Annual Report 2017-18

Portsmouth Safeguarding Children Board

Safeguarding is everybody's responsibility

This report gives an overview of the work of the Portsmouth Safeguarding Children Board (PSCB) from April 2017 to March 2018; 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/**

Foreword … from the PSCB Independent Chair, Dr Richard John

'This is my first report as the new chair of the Portsmouth Safeguarding Children Board (PSCB) having taken over from Reg Hooke on the 10th September 2017. I would like to take this opportunity to thank Reg for his hard work and commitment in working with our partners and community to keep children safe in Portsmouth.

The PSCB is a statutory partnership that works with agencies, including but not exclusively health, police, social care, education, probation and the voluntary sector to safeguard and promote the welfare of children in Portsmouth. The future arrangements of the PSCB are currently under review in line with the Children and Social Work Act 2017. This will ultimately present some challenges and changes, however, it is important to highlight that any changes will be made with the full consultation of our partners and the safety of children of Portsmouth will remain at the heart of any variation of local arrangements.

This report summaries a year's work and indicates opportunities, risks and our collective priorities. Listening to voice of the child and our community is key to us. Having listened to the views of one of our care leavers we have changed our website and invite you to visit our site. We have worked hard to promote and deliver a culture of restorative outcomes through training and workshops and continued to undertake a broad range of audits within our partnership organisations which have presented an excellent platform for identifying best practice for sharing and reflective learning.

Children in a modern society face a number of challenges and our priorities reflect this. I am proud to work with such committed and dedicated professionals who are resolute to keeping children safe in Portsmouth within a changing and complex environment.'

Portsmouth Safeguarding Children Board
Annual Report 2016-17

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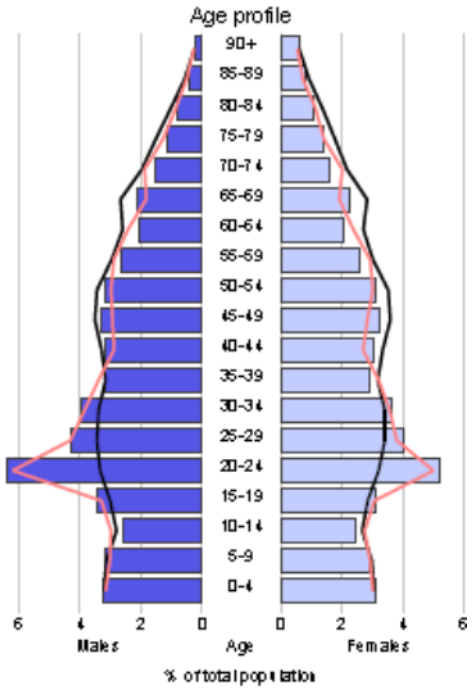
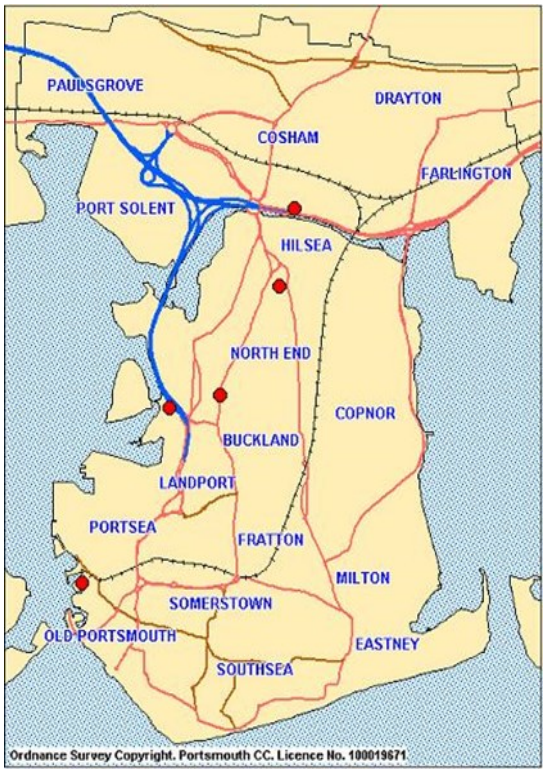
Introduction

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 209,000[1] it is recognised as being the most densely populated area in the United Kingdom outside of London.

Population by Age Group





The Children of Portsmouth

Approximately 43,990[2] children under the age of 18 years live in Portsmouth; this is 20.6% of the total population in the area. Portsmouth is one of the 20% most deprived local authority districts in England with 7,535 (20.3%) of children under the age of 16 years living in low income households.

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%.

Children and young people from minority ethnic groups account for 20.1% of all children living in the area, compared with 21.6% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Mixed Ethnic Group: White and Asian (3.5%), Asian/Asian British: Bangladeshi (3.5%) and White: Other White (2.9%). After English, Bengali and Polish are the most common languages spoken in Portsmouth schools

In January 2018 there were 25,298 children on roll at schools in Portsmouth in years R to 11. Of these:

- 4,752, 18.8% were registered as being eligible for free school meals on census day[3].
- 4,262, 16.8% of pupils in Portsmouth did not have English as their first language. After English, Bengali and Polish were the most common languages spoken in Portsmouth schools
- 3.8% of Portsmouth pupils had a statement or Education, Health and Care Plan. This compares to a national average of 2.9% and an average of 3.0% across the south east region[4]

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[1] Hampshire County Council: Small Area Population Forecast

[2] Public Health England: Public Health Outcomes

[3] Includes all pupils at state-maintained schools, free schools, city technology colleges, studio schools, direct grant nursery schools

[4] https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

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?

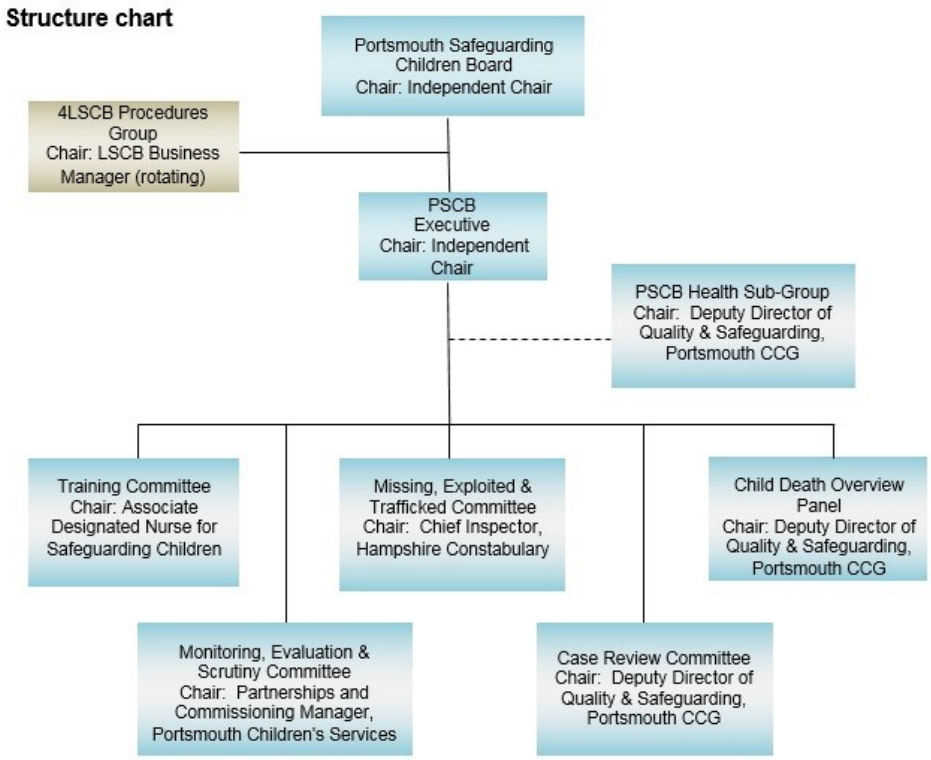
The Board is made up of representatives from local statutory and voluntary sector agencies that work with children and their parents or carers and 3 long-standing Lay Members. The Board is led by an Independent Chair whose role is to hold agencies to account.

It is the responsibility of the Local Authority Chief Executive to appoint the Independent Chairperson (with the agreement of a panel including LSCB partners and Lay Members) and to hold the Chairperson to account for the effective working of the PSCB. In order to provide effective scrutiny, an LSCB 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.

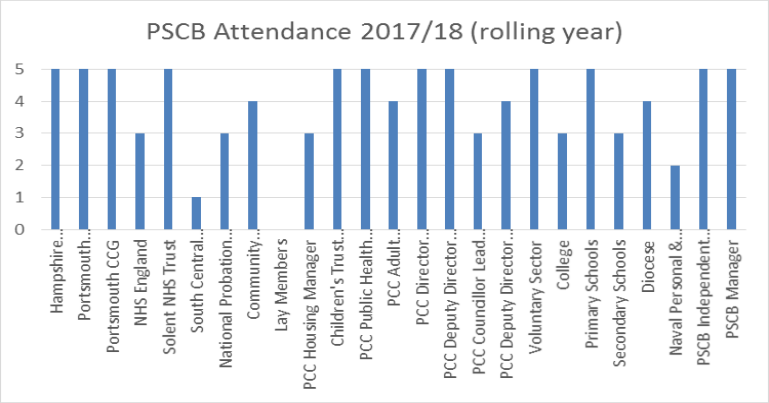
A significant amount of the PSCB's work is undertaken by the Executive Group and Committees. These help to progress many of the detailed actions in the PSCB Business Plan

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



Membership and Attendance

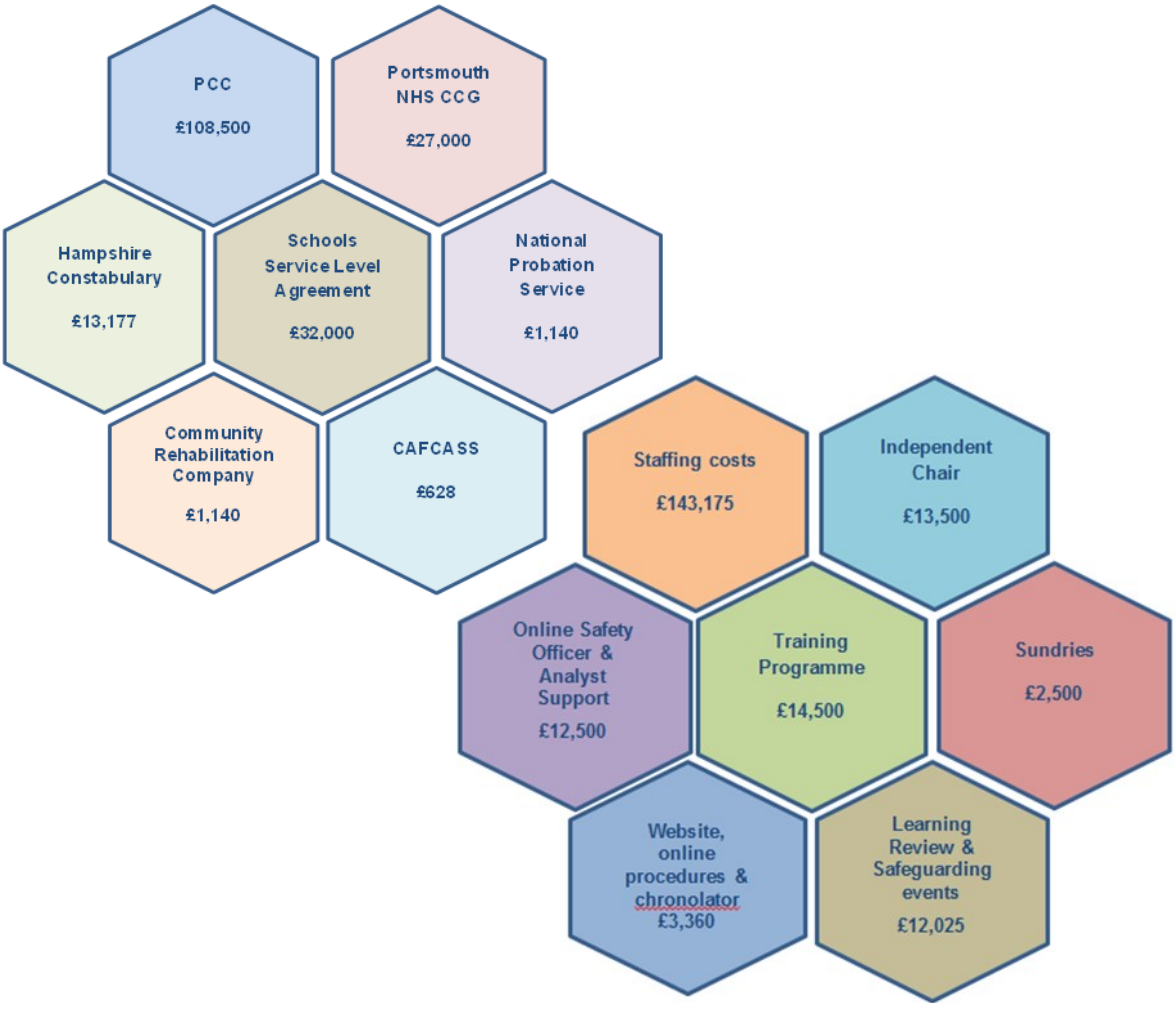
A list of the statutory and non-statutory Board members as at 31 March 2018 and their attendance is shown below. We are confident the Board is represented by the right local statutory and voluntary agencies who are engaged appropriately in the Committees.



Financial Arrangements

The Safeguarding Board is jointly financed by contributions from partner agencies, with the largest proportion coming from the local authority. The Board has again successfully managed a balanced budget, despite there being no change in member contributions for 5 years. All PSCB member organisations have an obligation to provide resources (finance and in kind) to enable the PSCB to be strong and effective

Income total = £183,585 + £60,163 (carry forward from 2016-17) = £243,748



The Business Plan

In April 2017 the PSCB published a new 2 year plan which set out the focus and planned ambitions of multi-agency safeguarding activity in Portsmouth, to ensure that **children and families in Portsmouth have access to the right support at the right time**.

The plan seeks to ensure that while the PSCB continues to oversee and drive improvements in its "core business" through which significant numbers of children are safeguarded, it also seeks to ensure that we maintain an overview of safeguarding issues which affect particular groups of vulnerable children and young people. We continue to learn more about the nature and scale of problems such as child sexual exploitation; radicalisation; the impact of living with domestic abuse etc., and the PSCB needs to ensure that multi-agency responses to these and other issues are child focused, informed by national and learning, and are proportionate and effective.

The PSCB Business Plan 2017-2019 is intentionally brief and focused on **strategic priorities** that form the basis of the work of the Board over this period**.** These priorities support the statutory functions of the PSCB and the partnership response to protecting vulnerable children and young people, preventing harm and promoting their welfare.

In developing our plan we took into account various strategies and the priorities of our partners to ensure that we have a holistic approach that adds value to safeguarding Portsmouth's children and young people. This plan is set in the context of other multi-agency plans held by Portsmouth's Childrens Trust, Portsmouth Safeguarding Adults Board and Safer Portsmouth Partnership.
The priorities were agreed based on the issues identified as having a significant impact on the safety and wellbeing of children in Portsmouth. These priorities are driven and informed by:

- Consultation with members of the PSCB about progress with existing priorities and developing areas of concern
- The statutory functions of the PSCB
- A review of the Business Plan for 2014/17
- Learning from the PSCB dataset, local and national case reviews, audits of practice reports to the PSCB and scrutiny of issues by the Board
- Discussion with groups of children and young people

Priorities for 2017-18 and how we delivered against them

1. Children Experiencing Neglect

The PSCB reviewed the findings of Ofsted's national thematic inspections of neglect and noted their finding that 'the local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and a systematic improvement programme addressing policy, thresholds for actions and professional practice'. As such the Board worked with its partner agencies to develop a multi-agency strategy for Portsmouth to coordinate and focus the work of partner agencies with families where neglect is an issue.
The objectives of this strategy are:

- To strengthen local responses in line with current national and local guidance, policies and good practice
- To ensure families receive a coordinated response from those who work with them and their children.
- To adapt, rather than duplicate, existing guidance, policies or procedures to tackle neglect.
- To raise awareness and improve the safeguarding duty of all relevant agencies with regards to neglect

Priorities for 2017-18 and how we delivered against them

We revised the neglect tools used by the workforce to ensure they were relevant for children at all developmental stages, and covered emerging issues such as childhood obesity being considered as neglect. The practice guidance that supports the identification and response to neglect was updated to include a guide to recognising the severity of neglect, to support the workforce in identifying the appropriate response as the right time for the child.

During Safeguarding Week in November 2017 three workshops were held to update the workforce on the neglect tools and practice guidance, covering how and when to use these and how they can support work with families where neglect is a feature. There was also a whole day conference that focused on 3 of the key issues identified by the workforce that they wanted more support and/or information about. These were:

- Working with resistant families and addressing disguised compliance
- The role of the Early Help & Prevention Service in address emerging issues of neglect
- The impact of diet and obesity on a child's well-being

The Board has worked with the Local Authority, Police and health agencies to agree a set of indicators to add to the existing dataset, to enable monitoring the impact the implementation of the strategy and revised tool has on outcomes for children. It is planned that during 2018-19 the Board will undertake an audit of the quality of Early Help Assessments to consider how well emerging indicators of neglect are being identified and responded to.

2. Missing, exploited and trafficked children

The PSCB have worked with the LSCBs in Hampshire, Southampton and the Isle of Wight to produce a pan-Hampshire Missing, Exploited and Trafficked (MET) Children Information Guide for the workforce. This builds on the previous MET Protocol and includes information on Child Sexual Exploitation; Children Missing from Home, Care and Education; and Trafficked Children; but now also covers Child Criminal Exploitation, County Lines and Internal Trafficking. It is a comprehensive multi-agency information and procedure document to direct practitioners working with children affected by these issues. By producing this as a pan-Hampshire document it ensures there is clear guidance for all those working in the local area, but also consistency of recognition, identification and response to MET children by those who work in our partner agencies that cover 2 or more of these LSCB areas.

To ensure there is a clear focus on the identified issues for children in Portsmouth, the PSCB MET Strategic Committee have reviewed the MET Strategy and set the 3 priority areas in Portsmouth:

1. Exploitation - CCE and threat/risk from county lines, including links to CSE
2. Unaccompanied asylum seeking children and trafficking (including internal trafficking); and
3. Risk of radicalisation - the links between this and other forms of exploitation

Within this, two key themes will focus the work in these areas:

i. Neglect and deprivation (Adverse Childhood Experiences); and
ii. The use of technology to facilitate exploitation and safeguarding in a cyber enabled society.

In December 2017 the pan-Hampshire LSCBs organised and delivered a pan-Hampshire conference introducing the emerging threat to children of their criminal exploitation by Organised Crime Gangs. This included lived experiences of gang members who were exploited as children and now work to divert children who are vulnerable to exploitation. It was attended by over 200 practitioners from across all sectors. This event was followed up by two workshops in Portsmouth attended by 210 practitioners in February 2018. These were organised by Active Communities Network and gave an update from Hampshire Constabulary on their operational activity to address CCE; and a presentation from the Boarders Project to give workers more information on the impact of CCE and how they can help young people involved in CCE.

Given the growing numbers of children being identified as having been trafficked, the PSCB commissioned Barnardo's who operate the Independent Child Trafficking Advocacy (ICTA) Service to offer workshops during 2018 to particularly raise awareness of internal trafficking and the ICTA Service. The first of these was held in February 2018 with a further 2 commissioned for later in the year.

Priorities for 2017-18 and how we delivered against them

The MET Strategic Committee also identified that children from ethnic minority communities were under-represented in those identified at risk of CSE. Therefore the PSCB commissioned the specialist BME worker with Barnardo's to deliver 2 sessions for practitioners specifically aimed at raising awareness of CSE within ethnic minority communities. These sessions will continue to be delivered over 2018.

In addition to these bespoke workshops, the PSCB continues to offer both a taught and an online course on Working with Exploited Children. This course has been reviewed and updated throughout the year to include information on criminal exploitation and county lines.

The MET Committee are working with services and agencies to ensure that relevant data is available to allow members to consider how effective the MET Strategy is. This has included identifying relevant data from education; working with Children & Families Service and Barnardo's to revise the information available from return interviews with missing children; and the Police MET and FIB Teams identifying what data and information can be shared on perpetrators and the prosecution of these.

A short-life task group was developed under the MET Strategy Group to look at the processes and procedures for supporting children in Portsmouth who had gone missing from home and were identified as being a 'medium risk'. This group was established following Hampshire Constabulary's decision that their MET Team would focus on the priority (high) risk children, it was agreed that a pathway for management of medium risk children needed to be developed. This group agreed that Neighbourhood Police Teams will take on oversight of these children and work with Locality Teams and other relevant professionals to respond appropriately to these children. This will allow more effective ownership within Neighbourhood Policing Teams, Locality Teams and Barnardo's to deliver joined up planning.

Given our emerging understanding of criminal exploitation of children, the MET Committee is engaged with a review of the Portsmouth CSE Risk Assessment Tool alongside pan-Hampshire colleagues and Barnardos. This group will use tools, data and profiles from across the teams to develop a mechanism for the assessment all types of child exploitation. This will be supported by academic oversight and include consideration of the impact of adverse childhood experiences and trauma

3. Children Affected by Domestic Abuse

The PSCB are represented on the Domestic Abuse Strategy Group and the Commissioning Group for Portsmouth by the PSCB Safeguarding Partnerships Manager, to ensure that there is a sharp focus kept on the impact of children caused by domestic abuse. During the year this has included highlighting concerns about the apparent drop in the number of referrals from health services to domestic abuse services and by the PSCB presenting a report to the Safer Portsmouth Partnership asking for their support to raise this issue. Solent NHS Trust and Portsmouth Hospitals Trust are putting action plans in place to ensure that Health Visitors and Midwifes are routinely asking whether domestic abuse has taken place; that appropriate risk assessments are completed; and referrals made to Domestic Abuse Services where appropriate.

The PSCB also requires assurance by the Safer Portsmouth Partnership of the effective delivery of the objectives within the Domestic Abuse Strategy in driving improvement to practice and outcomes. During 2017-18 a pilot was launched in the North Locality (funded by the Violence Against Women and Girls strategy) introducing a new model of intervention for parents whose children have a child protection plan where both parents are using unhealthy behaviours within their relationship and it is clear that the current victim and perpetrator intervention is not appropriate. This has strengthened the partnership between specialist DV provision and child protection processes and is designed to keep more children in the family home and in a safer environment.

The PSCB aims to raise professional awareness regarding the impact of domestic abuse on children to ensure they are appropriately identified, protected and supported. This is achieved by supporting multi-agency attendance on a specialist taught course delivered by the specialist Domestic Abuse Service. Both this specialist course and the PSCB Safeguarding Training give the same message about quality assessments to identify individual need resulting in bespoke plans to meet those needs. Within the PSCB Child Protection course domestic abuse case examples are embedded to support learning.

The PSCB has supported the pilot and subsequent introduction of Operation Encompass into Portsmouth. This scheme means that Hampshire Constabulary send a notification to the child's school when they have responded to a domestic abuse incident in their household the previous day. This allows the school an opportunity to provide immediate support as well as consider longer term needs for the child.

PSCB Safeguarding Training

During 2017-18 1,889 delegates have attended PSCB courses:

- **1,306** spaces were filled on the **multi-agency and eLearning modules**
- **583** delegates were taught in **single agency settings**

The attendance figure shows an overall 31% decrease from the previous year. Whilst there have been 911 fewer practitioners accessing the multi-agency taught and online courses, there has been a 12% increase in the number of practitioners receiving safeguarding training in a single agency setting.

Sector	Number of attendees
Armed Services	4
Early Years & Childcare	138
PCC Adult Social Care Services	1
PCC Community Safety	21
PCC Children & Family Services	85
PCC Early Help and Prevention	62
PCC Education Services	19
PCC Housing, Youth & Play Services	52
PCC Other (e.g. Business Support)	8
PCC Public Health	5
Hampshire Constabulary	2
Portsmouth Hospital Trust	11
Schools and Colleges	559
Solent NHS Trust	13
Sport & Culture	5
Voluntary & Community Sector	321

Course	Numbers attended
Basic	115
Early Help	84
Child Protection	92
Supervision	25
Managers	61
Designated Safeguarding Leads	30
CSE	81
Basic Inset Training in Schools	497
Bespoke/Single Agency	86
PSCB Briefings	95
E-learning	723
GRAND TOTAL	**1889**

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.

Restorative Practice

Some of the reduction in numbers attending the Safeguarding Training Programme can be attributed to the introduction of a large scale programme of Restorative Practice Training that the PSCB Training Manager has supported. The Restorative Approach has been adopted in Portsmouth by all services working with children and families in the city. The Board is aware that practitioners only have so many days a year that they can attend training, and so by them attending the Restorative Approach training this may have impacted on their availability to attend Safeguarding Training.

PSCB Training Programme

PSCB has held 9 Restorative Practice courses, with approximately 91 staff from across services in the Local Authority having attended these. Of the 69 education settings in Portsmouth, 24 have so far received training in Restorative Practice, including:

Further Education College	1
Secondary Schools	5
Pupil Referral Unit	1
Primary Schools	17

Solent NHS Trust has trained 143 of their practitioners who work in Portsmouth, including:

Health Visitors	35
Community Health Nurses	9
School Nurses	13
Clinical Team Leaders	9
CAMHS Staff	34
Children's Therapy Services	34
Breastfeeding Support Workers	3
Family Nurse Practitioners	6

The PSCB Training Manager has been consulting with agencies and listening to feedback from practitioners to understand how we can improve attendance in 2018-19. Some of the changes that we will be making are:

- Publishing the dates of the courses - when the programme was originally introduced the dates were not advertised as it was felt important to ensure there was a good range of different agencies represented on the courses. However, practitioners have fed back that this makes it difficult to then accept the date offered, so we will now be publishing the dates of all courses in advance
- Simplifying the booking process - previously this has been a manual system where the applicant has had to identify the course, access the booking form from the website and then email their application to the PSCB Training Manager. During 2018-19 we will be moving to a web-based booking system, which will be a one-step process.
- Reviewing the course content - to ensure that both taught and online courses are relevant and up to date, and accurately reflects changes made to systems, processes and structures in Portsmouth. As well as reviewing what we have learnt over the last few years as to the challenges faced by children and families living in Portsmouth, and emerging concerns such as criminal exploitation etc. The review will also consider course length to consider how much time is required to disseminate the required and relevant information. Wherever possible taught courses will be no longer than 3 hours or 1 day, to lessen impact on time spent away from core business.
- Mapping course content against required professional standards for practitioners - to ensure that professionals in health, social care, education, early years etc. can more easily identify how the training offered by the PSCB maps against standards required by their relevant professional accreditation bodies.
- Introduce topic/issue based training into the programme - for those experienced practitioners who have completed all of the relevant core safeguarding training. To recognise the need for more advanced courses that focus on specific issues, such as Safeguarding Children with Disabilities, Working with Children Experiencing Neglect etc.

Joint PSCB & PSAB Safeguarding Improvement Board

During 2017-18 two inspection reports from the Care Quality Commission (CQC) were published regarding the quality of health provision in Portsmouth

- CQC Portsmouth Hospitals NHS Trust, Queen Alexandra Hospital Quality Report (publication date 24th August 2017).
- CQC Review of health services for Children Looked After and Safeguarding in Portsmouth (publication date 19th September 2017)

These reports both identified areas of good practice as well as some areas concern relating to safeguarding of children and adults in Portsmouth's health services. To ensure that both the PSCB and Portsmouth Safeguarding Adults Board had sufficient oversight of the improvement activity in partner agencies, whilst not overly burdening them with duplication of reporting; a Joint Safeguarding Improvement Board was convened to seek assurance that appropriate actions have been identified and undertaken to address the areas of concern. As many of the patients who will attend Portsmouth Hospitals Trust will live in Hampshire, the Safeguarding Improvement Board has also sought to work in partnership with the Hampshire Safeguarding Adults Board and the Hampshire Safeguarding Children Board.

This Board is jointly Chaired by the Independent Chairs of the PSCB and PSAB and the membership is made up of:

- Chief of Health & Care Portsmouth, NHS Portsmouth CCG/Portsmouth City Council
- Deputy Director of Quality and Safeguarding, NHS Portsmouth CCG
- Head of Safeguarding, Portsmouth Hospitals NHS Trust
- Associate Director of Quality and Governance, Portsmouth Hospitals NHS Trust
- Public Health Consultant, Public Health
- Director of Children's Services, Portsmouth City Council
- Head of Health & Wellbeing Partnerships, Healthwatch Portsmouth
- Associate Director Quality & Nursing, South Eastern Hampshire/Fareham and Gosport Hampshire CCG Partnership
- District Manager for Hampshire Children's Services, Hampshire County Council
- Chief Superintendent, Head of Prevention and Neighbourhood Command Hampshire Constabulary
- Board Manager, Portsmouth Safeguarding Adults Board
- Safeguarding Partnerships Manager, Portsmouth Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Children Board
- Strategic Partnerships Manager, Hampshire Safeguarding Adults Board

Portsmouth Hospitals Trust, Solent NHS Trust, Portsmouth Clinical Commissioning Group, Public Health and the Society of St James had all developed detailed action plans in response to the recommendations in these reports.

The objectives of the group are:

a. To ensure appropriate actions have been identified and undertaken to address the areas of concern

b. To provide a direct line of reporting and accountability for the actions / work streams being undertaken by providers

c. To provide an accessible escalation route to address any areas that may prevent or hinder the necessary actions being taken

d. To provide strategic support to providers as required.

This work is ongoing and aims to be completed by September 2018, at which point any actions still outstanding will be reviewed by the PSCB and PSAB respectively.

What we have learned in 2017-18

What our dataset tells us

There were 20,518 contacts to the Multi-Agency Safeguarding Hub for 10,905 children. The percentage of these that led to an assessment is good (96.7%), which indicates that the workforce has a better understanding of the thresholds for safeguarding.

However, the number of these assessments that led to the child being referred to Children and Family Services was up 12% on last year.

The number of children on a Child Protection Plan in March 2018 was 288, a 19% increase from the previous year, and the number of repeat Child Protection Plans also increased to 12%

The number of Children Looked After rose significantly during 2017-18, from 358 to 419. However, 100% of these children are in 'good' or 'outstanding' placements.

There has been a significant reduction in the number of children being reported missing 3 times in 90 day, down from 201 in 2016-17 to 144 in 2017-18. During the same period the number of children being identified as trafficked has increased by over 300% from just 12 to 50.

There have been no reported incidents of FGM or forced marriage during 2017-18.

It appears that there is greater awareness of the role of the Local Authority Designated Officer, with an increase of 32% in the number of allegations reported.

Indicator	Value	Increase from	Reduction from
Number of Looked After Children	419	17.03%	---
Number of children on a Child Protection Plan	288	19%	---
% of CP Plan due to neglect	68.94%	1.17%	---
% of CP Plan due to emotional abuse	25.26%	---	4.49%
% of CP Plan due to sexual abuse	0.68%	---	1.8%
% of CP Plan due to physical abuse	5.12%	5.12%	---
% of CP Plans where domestic abuse is present	35.07%	---	6.67%
Number of children who were Children in Need (rate per 10,000)	229	23.78%	---
Number of referrals to Children & Families Service	2,785	12.34%	---
Number of child deaths	10	---	9.09%
Number of children missing 3 times in 90 days	144	---	28.35%
Number of new referrals of CSE investigated by Police	83	---	9.78%
Number of victims of trafficking	50	316.66%	---
Number of children linked to high risk domestic incidents	862	121.5%	---
Number of Fixed Period School Exclusions	2,260	24.1%	---
% early years settings rated good or better	94%	---	4%
% of schools graded by Ofsted as outstanding or good	84.1%	3.5%	---

Over the year the Board's Monitoring, Evaluation and Scrutiny Committee (MESC) reviews 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.

What we have learned in 2017-18

All partners are effectively providing regular updates on the Recommendations made from the dataset.

When reviewing the data for 2017-18 the Board received the following messages:

Significant positives

- Child protection conference quoracy is improving as well as good participation by families and reports being received on time
- Allegation management continues to function well
- Good workforce development in place for all agencies
- Good multi-agency grip on CSE and missing children through Operational Group and data tracking
- Good take-up of PSCB training

However…

- Continued high pressure on the safeguarding system in terms of numbers
- Repeat child protection plans and plans lasting over two years are rising issues
- School exclusions are rising
- There appears to be a rise in trafficking (but as will be explained later in this report this may be due to the introduction of the Independent Child Trafficking Advocacy Team being introduced in Portsmouth)

Recommendations

- MESC to undertake multi-agency audit on repeat child protection plans (this audit is planned for quarter 3 of 2018-19)
- Police to report back to the Board on the reasons behind increase in numbers of children being trafficked (this is being considered by partners in the Missing, Exploited and Trafficked Strategic Group and a report will be presented to Board in February 2019)
- MET Committee to report back to the Board on why we continue to have low numbers of low and medium risk CSE assessments (the PSCB has written to all agencies to ask how many assessments they have completed that scored as low or medium, and what they have done as a result. To ascertain whether more assessments are being completed and then not submitted to the MET

What we have learned in 2017-18

Learning from PSCB Audits

The PSCB oversees a range of audit activity to understand the effectiveness of early help and safeguarding in the city. These include multi-agency audits, single agency audits and 'deeps dives' into specific topics.

During April 2017 to March 2018 the Board supported by its partner agencies completed 3 multi-agency audits, the findings of which were reported to the Board. Specific actions relating to cases were fed back to the relevant services and progress on the actions resulting from the recommendations in the audit reports were monitored by the Board's MESC.

Intra-Familial Child Sexual Abuse

This aim of this thematic learning review was to understand how effective multi-agency practice was in responding to a sample of four children where disclosures had been made that sexual abuse may be occurring within a family.

How we did this:

- We looked at cases that had been considered as a Section 47 Enquiry or at a Child Protection Conference where the child had disclosed that they had been sexually abused by a family member. Of these lists four cases were chosen to be considered within this audit.
- For two of these children the child protection process had concluded and so it was agreed that an audit based on agency records would be appropriate. A tool was devised that was sent to all agencies known to have worked with the child that asked them to describe their involvement; write a chronology of key events; and to evaluate the engagement with the child and their family.
- In the other two cases the child was either now being looked after or was on a Child Protection Plan. It was agreed that it would be more appropriate to invite the key practitioners who knew the child best to attend a reflective practice meeting.

What we found:

- Swift and appropriate responses to the allegations, both by family members and the workforce
- Having Children's Social Care structured into locality teams has helped build up the social history and genogram of the extended family that all live in the local area
- Social Worker demonstrated good practice in recalling the archived records in order to understand the historic working, issues and social history of the family
- Good robust Team Around the Family working ensured that all the agencies involved with family members shared the same awareness parent(s) ability or inability to be a protective factor
- There were lots of positive efforts to engage the child, both by the social workers and the schools
- Where there are large, complex families with multiple child protection concerns it would help to have a lead Social Worker reviewing all of the known information and considering where there are any contradictions/duplications in plans for children in the extended family
- Foster carers are trained to contact the social worker if the child in their care were to make a further disclosure. The Social Workers are then not always remembering to inform the police, who would then to decide whether this changes their prior decision not to pursue an allegation.
- National changes to the bail process means that when a suspect is released following arrest and pending investigation, cases need to be referred to a Superintendent who could apply bail conditions in exceptional cases where to not do so might leave the victim at risk. The Board will be reviewing this over the coming year to ensure it responds appropriately to challenge this process should there be concerns that this is not appropriately safeguarding children
- When the actions in the initial safety plan were complete the cases were quickly stepped down from Child in Need, keeping them open for longer would allow consideration about what work should be done with the child to address their sexually harmful behaviour.

Learning from PSCB Audits

Recommendations:

- For the Board to scrutinise support and resources currently available across partner agencies for child demonstrating sexually harmful behaviour, to consider whether we have in Portsmouth a sufficient and up response to this issue.
- For Children & Families Service to develop guidance for Social Workers to help families plan for the longer term, rather than just supporting them to develop a safety plan to address the immediate presenting concerns
- For the Board to scrutinise the current advice and guidance available to supervisors to support professionals working with cases of child sexual abuse. To consider whether this is sufficiently robust enough for them to adequately support practitioners working with often difficult and complex cases.
- A multi-agency task and finish group to develop practice guidance on how we manage large and complex families. To consider how we could be smarter in putting our knowledge and analysis together to make sure we have all the necessary information and a coordinated approach.
- That health agencies present the pathway for medical support for victims of historic child sexual abuse, so the Board can be assured that there is appropriate support in terms of considering if there are any sexually transmitted diseases, injuries and/or pregnancies.
- Hampshire Constabulary to report back to Board how it can address the difficulty that arises when children's allegations cannot pursued due to there being insufficient evidence to bring a charge. In these instances the message the child hears is that they aren't being believed, so how can support be made available to help the child understand this decision.

What we are doing as a result

- The Designated Doctor for Portsmouth is working with Hampshire Constabulary and colleagues in the MASH to develop a protocol and easy to understand flow chart of how to refer a child who is suspected to have been sexually assaulted for a medical examination. To ensure this is well understood and embedded, the Designated Doctor will deliver a series of workshops to relevant staff on this protocol
- Portsmouth Children and Families Service is working closely with Portsmouth Abuse and Rape Counselling Service to commission appropriate specialist post abuse support for children who have experienced sexual abuse.

Learning from PSCB Audits

Quality of Reports Submitted to Child Protection Conferences

The purpose of the review was to repeat the audit completed in March 2016 to consider whether the quality of information supplied to child protection conferences had improved since the introduction of a Restorative Approach to these conferences

How we did this:

- We used the same audit tool as had been adopted in March 2016, with a few amendments to reflect recent changes in practice, to enable us to directly compare these findings to the earlier audit.
- 10 ICPCs held in July 2016 were selected, ensuring there was a representational selection from each of the three locality areas in Portsmouth. All the reports submitted to these ICPCs were then audited

What we found:

- Of the 52 reports audited 42.3% were considered to be of a good quality overall and 42.3% were considered to be adequate
- 15.4% of the reports were of an inadequate quality overall.
- There was no noticeable change in the overall quality of reports to Initial Child Protection Conference since the previous audit completed in March 2016.

Recommendations:

- For the Board to develop guidance and examples of good practice to share with agencies to improve the quality of reports to Initial CP Conferences
- The PSCB Chair will write to all partner agencies summarising the findings of this audit and to reinforce the expectation that:
    - the child's views and wishes are included in reports to ICPC (where children are pre-verbal or have limited communication skills, that an observation of their interactions with their parent/ carer are included); and
    - reports to ICPCs are shared with families prior to conference.
- For the CCG to undertake a separate audit of GP reports to CP Conferences, to explore the barriers to GPs providing reports and provide guidance to help them understand the importance of submitting a report.

What we are doing as a result

- The PSCB Training Manager is revising the Child Protection Training Course, to ensure the relevance of completing the reports to Child Protection Conferences is well understood and that participants understand what a 'good and robust' report would look like
- Once these recommendations are complete, the PSCB Monitoring, Evaluation and Scrutiny Committee will conduct a dip sample of reports submitted to 5-10 Initial Child Protection Conferences to consider the impact upon the quality of these reports.

Learning from PSCB Audits

Quality of Early Help Interventions

The purpose of the review was to consider whether early help assessments are being used appropriately to help clarify all of the issues being experienced by the family; and to coordinate the multi-agency response.

How we did this:

- Two cohorts of children were identified for whom we would expect to see a robust early help response to an emerging need. These were:
- Children aged 0-5 years who were not brought to medical appointments on 3 or more occasions; and
- Children aged 5-10 years with chronic absence from school with less than 50% attendance.
- Five cases from each cohort were sought.

What we found:

- In all of the cases reviewed there appeared to be robust application of the thresholds, and the cases had been appropriately stepped up to Child in Need/Child Protection or down to Early Help
- There was evidence that nurseries and pre-schools are not routinely invited to Team Around the Family meetings nor is the Early Help Assessment and plan sent to them
- There was a strong sense from the cases that whole family working is not embedded.
- GPs were not routinely aware of the concerns about the safety and welfare of the child, nor did they appear to have received a copy of the Early Help Assessment which would have helped inform them of the concerns.

Recommendations:

- Solent NHS Trust and Healthy Child programme commissioners to ensure that in the development of the ECHO service, there is robust and regular liaison between Health Visitors and the registered GP for children who are of concern. .
- A 'was not brought' policy should be introduced in Portsmouth to ensure there is a consistent and robust response to families where children are frequently not brought to medical appointments.
- The PSCB will write to all relevant agencies to ensure that the Lead Professional ensures a copy of the family's Early Help Assessment is sent to the appropriate nursery/pre-school (with consent).
- For Children and Families Service to ensure that engaging early years settings in early help processes is referenced in the processes for and/or role description for Family Lead Professionals. Additionally, the Think Family Mentors should remind those Lead Professionals they work with of the need to send the EHA and Plan to the early years setting as appropriate.
- For Children and Families Services to review their Step Down Protocol and process to ensure that Social Workers are routinely having conversations with the agency they identify as best placed to take on the lead professional role, to ensure they are best placed to take on this responsibility and have agreed to this before the case is transferred.

For Portsmouth Hospitals Trust to carry through on their commitment to identify a link Band 7 midwife for each of the city's 3 Multi-Agency Teams to ensure that there is early identification of pregnant women who will need additional support to safeguard and promote the welfare of their baby.

What we are doing as a result

- The PSCB will work with the Hampshire, Isle of Wight and Southampton LSCBs to develop a pan-Hampshire 'Was Not Brought' police for health agencies to ensure there is consistency of approach across the 4LSCB area
- Within the re-development of the PSCB website planned for quarter 1 of 2018-19, a dedicated Early Help section will be created. All of the relevant tools, assessments and practice guidance relating to early help will be located within this to make these resources easier to access for the workforce.

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.

Working Together to Safeguard Children 2015 states that one of the key functions of a Local Safeguarding Children Board is *'the monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve'*.

Part of the way in which Portsmouth Safeguarding Children Board (PSCB) discharges this function is by carrying out Safeguarding and Early Help Compact Audit self-assessments. This audit is carried out in a two-year cycle with half of all agencies to whom the duty applies completing the audit each year.

This is the 6th year that Portsmouth Safeguarding Children Board chosen to combine various duties to test agencies compliance with safeguarding legislation. 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 processes.

The PSCB Monitoring, Evaluation & Scrutiny Committee (MESC) reviewed the returns submitted in 2017-18 and it was noted that usually a random sample of 12 agencies will be chosen for a moderation visit each year. This is a measure to test the validity of the evidence against which they are self-assessing their grades for each standard. The PSCB Safeguarding Partnerships Manager attends each of these to allow for some continuity and is accompanied on each by a Board or Committee Member.

This year unfortunately only 1 provider visit was managed due to the increased administration time taken to collate and analyse the provider returns. The PSCB MESC agreed that this was a position that should not be replicated in future years and is developing an agreement that this work will be shared by members for the 2018-19 to ensure that the commitment to visit 10% of all providers submitting a return is completed.

However the MESC members were reassured that evidence from visits completed in previous years showed that providers were very objective in their self-assessment. In cases where grades were found to be inaccurate this was always due to the provider being cautious and under-scoring their processes, and that there was no evidence of over-inflation of grading. It is noted though, that in order to give full assurance to the Board of the effectiveness of safeguarding and early help processes in the city that these moderation visits must occur in future years.

<u>What we learnt</u>

114 agencies were sent the self-assessment tool to complete this year and we received 85 completed returns.

The return rate this year is very disappointing with only 75% of agencies sent the tool completing it, this compares to an average response rate of over 95% in the previous three years. It is unclear as to the causes for this as the same method to chase late return was used this year. However, 72% of those not responding were from the voluntary and community sector, so consideration should be given as to whether a shorter more applicable tool may improve this return rate in future years.

Overall MESC members were satisfied that these results demonstrated that services have a clear understanding of their responsibility to safeguard and promote the welfare of children. The feedback from many agencies is that they find the tool helpful as a self-assessment of their safeguarding processes. Schools have reported that they find it useful in preparing for Ofsted Inspections and in reporting to their governing bodies on their compliance with Keeping Safe in Education 2016. Many smaller voluntary organisations have actively requested to complete the tool to identify which areas they need more support and/or training.

Partner Compliance with Statutory Safeguarding Requirements

What was also particularly noticeable this year was that all agencies provided an appropriate description of the evidence they have to support their self-assessment. This varies from the policies and procedures they have in place, to a description of the training staff have received. This gave MESC members additional confidence that these grades are an accurate reflection of practice within these services.

The 3 standards where services felt they had the most improvements to make were:

- Safe Recruitment - Within this 12 services recognised that they needed to improve the training those staff involved in recruitment received. Half of the GP Practices also considered that they weren't sufficiently ensuring that any tempoary and agency staff were clearly informed of their responsibility to safeguard children.
- Equality of opportunity - it is interesting to note that of the 3 GP Practices, 10 early years settings, 14 schools completing this audit felt the need to complete an equality impact assessment when making changes to their service was not applicable to them. A further 6 services ignored this question completely and left their assessment blank. The high number of services not addressing this question will obviously skew the overall percentages. A similar finding was highlighted in the report summarising the findings from this audit completed in 2016-17. MESC will need to consider the implications of this for future audits as it was this one question in particular that affect the overall results.
- Disabled children - Interestingly all services who assessed whether they are proactive in identifying when it is working with a disabled child or their family graded themselves as outstanding or good. The questions within this standard that attracted the most assessments of 'requires improvement' or 'inadequate' were whether their staff:
  - ⇒ that work with disabled children: have been given specific training
  - ⇒ understand the relevant concerns to make a referral to Children's Services in a timely fashion
  - ⇒ receive training in communication skills and methods to work with disabled children and young people

This is the same situation as was found in the 2016-17 audit, so would demonstrate that this is a significant

Recommendations

1. Agencies that did not supply a return this year they will be included in the list asked to submit a return in 2018-19. Should they not submit a response, then a meeting between the PSCB Independent Chair and a senior manager within that service will be arranged.
2. As a matter of urgency the PSCB Independent Chair will write to all services in Portsmouth to ask them to detail what training is currently available to the workforce in relation to working with disabled children. The PSCB Training Committee will review these responses and present a report to Board with recommendations as to how current training provision in this area can be improved or whether additional training should be commissioned.
3. The PSCB Independent Chair will write to all services in Portsmouth to ask them to detail what training is currently available to the staff involved in the recruitment process. The PSCB Training Committee will review these responses and present a report to Board with recommendations as to how current training provision in this area can be improved or whether additional training should be commissioned.
4. For Portsmouth CCG to review their safeguarding training for GP Practices to ensure it emphasises the need to ensure any temporary and agency staff are clearly informed of their responsibility to safeguard children. Evidence of this should be provide to PSCB MESC by September 2018
5. Given the high number of nil returns from community and voluntary organisations; the PSCB Safeguarding Partnerships Manager will work with the Children and Young People's Alliance to develop a tool that is more relevant and easier to complete for this sector

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.

Child E Serious Case Review

Child E was 18 days old when he died. It became apparent that his injuries were not consistent with the explanation given by his mother. Following criminal proceedings his mother has been found guilty of his murder.

The case was considered by the Portsmouth Safeguarding Children Board (PSCB) at its Case Review Committee on 22 January 2015 under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The committee found that this case met the criteria for a serious case review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children', 2013 (now 2015).

Working Together allows LSCBs to use any learning model consistent with the principles in the guidance, including systems based methodology. An Independent Social Work Consultant was commissioned as the lead reviewer to complete the work using a hybrid approach.

Whilst the Review was completed in 2015 publication was delayed until February 2018 due to criminal proceedings.

Safeguarding Concerns

- During her pregnancy with Child E, his mother (Mrs X) received no antenatal care and was, at least partly, in denial about her pregnancy
- Whereas Mrs X had been seeing her GP 2 to 3 times a month, during her pregnancy she had withdrawn from all medical appointments.
- Child E was born at home with the assistance of an ambulance crew, which had only been called when she had been in labour for 3 days and was in the final stages.
- Mrs X and Child E were taken to hospital following his birth and were there for 4 days. During this time a heated argument was witnessed between Mrs X and her partner Mr W. Maternity Services referred Mrs X and Child E to Children's Social Care and an assessment was started.
- Whilst in hospital Mrs X disclosed she experienced mental health issues and domestic abuse.

Findings

1. Better use of early help and intervention - Early signs of neglect were not shared between professionals because no use was made of the mechanism for doing so (i.e. Early Help Assessment).
2. The role of supervision for all agencies - The review highlights the necessity of good reflective supervision and management scrutiny in all agencies. This is particularly prevalent in families such as this where the issues are complex.
3. Assessment of the impact of specific parental issues (DA, alcohol misuse, parental mental health) - Information was held about both adults that was not widely shared and as a result the information was not considered in terms of the impact of their issues on their parenting capacity.
4. Exchange of information between agencies - In the referral and assessment process, the exchange of information between agencies is crucial. Poor exchange of information is likely to result in the wrong application of thresholds and subsequently flawed assessments. In this case the exchange of information between agencies was left wanting particularly in relation to the adults' respective histories.
5. Risks associated with concealed pregnancies - The risks associated with concealed pregnancies are well documented within literature. Within SCRs, families where concealed pregnancy is an issue form a small but significant number. Agencies need to have a shared understanding of these risks and their role in dealing with them.

The recommendations made to address these findings and the action taken thus far, can all be found in the Board's response to SCR Child E, on the SCR Page of the PSCB website. This page also includes the full SCR Child E Overview Report.

Case Reviews

During 2017-18 seven cases have been brought to the attention of the Case Review Committee for discussion. In these cases all agencies who knew the family were asked to provide a summary of their involvement.

A summary of the discussions of the cases are circulated to all participating agencies for dissemination to support learning and highlight good practice. In one case it was felt that although it did not meet the criteria for a SCR, there were sufficient concerns about the way that agencies had worked together that the PSCB have commissioned an Independent Consultant to complete a Learning Review

Child G

This Learning Review is being undertaken to consider the effectiveness of agency involvement with Child G and his family. Following his diagnosis of a life-limiting medical condition, there had been concerns that his mother had not been able to meet all of his care needs and that he experienced neglect; despite ongoing support and packages of care from health professionals and children's services. In particular the concerns focused on poor home conditions and Child G not being taken to his health appointments.

The case was referred to the Case Review Committee by Solent NHS Trust following a re-admission to hospital due to Child G being acutely unwell. Paediatricians considered his life to be in danger due to malnutrition, pressure ulcers and a high risk of aspiration.

The Case Review Committee considered this information and concluded that there was insufficient evidence to suggest that the deterioration in DH's health was linked to abuse rather than his life-limiting medical condition. However, the scoping exercise did highlight that there had been issues around the way agencies worked together, and differences in opinion as to how the suspected neglect was addressed.

So whilst the case does not meet the criteria for a Serious Case Review, it was agreed by the PSCB Independent Chair that a Learning Review should be commissioned to provide insights into the way these organisations had worked together to safeguard and protect the welfare of Child G. As set out in Working Together 2015, it was felt that this review would provide an opportunity for the services involved to identify opportunities to improve their practice, multi-agency working, engagement with resistant families and transition planning for children with life-limiting medical conditions. This review is due to present its final report to Board in October 2018

Multi-Agency Reflective Practice Meetings

In two of the cases (and one that was originally referred in 2016-17) it was recommended that a multi-agency reflective practice meeting be held.

Child CC

The referral was made to the Case Review Committee (CRC) in November 2016, regarding a child but the case also involved an adult at risk. The criteria for a Serious Case Review was not met but the CRC and the Portsmouth Safeguarding Adults Board (PSAB) Safeguarding Adults Review (SAR) sub-group, decided to proceed with a multi-agency reflective practice meeting. This would consider how agencies had worked together and what lessons could be learned to improve the outcomes in future situations.

CC is a teenage child who lives with her mother. In 2016 mother was found guilty of the coercive and controlling behaviour of her daughter following numerous reports to the police by CC to either report her mother missing or express concern for her welfare. These calls were usually the result of the mother leaving messages for her daughter that led her to believe her mother intended to harm herself.

Findings and Learning Points

- Tendency of services to focus on isolated incidents. Lack of seeing the bigger picture of the situation.
  - ⇒ The sum impact of events needs to be considered.
  - ⇒ Individual agencies to be assured that they understand how to identify and respond to the cumulative effect of individual incidents and escalate / refer accordingly.
- Both individuals seen by multiple agencies on multiple occasions i.e. lots of input but not coordinated as no individual / agency seemed to be taking the lead.
  - ⇒ To allow for more effective multi-agency working there needs to be an understanding of different agencies and individual roles, and in particular where responsibility of each starts and finishes
- The high intensity user group at the hospital agreed an approach to manage the mother's attendance at the Emergency Department, but didn't consider the impact this may have had on the child and other family members.
  - ⇒ Agencies to consider risk assessing the impact of withdrawing services to the individual on the wider family.

Child 1

Child 1's mother booked late for maternity care at 28 weeks gestation and disclosed having learning difficulties and epilepsy; mother's learning difficulties were not considered to be significant, and so no contact was made with the MASH. However when mother was admitted for induction of labour, the hospital midwife recognised quickly how significant mother's learning difficulties were and contacted out of hours MASH within 4 hours of admission.

Following his birth Child 1 was diagnosed with a cleft palate and he was transferred to the neonatal intensive care unit due to problems secondary to the cleft palate. On the neonatal ward it became apparent that his parents were struggling to meet their own needs. Child 1's feeding needs were complex and his parents were obviously finding these difficult to meet. A suitable placement was identified by Childrens Social Care for the family at a residential parent and baby placement in another local authority area. During the handover from the social worker to the placement staff upon arrival of Child 1 it became apparent that some of the medical equipment for feeding was missing (the syringes) and the placement did not have any they could use. Child 1 was taken to the local hospital and staff there became concerned that the placement's staff who had received training for feeding Child 1 did not seem sufficiently confident in using the nasal-gastric tube; and they were concerned that not a sufficient number of staff at the placement had received training to feed him competently.

Multi-Agency Reflective Practice Meetings

Learning identified:

- The health pathway for parents' with learning difficulties needs to be clarified for staff within Portsmouth Hospitals Trust and Solent NHS Trust - including the learning disabilities passport tool and guidance to staff about how to use it.
- All health practitioners who may come into contact with pregnant women must be aware of the 4LSCB Unborn/Newborn Baby Protocol. These staff should be aware of the appropriate safeguarding response when a woman is late booking her pregnancy. They must understand the risks associated with a late booking or concealed pregnancy and that this requires an urgent contact to the MASH.
- It is essential that when contacting the MASH regarding a safeguarding concern that the referrer is really clear as to how their concerns about the parent are (or may) potentially impact of the safety and well-being of the child. Staff must also be familiar with the Portsmouth Thresholds Document when completing an Inter-Agency Contact Form (IACF) and clearly indicate on this form the reason they feel it meets the threshold for a statutory response (tier 4) or a response form the targeted early help service (tier 3)
- When a professional decides that a contact should be made to the MASH, if they cannot complete this within a reasonable timescale they must discuss this with their manager and/or safeguarding lead.
- A checklist of all specialist equipment and care required to care for a child with additional needs should be routinely used at discharge meetings. To ensure all issues are properly considered, relevant plans put in place and that all required equipment is handed over.
- A process must be developed to ensure the qualifications, competency and procedures from provider settings are formally checked and verified, in relation to meeting the requirements of a child with identified additional medical and/or care needs.

Child 2

This case involves a 3 year old who now weighs 27.5kg (the weight of an eight year old). Child 2 was seen by a paediatrician in November 2017 but not brought to a follow-up apt in December 2017 and contact was made to the Portsmouth MASH.

The Reflective Practice Meeting for this case will be held in May 2018.

For 2 of the other cases that were not progressed to either a SCR, learning review or reflective practice meeting the following was agreed:

- A 19 year old care leaver who was discovered deceased in her supported housing with an aerosol canister in her hand. Had a history of substance misuse and recognised vulnerability factors and was open to Children's Services as a care leaver at the time of her death.
  - ⇒ a letter was sent to the independent chairs of both Safeguarding Boards recommending Children's Services and Solent NHS Trust review current transition arrangements and inform the Boards of the outcomes of this review and progress on any action plans. The aim being to ensure there are clear transition pathways and adequate safeguarding processes around when young people do not engage.
- TD aged 15, one of 3 siblings who was removed from home to care in 2012 as they were all experiencing chaotic care in the home environment with exposure to violence and neglect. All siblings are in separate care placements with complex individual needs. He was involved in an arson incident at some playing fields in Portsmouth and suffered burns resulting in him being hospitalised in intensive care. TD was discharged to a Children's Home. Previous to this incident TD had gone missing on 16 separate occasions.
  - ⇒ Recommendation made to the Board around developing a multi-agency process for dealing with extremely complex cases where a child is admitted to hospital, to ensure strategy meetings take place quickly so any risks can be identified and shared earlier on.
  - ⇒ The good practice within this case was also highlighted to the Board. As there was evidence of a robust multi-agency discharge planning meeting taking place at the hospital.

For the remaining two cases, it was felt that appropriate responses had been made in both and that there were no further recommendations required.

Child Death Overview Panel

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 purpose of the review 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.

The Portsmouth CDOP received 10 child death notifications during this reporting period of which 5 were reviewed. The reviews of the five remaining cases were delayed due to post mortem results and single agency reviews being finalised and these deaths will be reviewed when all relevant information is available. A total of 13 cases were reviewed by the panel over the last financial year but some of these deaths occurred in the preceding financial year. No themes or trends were identified from the deaths reviewed this year.

All cases (both expected and unexpected) discussed at panel were due to medical causes, perinatal/ neonatal events or known life limiting conditions. Boys' deaths accounted for a greater preponderance. None of the deaths reviewed had a Statutory Order in place at the time of the child's death or were subject to a child protection plan. None of the deaths included child asylum seekers and none of the children whose deaths were reviewed were within the 10% most deprived areas of England. All of the child deaths occurred in an acute hospital setting and the reviews were completed in less than six months since the child's death.

Last year the panel identified there was a requirement to provide refresher training on the Rapid Response process within Portsmouth. This was investigated by the panel and Hampshire Constabulary has recently trained emergency department staff at Queen Alexandra Hospital on the process. The aim is to roll this out further to partner agencies later in the year.

The panel previously identified the inconsistent quality of the returned 'Form B' from agencies. To ascertain the picture an audit took place during summer 2017 and the findings showed the forms audited contained a better than expected return rate. It was noted that some agencies have a tendency to attach documentation rather than input directly into the form. It would be preferable if all information is returned via one medium and this is being addressed accordingly by the panel.

Bereavement training for professionals supporting a family or sibling affected by the death of a child was considered by the Portsmouth CDOP to gain assurance that this was consistent and appropriate. Each panel member investigated the support provided to staff within their own agencies and the returned information was reviewed by the panel and it was deemed robust. Solent NHS also ran workshops for child practitioners to understand the impact of loss when experienced by children and young people and their families.

It was identified this year that it would be useful to capture the mother's BMI at 12 weeks gestation and to understand if there was any smoking in pregnancy. The Portsmouth Form B is to be amended to enable this information to be captured for future cases to help inform discussion at case reviews.

Child Death Overview Panel

The Portsmouth CDOP felt it was important to highlight to the workforce that in the City the infant (aged 0 to 1 year) mortality rate remains consistently lower than the England average with recent figures for Portsmouth at 2.8 per 1,000 live births, (England average 3.9 per 1,000) with no deaths due to sudden infant death syndrome (SIDS). The child (aged 1 to 17 years) mortality rate is also lower than the rest of England at 6.6 per 100,000, compared with 11.9 per 100,000. This is despite the proportion of children under 16 living in low income families being 24.0%, which is higher than the England average of 20.1%. It's not clear why the infant and child mortality rates are lower in Portsmouth, but its seems that the hard work done by the local authority and public health, health visitor and school nursing teams, primary care, maternity and neonatal services and paediatrics must have a role to play in this.

The Portsmouth CDOP reviewed local safe sleeping messages and colleagues within Public Health confirmed messages are regularly disseminated via various methods including articles within regular publications that are sent directly to homes and schools within the city. Whilst Portsmouth has not had any deaths related to sleeping practices during 2017/18 we recognise that our population is at increased risk due to the levels of deprivation in the city and will be supporting the work carried out across the 4CDOP area.

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. 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, 0.5 Team Leader with MH specialism, 5.5 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 Health Navigator - Specialist Safeguarding Nurse and 1 Health Visitor
- Education = 1 Pastoral Support Worker
- Other = 0.5 Probation Worker, 2 Independent Domestic Violence Adviser, 1 Youth Worker, 3 Think Family Mentors, 1 Early Help Practitioner and 1.5 Early Help Business Support staff
- Adult Social care (affiliated) = 1 Team Manager, 1 Assistant Team Manager and 3 Social Workers

The development of Targeted Early Help Teams led to a targeted Tier 3 service within Portsmouth from July 2017. Access to this service is either via a contact to the MASH or step down from Children's Services. Threshold is assessed on contacts and all contacts meeting threshold for Tier 3 are directed for allocation to the relevant Locality Targeted Hubs.

The Adult MASH continues to sit alongside the children's MASH. Whilst they are not integrated this affords very positive links and some good joined up working opportunities.

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.

Between April 2017 and March 2018 contact numbers averaged 919 per month, a decrease on last years' average of 1006. This resulted in a decrease to the total number of contacts into the MASH, from 12,076 for 2016/17 to 11,025 for 17/18.

MASH Contacts	16/17	17/18
Initial Decision MASH	2484(21%)	2951(27%)
Initial Decision MASH S47	807(6.5%)	468(4%)
Initial Decision MASH Early Help	2726(22.5%)	2384(22%)
Initial Decision Remain with Universal Services	6059(50%)	5222(47%)
Total MASH Contacts	**12,076**	**11,025**

When a contact is received by the MASH an initial decision is made by a senior social worker in accordance with the information provided and the PSCB thresholds for services document. This reduction in contacts suggests an increased understanding of threshold across the children's workforce in Portsmouth.

Where the information indicates that threshold may be met for a tier 3 or 4 service the contact is passed through the MASH team so that known, relevant information by each agency can be shared. This full information affords for robust decision making, so that the right children receive the right service.

Where the initial decision indicates that the threshold for a S47 enquiry is met, a multi-agency strategy meeting will be convened. This provides an alternative arena for information sharing, but again affords for robust decision making.

Where the MASH determines a contact meets the threshold for Tier 3 assessment and intervention these are passed to the recently developed Targeted Early Help Team for action. If the contact meets the threshold for a Tier 2 intervention these are coordinated by the Think Family Mentors who are now based within MASH Early Help.

Multi-Agency Safeguarding Hub

There has been an increase in referrals to Tier 4 in 17/18 from 16/17.

	2016/17	2017/18
Referral to Social Care - Tier 4	2059 (17%)	2217 (20%)
Targeted Early Help - Tier 3	N/A	897 (18%)
Think Family Mentors - Tier 2	359 (3%)	929 (8.5%)

There have been 3 multi-agency audits completed during 2017-18. On each occasion 30 contacts were considered by Senior Managers from Children's Services, Health and Police.

These audits evidence threshold being applied appropriately, there is good multi-agency working and information sharing. Work is carried out in a timely way. The ongoing area for improvement is that the issue of consent is explicitly recorded in all cases. The audits do evidence a good improvement in this.

The City's Prevent offer remains situated in the MASH, the chair of Channel Panel is the Senior Manager responsible for Adult MASH and Service Leader for the Children's MASH is taking on deputy chair role. Both the chair and deputy chair are National peer reviewers for the Prevent programme.

Early Help and Prevention

In Portsmouth, Early Help and Prevention is about enabling 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-located teams 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:

To adopt a restorative approach

To utilise specialist/expert knowledge through a team around the worker model, rather than referring families on to one service after another.

To intervene for only as long as is necessary for families to effect positive change that can be sustained for their stronger future.

To develop the volunteer offer to families with children and young people 0-19 years through the Family hubs

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, restorative practice and targeted family support. The Early Help offer in Portsmouth is integrated with Health Visitors, School Nurses and Family Nurses working alongside the 5-19 Early Help team provided by Portsmouth City Council Portsmouth

The integrated 0-19 early help team are also responsible for the co-ordinating the behaviour management offer which is available City wide and delivering the Young Carers service and the 4U project which helps young people with LGBTQ matters.

Children in need (including children subject to protection plans) and looked after children

As at March 2018 Children's Social Care were working with 872 Children in Need; 286 Children subject of Child Protection Planning and 415 Looked After Children (which included 72 Unaccompanied Asylum Seeking Children).

The locality based teams are working well across children's social care, police neighbourhood teams, community health workers and the newly established targeted early help teams. However, between April 2017 and 2018 2742 referrals were made to children's social care - an increase of 10.9 per cent.

The quality assurance framework for children's social care was refreshed this year and a robust program of live auditing (auditing alongside the social work practitioner) was introduced. A total of 144 cases were audited between April 2017 and March 2018, with 74% graded good. An external auditor has been commissioned to reassess 20% audited cases and this has demonstrated that the service is clear what good practice looks like.

Social work assessments continue to be timely and a range of practice tools are now being used to assist children and families understanding what harm a child is experiencing or at risk of suffering- and then what needs to change to increase safety. This is supporting the implementation of restorative principles in practice.

Child protection conferences are now underpinned by restorative principles - with children and families being at the centre of the process. The number of children made subject to protection plans increased as we introduced this new way of working but as the conference chairs have become more proficient in facilitating the new approach the numbers are starting to fall and this should be evident in a clear reduction in the number of children subject to protection plans next year. As at the end March 2018 there were 196 plans recorded under the neglect category; 73 under emotional abuse; 15 under physical abuse and 2 under sexual abuse.

Children's Social Care have continued to work closely with the police driving activity to support children going missing from home and care, being exploited or trafficked at risk of exploitation or trafficking. At any one time there are about 11 children in the city considered at high risk of CSE and 23 children at medium risk. However there is more work to do across the children's workforce to identify more young people who are at low risk so as to offer keep safe work at the earliest opportunity.

Domestic abuse remains a significant issue for the city, with 5,500 recorded instances. Approximately 70% child protection conferences have domestic abuse as a feature and almost 50% children who come into the care of the local authority do so as a result of domestic abuse.

Children's Social Care has continued to facilitate participation events for children, carers and staff so as to promote their involvement in the designing and delivery of services. During 2017/18 the number of children aged 5 or older participating in child protection conferences increased to 74%. Further participation of looked after children in their reviews has remained high at 93%. In the annual participation survey, completed February 2018, 100% children in care who took part, reported that they felt safe and well cared for and 90% of children reported feeling well supported by their social worker. This reflects an increasingly stable and competent workforce.

In Portsmouth we have seen a steady rise in the number of unaccompanied minors coming into the city through the Port. Between April 2017 and March 2018 85 unaccompanied minors came into the city, a rise of 118% from the preceding year, which had seen a rise of 30% on the year before.

As a result of the rise in both the generic population of children coming into care and the unaccompanied minors Children's social care continue to seek local foster carers and our local Foster-Portsmouth campaign continues to be successful. Despite the significant rise in care numbers, the proportion of children placed more than 20 miles away remains low - at 14%.

A lot of attention has been afforded to placement stability and examining the reasons behind placement disruptions. A high proportion of children in care only experience 3 placements, but there are a small number of children who have experienced significant disruption. Robust focus by the independent reviewing service is now afforded to children whose placements are fragile and next year we will implement a new trauma informed model of care to promote increased stability.

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 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".

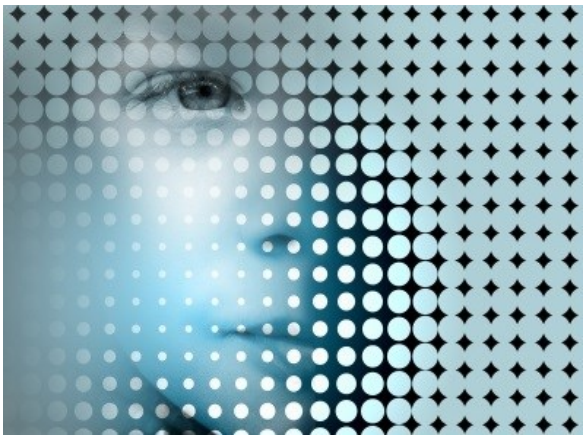
There were 30 young people subject to private fostering arrangements between 1st April 2017 and 31st March 2018, increased from 25 in 2016-17 and 11 in 2015-16.

23 of these were new notifications. At the end of March 2018 there were 5 open private fostering cases. Of the current Private Fostering Arrangements 5 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, 1 from a language school, 3 from Private Foster Carers, 1 from parents, 1 from MASH, 11 from the Locality Teams, 1 from a school, 2 from a guardianship agency for students from abroad, 1 from Heathrow airport and 1 from Portsmouth City Council housing.

Children who offend or are at risk of offending



The Portsmouth Youth Offending Team (PYOT) Partnership Management Board oversees youth justice services for the Portsmouth City Council (PCC) area comprising the local Youth Offending Team (YOT), Junior Attendance Centre (JAC) and Appropriate Adult (AA) services contracted out to The Appropriate Adult Service (TAAS). Broader preventative functions in the PCC area are served via Early Help and Prevention services and the voluntary sector.

Portsmouth Youth Offending Team is a multi-disciplinary team working with children who have committed offences aged 10 to 17 (and in exceptional cases, aged 18). In 2017/18, it was aligned with Portsmouth City Council's Harm and Exploitation services, recognising the vulnerability experienced by children who offend, as well as the risks they may pose to others. It remains co-located with Children and Families teams, including the MASH, South Locality and Through Care, and maintains good links in terms of safeguarding.

Caseload levels from 2016/17 have been maintained- marking an increase from previous years but stabilising to a degree. Work has been completed to understand this, with a view to reducing the number of children who are known to the team via delivery effective interventions and joint working with partners.

The Joint Decision Making Panel (also known as Triage) continues to meet on a weekly basis; making recommendations for outcomes in response to offending by children based on holistic assessment. Since December 2017, a representative of Early Help has also attended to inform discussion and contribute to decisions made. The YOT have also continued to access consultation and clinical supervision via the Hampshire and IOW Forensic CAMHS Service.

Overall, PYOT works towards 3 national Key Performance Indicators- Reducing First Time Entrants, Reoffending and Use of Custody. At year end 2017/18, the number of first time entrants had reduced to 67 in 2017 from 90 in 2016 and a previous a high of 117 in 2014. Reoffending data showed fluctuation and a slight reduction from a previous high in July 2011-June 2012. The number of custodial sentences imposed had increased in from 8 in 2016/17 to 12 in 2017/18, but an overall reduction since a high of 24 in 2011/12. Work is ongoing to understand these trends, and achieve further reduction, included specific sets of analysis planned to take place during 2018/19.

The key outcomes sought by PYOT in the coming year, as set out in its Annual Strategic Youth Justice Plan, are:

- Portsmouth Youth Justice services are offered innovatively, within resource available, across the partnership
- A culture of performance and accountability is embedded within PYOT
- Reduction in First Time Entrants
- Reduction in Reoffending
- Reduction in Use of Custody

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 (2018) 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 2017-2018 has increased by 32% from the previous year with 238 notifications being received. These were in relation to staff working in the following agencies:

Children's Social Care	20
Schools	87
Further Education	2
Early Years	25
Faith Groups	3
Police	1
Health	12
Foster Carers	39
Childminders	1
Adults	1
Other PCC Departments	2
Public Services	2
Charity	19
Sports	10
Commercial	12
Other	2
Total	**238**

The most significant increase has been in notifications regarding staff and volunteers in Childrens Social Care, Early Years, Further Education, foster care, charities, sports and commercial organisations.

The data for CSC staff has been impacted by multiple allegations from one young person against several staff in one residential children's home. These allegations were all found to be false, unfounded, or did not meet LADO criteria.

Notifications relating to health workers and school staff have also increased.

These increases are likely to be linked to safeguarding education, awareness raising and an increased awareness of the LADO role and requirement to notify.

Where decreases have been noted these relate to small numbers of staff and small decreases from last year's figures.

A strategy discussion or meeting, chaired by the LADO, between the LADO and key agencies happens in 100% of cases within 2 working days from the notification being received. This ensures an action plan is in place to ensure that no child or children are left in a position where they are at risk of harm. Where initial strategy meetings were required this was achieved within 2 working days in 71% of cases. A designated minute taker is present at the meeting and minutes are sent out within 5 working days.

Allegations against adults working with children

The outcomes of the allegations in the 238 cases were:

Substantiated	15	6.3%
Unsubstantiated	23	9.7%
Malicious	2	0.8%
Unfounded	6	2.5%
False	23	9.7%
Advice only	65	27.3%
Did not reached criteria	59	24.7%
Transferred to another Local Authority	25	10.5%
On-going	20	8.4%

Keeping Children Safe in Education (2017) states that 90% of cases should be resolved within 3 months. In the twelve month period 79% of cases were resolved within 3 months. It is further guidance that 80% of cases should be resolved within one month; this was achieved in 69% of cases.

Further detail and information is available within the Management of Allegations Annual Report which will be presented to the PSCB on 31st October 2018.

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.gcsx.gov.uk