce around safeguarding children with disabilities
7. Agencies reported that whilst they found the process of completing this audit useful in terms of their self-development of their safeguarding practice; they found Survey Monkey a difficult tool to use for such a long survey. For next year's audit the MESC should consider using an excel spreadsheet for collecting responses.
8. That the MESC change the wording of question 3.4 ' *All individuals who come into contact with children and young people on an individual basis have regular, recorded case management supervision and can access further support when required*'. To make it more inclusive of differing arrangements in different types of settings. So making it specific for those roles for which the Board would expect to have access to a form of supervision, such as the member of staff with lead safeguarding responsibilities or school pastoral staff etc.

Safeguarding Children in Portsmouth

Vulnerable Groups

Children can become vulnerable and subsequently at increased risk of harm for a variety of reasons. National Serious Case Reviews demonstrate that children living in households where there is domestic abuse, substance misuse or their parents are mentally ill are known to be at a greater risk. We also understand the long-term damaging effects of neglectful parenting on children. We know that children who go missing from school or missing from home are also placed in greater danger of harm. Despite this it is not always possible to know the complete picture of the children whose safety is at risk because some abuse or neglect may be masked. To counter this partners in the PSCB have identified some groups of children that are understood to be at particular risk. This helps ensure that their needs are understood and that they form part of our local picture. The PSCB annual report details our understanding of the categories of children and young people identified as being vulnerable and in need of protection.

Children Exposed to Domestic Violence and Abuse

Following receipt of a report to Board in June 2016 that provided an update of the progress on the Domestic Violence and Abuse Strategic Review; the Chair commissioned a scrutiny discussion at the Board meeting in September 2017.

The Board identified the need to further explore this area as domestic abuse is a cross-cutting issue that affects adults and children. In 2015/16 there was the highest number of reported incidents to the police (5053) and 29.5% (3954) of contacts with the MASH involved domestic abuse. Also the Board were aware that the recent publication of triennial serious case reviews identified that "of the many risk factors identified in the parents' backgrounds, the most prominent in these reviews is the ongoing risk posed by situations of domestic abuse". In terms of the welfare of children in Portsmouth an appropriate safeguarding response for children witnessing domestic abuse is important as we know that exposure to domestic violence and abuse can have a wide range of ill-effects on children and young people, and is a significant feature in the backgrounds of children who are vulnerable to other abuse such as child sexual exploitation.

It is recognised that providing effective interventions and support may reduce the likelihood of children being affected by or perpetrating domestic violence and abuse in adulthood. It is also accepted that an effective response to domestic abuse is a good indicator of effective multi-agency working in respect of safeguarding.

As part of this exercise the PSC Business Unit contacted all partner agencies to map what current provision was available for children witnessing domestic abuse. This information was disseminated to all agencies and a list of available resources published on the PSCB website to ensure that the workforce in Portsmouth is aware of the support available for the children they work with.

Two actions came from this scrutiny:

1. For each member to raise awareness around domestic abuse and the impact on children within their own agencies and ensure information that is available is highlighted to front line staff.
2. The MESC to complete a multi-agency audit to look at the quality and effectiveness of safeguarding interventions with children when domestic abuse was identified in their household (the findings of this audit are discussed earlier in this report on page 17

The Board agreed all of the recommendations in the audit report and agreed that agency progress on these needs to be monitored regularly by the MESC.

As part of the response to strengthen the care and support for children living with domestic abuse, the Board endorsed the delivery of Operation Encompass in Portsmouth. This is a pilot project between the police and education settings to provide support for affected children. It involves the police contacting the school or college prior to the start of the day if a domestic abuse incident occurred on the previous evening and a child was present. The school can then offer either overt (e.g. discussion with student around support for day) or silent (e.g. teachers aware and flexible around types of behaviour) support depending on the needs of the child.

In light of this work, the Board have agreed that the response to children living with domestic abuse should be a priority area for the Board in its 2017-19 Business Plan.

Safeguarding Children in Portsmouth

Exploitation, Missing and Trafficked Children

During 2016-17 the PSCB Strategic Missing, Exploited and Trafficked (MET) Committee worked to develop an action plan to underpin the April 2016 - March 2019 MET Strategy. The MET action plan is structured into the same five key pillars as the strategy and the leads for each were confirmed as:

1. Scrutiny and Oversight - Hampshire Constabulary
2. Understand and Identify - Childrens Social Care
3. Prevention - Barnardos and PARCS
4. Intervention and Support - Health, Barnardos and Childrens Social Care
5. Disrupt and Bringing to Justice - Hampshire Constabulary, Probation, Youth Offending Team and Love 146

In order to better understand the support available for the most vulnerable children in Portsmouth, and to ensure they are being appropriately assessed for their risk of being exploited a representative from CAMHS has joined the group this year.

As expressed in the earlier section looking at the Board's progress against the priorities in the Business Plan, the MET group has identified a 'scorecard' of indicators from a range of agencies that it felt would best express the level of vulnerability amongst children in Portsmouth and the impact of the work being undertaken to address this. The scorecard has improved the MET Groups understanding of the level of need and activity, however it has lacked the ability to identify from the data what impact the interventions are having. Thus during 2017-18 work will be undertaken with the Operational MET Group to explore what narrative analysis can be added to the data to better understand what the data is telling us.

Children identified at risk of CSE:	High risk	20
	Medium risk	134
	Low risk	72
Numbers of missing children (Total Episodes)		1,577
Number of children going missing 3 times in 90 days		201
Number of missing children linked to CSE		10
Number of children victim to trafficking offences		12

The direct work with young people helps to evolve our understanding of the model of CSE most commonly seen in Portsmouth and the types of grooming activity employed. This information is used to inform the training that is delivered by the PSCB and shared with partner agencies to help support their identification of victims and disruption activity in Portsmouth.

The most common primary model of CSE identified amongst the young people engaging with the U-Turn Service is peer on peer exploitation (48%), followed by internet exploitation model (22%) and closely by boyfriend/girlfriend model (20%). Internet exploitation features in many cases as a secondary model of exploitation or young people have been identified as vulnerable to this, and therefore online safety features in all support programmes

The link between sexual exploitation and trafficking needs to be better understood. So that as soon as a young person is moved for the purpose of sexual exploitation it is recognised that this is then trafficking and a National Referral Mechanism (NRM) and Independent Child Trafficking Advocate (ICTA) referral is completed so that all appropriate support is available to the child.

Missing Children

A missing toolkit has been developed to improve practice around children missing from home or care. The toolkit provides the workforce with process maps on the appropriate response for when a parent/carer reports a child missing and there are also clear instructions on who is responsible for undertaking the return interview with the child. The toolkit is closely linked to the PSCB Thresholds Document, so that where the risks to the child are thought to be high then a strategy meeting will be convened to address the risks are and how best to mitigate the ongoing concerns. Similarly when a child is reported missing 3 times in a 90 day period a child protection investigation will be commenced.

In March 2016, new Government guidelines were implemented requiring children to be offered a return interview within 72 hours of being returned home, whereas previously these were to be completed within 5 working days. Previously all return interviews were completed by the Miss-U Service, a service commissioned by Portsmouth City Council. In order to meet this increased demand following these revised timescales a new approach has been adopted, whereby any children open to Children's Social Care will have their return interview completed by a Social Worker and the Miss-U Service offers return interviews to those not known to or not currently open to Children's Social Care.

When return interviews are completed, the worker will also be alert to whether the child is at risk of sexual exploitation and if suspected a CSE risk assessment will be completed.

Return interviews are assessed to consider the 'push' and 'pull' factors that were evident in the missing episode, and these are analysed to consider whether any trends are emerging. The issue that is identified in the majority of return interviews as a pre-cursor to the missing episode is arguments at home, relationship difficulties in the second most frequently cited 'push' factor.

Child Trafficking

The Independent Child Trafficking Advocacy (ICTA) Service delivered by Barnardo's launched on 30th January 2017. Portsmouth is part of the early adopter site of Hampshire County and to date has received to date 56 referrals, 29 of these have been from Portsmouth. The ICTA Service is the statutory provision for the next 2 years with the Home Office contract of specialist support as there is now the duty to notify in line with the Modern Slavery Act.

There is a growing understanding that trafficking can be both internal and external, yet there appears to be a gap in identification at the moment, with few internal trafficking cases being identified. The training offer around trafficking this year will be reviewed to ensure that it covers new developments in legislation, understanding and provision.

Unaccompanied Minors

Between April 2016 and March 2017, 39 unaccompanied minors (UAMs) were located in Portsmouth and subsequently accommodated by Portsmouth City Council. The number has significantly increased over the last four years, from just 9 in 2012-13.

The table shows the breakdown of sex, age and ethnicity of UAMs arriving in Portsmouth.

The Local Authority has continued to develop targeted services with Barnardo's, the Red Cross and the Salvation Army so as to promote inclusion and community cohesion.

It is interesting that the largest cohort of unaccompanied minors continue to be Albanian - albeit that this seems to be reducing (43% 2015/16 to 26% 2016/17). A pattern of missing behaviours is emerging with this cohort of young people and this is currently under investigation so as to consider the connections between these young people - pre and post accommodation by Portsmouth City Council.

Sex		Age		Ethnicity		
Male	38	10	1	Afghan		4
Female	1	13	1	Albanian		10
		14	4	British		1
		15	3	Eritrean		1
		16	15	Iranian		2
		17	14	Iranian Kurd		3
		18	1	Iraqi		3
				Iraqi Kurd		7
				Libyan		1
				Not Recorded		2
				Sudanese		3
				Syrian		2
Total	39	Total	39	Total		39

Private Fostering

A privately fostered child is defined as 'a child who is under the age of 16 (18 if disabled) and who is cared for, and provided with accommodation, by someone other than:

- the parent
- a person who is not the parent but who has parental responsibility, or
- a close relative defined in this context as a brother, sister, aunt, uncle, grandparent or step-parent.

A child who is looked after in their own home by an adult is not considered to be privately fostered. Children who are privately fostered are amongst the most potentially vulnerable and the Local Authority must be notified of these arrangements.

Information collected locally mirrors the national situation in relation to low notifications and reports rarely coming from parents. Portsmouth have invested in a full time Private Fostering Social Worker to coordinate activity and increase the marketing "reach".

There were 25 young people subject to private fostering arrangements between 1st April 2016 and 31st March 2017 which is a significant increase on previous years. Twenty Four of these were new notifications. At the end of March 201 there were 7 open private fostering cases. Of the current Private Fostering Arrangements 10 people with parental responsibility made a financial contribution to the placement..

In all cases the child was visited within 7 working days of receipt of notification of the arrangement and additionally throughout the year on a six monthly basis, and an annual review was required in only one case. The notifications were received from a variety of sources, 5 from language schools, 2 from Family nurse partnership,1 from Gatwick airport,1 from MASH,I from housing and the rest from Locality Teams. This highlights a growing awareness across the partnership.

Female Genital Mutilation (FGM)

What we know from our dataset is that there have been no reported incidents of FGM involving children (under the age of 18yrs). The MASH has received contacts regarding concerns for children of mothers who have been subject to FGM, but following further investigation there have been no substantiated concerns that they are planning for the procedure to be conducted on their child.

The Board has been working with the Police and Crime Commissioner Office for Hampshire, the Isle of Wight, Portsmouth and Southampton to bring together a group of statutory partners along with members of relevant community groups and voluntary organisations to develop a strategy and action plan for increasing community awareness of FGM. The group has recognised that in addressing FGM we need to encourage a community based response to FGM, with support from statutory services in order to build relationships and trust. The group is also considering how we engage with men and boys as well as women and girls; for example, the Gambian Group are made up of a number of open minded men who engage with other men in their community who do not want their daughters to undergo FGM.

During the year the group has reviewed the current support available:

- The Perineal Repair Clinic provides a service for women who have sustained, significant perineal trauma during childbirth, antenatal women who experienced trauma in their previous pregnancy and are pregnant again and also women who had FGM. Community midwives refer women to the clinic who disclose they have had FGM at their first visit. Depending on the type of FGM, the clinic can advise on the best place for the women to give birth which is often in a midwife led birth centre so reducing the amount of people involved/ made aware of her FGM as this is something women find difficult to talk about culturally. They also discuss the legal implications and all women receive the leaflet in their own language - ***'HM Government, A Statement Opposing Female Genital Mutilation". Women are advised that the team have a responsibility to refer to the hospital's Childrens Safeguarding Team if a female infant is born to anyone who has disclosed they have had FGM. When Mother and Daughter leave hospital, the Health Visitor is advised that the hospital recorded that she was 'intact'"*** when born, and that information is recorded in the child's medical notes.
- Counselling services are provided by Solent NHS Trust and, so far, one female had been referred to this service.
- Southern Domestic Abuse Service (SDAS) have been funded by the Police and Crime Commissioner to engage with affected diaspora communities and, in conjunction with the Red Cross have delivered workshops to the community with Refugees and Asylum Seekers, presenting on subjects including child abuse and domestic abuse. It was recognised that those attending the workshops, did not have an understanding of the law surrounding FGM. The workshops have been well received and as relationships have developed, women attending the workshops have started to encourage other family members and friends to attend. Currently workshops are exclusively for women.

Children Who Offend Or Are At Risk Of Offending

Portsmouth Youth Offending Team (YOT) is a multi-disciplinary which works with young people who commit criminal offences. The team has continued to experience staffing challenges during 2016/17 but following some successful recruitment activity during early 2017/18 should soon be in a stronger position.

As one of the teams within Children Social Care, YOT continues to have a clear link with the safeguarding teams and uses this to seek appropriate advice and make inter-agency safeguarding referrals where appropriate as well as working with some young people as part of their safeguarding plan.

During 2016/17 there was a gradual but significant increase in the number of cases held by the YOT alongside interventions completed.

The YOT and Hampshire Police Triage Decision Making Panel continue to appropriately divert children and young people from the criminal justice system. Between April 2016 and March 2017, 229 discussions were held at the panel with robust and appropriate outcomes reached for each child and young person in every case. In addition police officers used community resolutions in 140 cases.

A small number of young people that YOT worked with completed an e-survey which highlighted some positive feedback for example 83% of responders felt their YOT workers did enough to help them take part in their order. 100% of children reported the YOT helped them feel safer and 100% also felt they had enough of a say in what went into their referral order contract, supervision and sentence plans. 72% of young people understood why they were working with YOT and identified reasons indicating an acknowledgement of their offending.

The number of First Time Entrants (FTE's) to the criminal justice system has risen considerably during 2016/17 and reasons for this (which are likely to multi-systemic) will be explored during 2017/18.

Using national data which (for which there is a two year lag) Portsmouth re-offending rates had reduced and have then remained consistent for the last couple of years. They are however higher than for similar local authorities, some of which have managed to reduce their rates. The reasons for this will also be explored during 2017/18. A local tracker is being utilised to try and capture more up to date information.

The Priority Young Person Strategy for those who have been convicted 4 times or committed more than 5 offences in a year has continued to scrutinise the support available to young people in an attempt to reduce or halt ongoing offending. Partner agencies will be reminded of the importance of this meeting during the coming period.

Having somewhere suitable to live is critically important and 95% of young people were in suitable accommodation at the conclusion of their YOT intervention at the end of Quarter 4. This was a rise on the earlier part of the year.

The number of young people who were not in Education, Employment & Training (EET) at the end of Quarter 4 had increased for those who were above school age. For those children highlighted the majority were either the responsibility of other Local Authorities, placed out of the area or in custody/. It is an important area to remain focussed on.

The YOT continues to be an active member of the local Missing, Exploited and Trafficked (young people) operational group. Children can be exploited in a number of ways for example sexually or criminally and this will have an impact on their life chances.

The government has been in the process of considering the Charlie Taylor Report which was commissioned to review the Youth Justice System in England and Wales. Youth Offending Services are awaiting guidance on any changes arising from this.

The priorities for the youth offending service in Portsmouth for the coming year are:

- **Timeliness of assessments**
- **Understanding the increase in first time entrants to the criminal justice system**
- **Increasing the use of restorative approaches**
- **Reducing reoffending**

Online Safety

During this year the PSCB Online Safety Implementation Plan has been further developed with the aim of raising awareness of the relevant issues, building professionals' confidence in dealing with children's safety online and encouraging agencies to embed online safety into their ongoing safeguarding practice. The Online Safety Committee was reconvened to support the delivery of this implementation plan.

The PSCB have reappointed an Online Safety Officer who supports the delivery of the training offer, researches good practice, identifies emerging online safety concerns and keep up to date with changes to national guidance. The Officer in turn produces regular newsletters for professionals working with children which updates them on these as well as local good practice and signposting to useful resources.

A training offer has been developed for 2016-17 which includes workshops for schools staff, sessions in Children's Centres to introduce the subject of online safety to parents of pre-school children and a forum for professionals working with children to enable the sharing of good practice.

The Online Safety Officer delivered training in collaboration with Barnardo's at a Portsmouth Schools PSHE event in October 2016 and attended the Hampshire Constabulary Sexting Competition in November. Between January and March 2017 a number of preparatory meetings were held with a range of organisations such as Portsmouth University, Hampshire Constabulary, the Sorted Team and Barnardo's to facilitate the Online Safety Day to be held in June 2017 at Portsmouth Guildhall for all professionals working with young people in Portsmouth. Information from this event will be disseminated via the PCSB website and the Online Safety newsletter.

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Current Status of Children's Mental Health and Emotional Wellbeing Against (Measured) Public Health Outcomes

The estimated prevalence of mental health disorders in children and young people of school age (5-16 years) in Portsmouth (9.5%) is above the national average (9.2%) and South East average (8.5%). The estimated prevalence of emotional disorders in the same group is 3.6%, which is the same as the estimated percentage for England. Portsmouth has a higher estimated prevalence of conduct disorder in school-age children and young people (5.8%) compared to England (5.6%) and the South East (5%). For all of these estimates Portsmouth does not stand out as being "worse" compared to its comparator areas (using the CIPFA nearest neighbours model).

Whilst the percentage of primary school-age children with emotional and mental health needs in Portsmouth (2.26%) is similar to England and the South East, the percentage of secondary school age children with emotional and mental health needs (3.12%) is significantly higher. It is also significantly higher compared to a number of its comparator areas.

15.6% of school-age children (5-16 years) in Portsmouth report low life satisfaction, which is higher than England (13.7%) and the South East (13.6%), though not (statistically) significantly so. 57.4% of school-age children say that they have been bullied in the past couple of months, which is higher than for England (55%) and the South East (57.3%), but again not (statistically) significantly so. For both life satisfaction and being the subject of bullying, Portsmouth is similar to its comparator areas (again using the CIPFA nearer neighbours model). Whilst this is the case, it is of concern that so many children in Portsmouth have low life satisfaction and are subject to bullying, both of which directly impact their mental and emotional wellbeing.

The percentage of children in Portsmouth aged 5-16 who have been in care for at least 12 months and whose score in the SDQ indicates cause for concern is 38.1%, which is not significantly different to the percentage for England, the South East or its comparator areas.

Nationally, the rate of young people aged under 18 being admitted to hospital as a result of self-harm is increasing, and this is also the case in Portsmouth, which saw a sharp increase from 75 presentations in 2013/14 to 168 in 2015/16. The admission rate for self-harm in 2013/14-2015/16 is significantly higher than England. Admissions for young adults (i.e. up to 24 years) are also high. It is possible that some of the reason for the sharp increase is due to improved A&E data coding and changes in clinical protocols, though at least part of the observed rise in the occurrence of self-harm locally (and nationally) is likely to reflect a true increase in self-harming behaviour, which is of concern. 94% of all QAH self-harm attendances in those aged under 18 years occurred in those aged 14 years and above (and 82% in those aged 15 years and above). It is important to note that self-harm presentations to healthcare services also only represent a fairly small percentage of all self-harm.

There have been 6 deaths due to suicide and injury/poisoning of undetermined intent in children and young people aged between 15 and 19 years in Portsmouth between 2007 and 2016.

In relation to measured protective factors (i.e. which can prevent or reduce poor mental and emotional health), Portsmouth is doing well on GCSE educational attainment, and less well on school readiness for those children (at the end of reception) that receive free school meals. In relation to risk factors (i.e. which can contribute to poor mental and emotional health), Portsmouth has higher rates of: looked after children; children in need due to socially unacceptable behaviour; school absence (half days); and first-time entrants to the youth justice system. Portsmouth also has high percentages of 16-18 year olds not in education, employment or training, and 15 year olds with a long-term illness, disability or medical condition diagnosed by a doctor.

To note: The information relates to data recorded for and between 2014/15 and 2016 (varies for each measured outcome).

Current Status of Children's Mental Health and Emotional Wellbeing Against (Measured) Public Health Outcomes

Early help emotional and wellbeing service: U Matter has been operational since January 17 and is proving to be a vital source of support for young people and families. The service is delivered by Relate and is commissioned by Portsmouth CCG. The service supports children, young people and their families by building resilience and improving emotional wellbeing by providing targeted therapeutic counselling and opportunities for young people to support other young people through peer support/mutual aid. The service is experiencing high demand and is currently exploring different ways to manage demand, working with commissioners and partners.

Child and Adolescent Mental Health Service: CAMHS are experiencing unprecedented and continuing demand this year, which is true of other CAMHS services both regionally and nationally. The demand for Autistic Spectrum Disorder (ASD) assessments has seen a particular rise this year compared to last year with a 100% increase. Despite the rising demand, our local CAMHS service continues to deliver a high quality responsive service in a timely way to children, young people and their families.

Children and young people mental health needs assessment (draft): This health needs assessment will inform decision-making on priority needs, gaps and areas for development in relation to mental health and children and young people.

Mental health and emotional wellbeing workshops: A recent workshop was also held to support the identification of needs and gaps across the system (i.e. health, social care, education). This highlighted the following as areas that would benefit from further focus: conduct disorder; behavioural issues; sleep disorder; bereavement and loss; self harm; support for Primary Age children i.e. 5 – 1; transition; autism.

Strategy for wellbeing and resilience in education: Considerable stakeholder consultation, particularly with schools, was undertaken to inform and develop this strategy. A multi-agency stakeholder working group has been established to oversee and deliver the strategy. Key areas of focus for schools will be:

- Recognising the value and impact of mental health in children and young people and how to provide an environment that supports and promotes resilience.
- Promoting good mental health to support children and young people and educate them about the possibilities for effective and appropriate intervention to improve wellbeing.
- Identifying mental health problems early in children and young people and offer support where appropriate.
- Referring appropriately to more targeted and specialist support.

Self-harm health needs assessment: The needs assessment has been completed and a set of draft recommendations presented to the Portsmouth Children's Safeguarding Board. A meeting has been convened to discuss and prioritise the recommendations, and to use the recommendations to inform an Action Plan. Work is already underway in relation to a number of the recommendations, including on the self-harm service pathways (i.e. QIPP - quality, innovation, productivity, prevention - work-stream and the new associated red/amber/green assessment tool for young people).

Suicide Prevention Strategy: This strategy is currently being developed by the Portsmouth Suicide Prevention Action Group (informed by the Suicide Audit in addition to other resources and sources of expertise), and will be agreed by the end of 2017.

Training: *Connect 5* training is being rolled out to front line-staff, including those in contact with children and young people. The training is designed to increase the confidence and core skills of front line staff so that they can be more effective in having conversations about mental health and wellbeing, help people to manage mental health problems and increase their resilience and mental wellbeing through positive changes.

Current Status of Children's Mental Health and Emotional Wellbeing Against (Measured) Public Health Outcomes

Future Work

Work that will be undertaken in the remainder of 2017 and in 2018 includes:

- Review of the support offer for young people/families with behavioural related issues that don't meet the criteria for CAMHS services. The purpose of the work is to understand the need, map out the current support offer which will then reveal the gaps in provision.
- Completion and sign-off of the Suicide Prevention Strategy.
- Implementation of the Suicide Prevention Strategy.
- Development and implementation of the Self-Harm Action Plan.
- Supplementary analysis for the health needs assessment on mental health in children and young people in Portsmouth – to include the identification of need outside of the healthcare setting.
- Continuation of the roll-out of key training to front-line staff.

[3]Public Health England. 2017. Children and Young People's Mental Health and Wellbeing. See: https://fingertips.phe.org.uk/ Uses 2015 data.
[4]Public Health England. 2017. Children and Young People's Mental Health and Wellbeing. See: https://fingertips.phe.org.uk/ Uses 2015 data.
[5]Public Health England. 2017. Child Health Profile: School-Age Children. https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-school-age Uses 2014/15 data.

[6]The SDQ score is generated from a behavioural questionnaire which measures a range of emotional difficulties including: conduct problems; hyperactivity, inattention as well as positive behaviour. See Department for Education. 2012. Guidance On Data Collection On The Emotional Needs of Looked After Children.
[7]Public Health England. 2017. Children and Young People's Mental Health and Wellbeing. See: https://fingertips.phe.org.uk/

[8]Portsmouth self-harm health needs assessment – 2016-17. Dr James Morris, Public Health. Can be requested from Amy.McCullough@Portsmouthcc.gov.uk
[9]2007-2012 Primary Care Mortality Database (ONS & NHS Digital) and Portsmouth 2013-2016 Suicide Audit (Public Health document).
[10]Public Health England. 2017. Children and Young People's Mental Health and Wellbeing. See: https://fingertips.phe.org.uk/

The Child's Journey

Early Help

In Portsmouth, prevention and early help is about enhancing the capabilities of every parent to provide a positive and supportive environment for their children to grow up in.

Some families may have needs which will require additional support - early help - to enable them to reach their full potential. At different times families may present with different levels of need, which might require limited support or more intensive support depending on need.

With the introduction of multi-agency co-location in three localities across the city - the north, centre and south - the early help offer to children and families has been strengthened. Through the Stronger Futures Strategy, led through the Children's Trust, agencies working with children and families have agreed:

1. To adopt a restorative approach
2. To utilise specialist/expert knowledge through a team around the worker model, rather than referring families on to one service after another.
3. To intervene for only as long as is necessary for families to effect positive change that can be sustained for their stronger future.

The aim of our early help offer in Portsmouth is to provide support to help families find their own sustainable solutions. Once improvement is made services will reduce or end so as to not create dependence.

We have developed a simple outcome-focused framework to determine the effectiveness of our early help work.

- Improved health, safety and education
- Secure accommodation and employment
- Reduced instance of crime, anti-social behaviour and domestic abuse

Key to our approach is to utilise a range of interventions from universal services, volunteering, family conferencing and targeted support.

Between April 2016 and March 2017 we were able to work with 858 families through the Troubled Families Programme. Success of this has meant that we have embedded this into a broader offer.

Multi-Agency Safeguarding Hub

The Portsmouth Multi-Agency Safeguarding Hub (MASH) was established in November 2015. It is the multi-agency front door that manages child safeguarding concerns and determines an appropriate response for the City of Portsmouth. The PSCB Threshold Document is used as guidance for the management of all contacts through the MASH

Multi-agency membership:

Children's Social Care = 1 Service Leader, 2.5 Team Leaders, 5 Social Workers, 1 Business Support Team Leader and 5 Business Support staff

Police = 1 Detective Inspector, 2 Sergeants and 7 Community Safety Administrators

Health = 1 Solent NHS Trust Health Visitor and 1 Health practitioner (employed through CCG)

Education = 1 Teacher and 1 Early Years Practitioner

Other = 1 Probation Worker 0.5 FTE, 2 IDVA and 1 Youth Worker

The Child's Journey

Multi-Agency Safeguarding Hub

The MASH process continues to allow for a senior social worker to oversee the allocation of all work and to endorse the recommendations from the multi-agency team for response.

In this financial year April 2016 - March 2017 contact numbers averaged 971 per month. Interestingly, the numbers of contacts were higher in Q1 and Q2 than Q3 and Q4, but overall higher than the previous years. This follows an upward trend over the past five years.

The initial response decision to contacts can be seen in the table below. Contacts reduced following the launch of the revised threshold document in November 2016, suggesting that there is now a better understanding of thresholds across the workforce.

Initial decision following contact to the MASH:

Alongside the revised threshold document, locality network meetings have also been implemented. These meetings provide a forum to discuss issues, including children and families causing concern and this may be assisting with the better application of threshold across the workforce.

The police remain the highest source of contact into the MASH with an average of 50% of contacts each month. The remaining 50% come from Health (approximately 10%), Education (approximately 10%) with the remaining 30% made up of family and all other agencies.

There have been two multi-agency audits of the MASH activity during this time period. The conclusions of these were that consent was being consistently gained and threshold was being appropriately applied. However, there is a need to ensure the MASH is resourced appropriately, having the right number of staff from the key agencies with the appropriate support.

In addition to the formal audit there have been two Peer Reviews (reflecting on CSE and PREVENT) carried out within the Children, and Families Service and both have highlighted the MASH as a well functioning process.

The Child's Journey

Children in Need, Children Subject to Protection Plans and Looked After Children

This year children's social care experienced an increase in demand for social work support - particularly in relation to adolescents. Between April 2016 and March 2017 78 referrals were made to Children and Families Services. An increase of 18% with the number of adolescents rising by 21%. At the end of March 2017 there were 833 children in need, 242 subject to child protection plans and 358 looked after children (including 45 unaccompanied asylum seeking children).

Audits within social care continue to evidence good practices in assessment and care planning and the social work teams continue to demonstrate good performance outcomes against key indicators - egg timeliness of assessments, timeliness of child protection conferences and timeliness of reviews.

Last year the children's social care teams supporting children in need and children subject to protection plans were organised into three locality areas of Portsmouth - the north of the city, centre and south of the city. Social workers now sit alongside health visitors, school nurses and family support workers to provide a seamless service across targeted early help and statutory provision for children and families. Police neighbourhood teams and school clusters are organised across the same locality boundaries which is improving joined-up multi-agency working.

Children's social care have continued to take a lead role in activity to reduce the instances of children going missing and manage/reduce risks associated with exploitation and trafficking. The council led a scrutiny review of work with children at risk of exploitation and a peer challenge was also facilitated; both activities noting the positive work undertaken by social workers. The recommendations for the partnership will be reflected in the updated missing, exploited and trafficked strategy.

Children's social care has continued to facilitate participation events for children, carers and staff so as to promote involvement in the design and delivery of services. The Children in Care Council has been working on a number of projects this year -including a digital application for key documents used through smart devices and an innovation bid for staying close to residential care. During 2016/17 the number of children aged five or older participating in child protection conferences increased to 86%, whilst participation in looked after children reviews has remained high at 87%.

In relation to looked after children, the numbers of unaccompanied asylum seeking children coming into Portsmouth has remained high. Thirty nine unaccompanied minors arrived between April 2016 and March 2017; nine more than last year. This is putting significant pressure on the system and a regional response is being sought.

The Foster Portsmouth brand continues to be strong and the pool of local foster carers remains high - meaning we only have 14% looked after children placed more than 20 miles away. The Corporate Parenting Strategy will need to be refreshed in accordance with the additional duties outlined in the Children and Social Work Act 2017.

Allegations Against Adults Working with Children

The Local Authority Designated Officer (LADO) is responsible for managing and overseeing allegations made against adults working or volunteering with children. Working Together to Safeguard Children (2015) and Keeping Children Safe in Education (2017) set out the framework for how the LADO role is delivered and the policy document is available on the PSCB website.

Notifications need to be made to the LADO within one working day of a manager becoming aware of an allegation or concern of a safeguarding nature regarding a person working or volunteering with children.

This framework for managing allegations should be used in respect of all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates s/he would pose a risk of harm to children.

The number of notifications to the LADO during 2016-2017 has increased by 20% from the previous year with 180 notifications being received. These were in relation to staff working in the following agencies:

Children's Social Care	9
Schools	81
Early Years	17
Faith Groups	3
Police	3
Health	11
Foster Carers	17
Childminders	3
Adults	1
Other	35
Total	**180**

There has been 53% increase in the number of notifications made regarding school staff, 29% increase in notifications against CSC and 27% increase in notifications against Health staff this year. Other areas of increased notifications include Police and Faith Groups, but numbers remain low. Reported allegations against Foster Carers and Early Years staff have slightly decreased this year.

LADO meetings are chaired by the LADO and held as soon as possible and within two days if a child or children are at risk of harm. This timescale has been met in 83% of cases. A designated minute taker is present at the meeting and minutes are sent out within 5 working days. This timescale has been met 83% of the time.

The outcomes of the allegations in the 180 cases were:

Substantiated	17	9.5%
Unsubstantiated	23	13%
Malicious	8	4.5%
Unfounded	1	0.5%
False	9	5%
Advice only / not reached criteria	99	55%
Transferred to another Local Authority	15	8.5%
Transfer to Designated Adults Safeguarding Manager	1	0.5%
On-going	7	3.5%

Keeping Children Safe in Education (2015) states that 90% of cases should be resolved within 3 months. In the twelve month period 87% of cases were resolved within 3 months. It is further guidance that 80% of cases should be resolved within one month, and current data estimates this is being achieved in 77% of cases.

Further detail and information is available within the Management of Allegations Annual Report which will be presented to the PSCB on 18th October 2017.

Notification forms can be found on the PSCB website. If you wish to discuss a matter with the LADO, they can be contacted on 0239882500 or email LADO@portsmouthcc.gov.uk

What Happens when a Child is Seriously Harmed or Dies

Serious Case Reviews

Local Safeguarding Children Boards are required to consider holding a Serious Case Review (SCR) when abuse or neglect is known or suspected to be a factor in a child's death or when a child has been seriously harmed and there are concerns about how professionals may have worked together.

The PSCB did not commission or publish any SCRs during 2016-17. The Board have completed a SCR which was commissioned following the unexpected death of an infant in 2014. The review of agencies involvement with this child has been completed, but the publication of the report has been delayed by the need to take account of parallel processes (e.g. legal proceedings). The partnership have progressed with implementing their actions plans and the Case Review Committee is monitoring the impact of these. The report will be published once court proceedings are completed

In addition the PSCB is committed to undertaking smaller scale reviews where the case does not meet the criteria for a Serious Case Review but it is considered that there are lessons for multi-agency working to be learnt.

During 2016-17 three cases were brought to the attention of the Case Review Committee for discussion. All agencies involved with the child and family are asked to provide a summary of their involvement. It is encouraging that in all of these cases there were examples of effective multi-agency working, such that none met the criteria for a SCR or required a partnership review.

A summary of the discussions of the cases are circulated to all participating agencies for dissemination to support learning and highlight good practice. In two of the cases where it was recommended single agencies have conducted a more thorough review of their practice and reported to Case Review Committee on the result of these reflections to ensure that any learning is disseminated more widely.

Some examples of how this learning has impacted practice are:

- Following a case referred by Hampshire Constabulary a scoping exercise by the committee and a reflective practice meeting with relevant professionals who'd worked with the child and her family was carried out. The conclusion of the Reflective Practice meeting was that the child was responded to at an appropriate level by the services involved in her care. However, the focus was on the child's health and emotional wellbeing and fear for their life with regard to her management of her long term health condition. This resulted in agencies not understanding the risk of CSE and potentially action taken to prevent the child from being exploited. As a result the Board have adopted the shortened CSE risk assessment tool developed by NHS Wessex, and Portsmouth CCG's Safeguarding Team have disseminated this across primary care settings, Solent NHS Trust and Portsmouth Hospitals Trust. the team raised awareness of CSE in health services and promoted the use of this tool in health by rolling out a programme of 'train the trainer' events.
- A case referred following a charge of Coercive Control being brought against a mother following her behaviour towards her daughter has led to the PSCBs Case Review Committee agreeing with Portsmouth Safeguarding Adult Board, that regular joint meetings would be held with their Safeguarding Adults Review Committee. The purpose of this is to allow better information sharing, joint learning events with those who'd worked with both the child and the adult and a more planned dissemination of the findings to both the children's and adults workforce.

The Portsmouth Child Death Overview Panel

Since April 1st 2008, Local Safeguarding Children Boards (LSCBs) in England have had a statutory responsibility for the child death review process.

The Child Death Overview Panel (CDOP) is the inter-agency forum that meets quarterly to review the deaths of all children normally resident in Portsmouth. It is a subcommittee of the Portsmouth Safeguarding Children Board (PSCB) and is therefore accountable to the PSCB Chair. The Portsmouth CDOP now has a new chair, the Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG, following the retirement of the previous chair.

What Happens when a Child is Seriously Harmed or Dies

Until 2015 PSCB partnered with Hampshire, Southampton and Isle of Wight Safeguarding Children Boards to form a single CDOP. However, following a review of these arrangements by the Independent Chairs each of the four LSCBs now has its own CDOP arrangements but on the two principles:

- Each LSCB works to the same Rapid Response procedures, as well as standard CDOP forms, across the four areas. There will be shared learning and data sharing on a minimum annual basis to ensure that any common themes and emerging trends are identified
- The four CDOPs will continue to produce one annual report, that will be managed by Hampshire CDOP and will be available on the 'about us' page of the PSCB website when published

The purpose of the CDOP Process is to determine whether a death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be prevented. If this is this case the panel must decide what, if any, actions could be taken to prevent such deaths in future.

During 2016-2017 there were a total of 11 deaths of children who were resident in Portsmouth notified to the CDOP.

The CDOP met 4 times during 2016/17 to discuss 12 child deaths in Portsmouth (one death was from 2014 and some of the deaths reviewed occurred in 2015/16). The breakdown of these figures is as follows:

- Children 0-4 years = 8
- Children 5-17 = 4
- Over two thirds of the children were female
- Of the 12 cases reviewed by the Portsmouth panel, 2 had modifiable factors and these have subsequently been addressed

There were no themes or trends connected to the deaths and there are currently no outstanding cases to review.

If during the process of reviewing a child death, the CDOP identifies: an issue that could require a Serious Case Review (SCR); a matter of concern affecting the safety and welfare of children in the area; or any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area, a specific recommendation is made to the relevant LSCB.

During 2016-17 there were no recommendations made to the LSCBs regarding the need for a serious case review. There were additional recommendations to agencies though. One of the cases reviewed included an ongoing Serious Case Review of a child who died in December 2014. This was one of the cases with modifiable factors. Unfortunately the process was delayed as there was a requirement for court proceedings to be finalised before the case could be reviewed. The review prompted the revision of the local Unborn/Newborn Baby Protocol to incorporate risks associated with concealed pregnancy. The protocol has now been updated and made available to the wider workforce.

Another of the cases reviewed highlighted the need for the Rapid Response process within Portsmouth to be reviewed and refresher training delivered. This is now being considered by the panel with an aim of completing this within the year.

The panel also identified the inconsistent quality of the feedback from agencies. To ascertain the full picture and identify actions that may be required an audit is underway. The findings will be communicated to the workforce highlighting the importance of including all the information an agency holds regarding a family.

Bereavement training and support for professionals working with a family or sibling affected by the death of a child is also being considered. The panel is also investigating the support offered to all family members following the death of a child to assure this is consistent and appropriate.