Annual Report on Safeguarding Arrangements 2020-21

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Introduction

This report presents the work that the Portsmouth Safeguarding Children's Partnership (PSCP) has done to keep children and young people safe during the period 1st April 2020 to 31st March 2021. As set out in Working Together 2018 the purpose is not only to detail the activity undertaken in this period, but to additionally include:

- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- a record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision

Foreword

1. The PCC Children, Families and Education Directorate leadership has particularly focused in 2020-21 on the following key safeguarding practice and organisational development improvement priorities:
   1.1. Acting on findings from the 2019 JTAI about the quality of planning and decision making. A rapid improvement plan was agreed with Children and Family service managers to address key findings, in particular the need to improve the quality of children's plans, strengthen oversight of child in need and child protection decision making and ensure that our response to contacts to the MASH is informed from the outset by a full multi agency intelligence picture. Quality assurance activity over the course of the year shows that while we cannot be complacent, good progress has been made in all these areas despite the amber rating of a number of relevant actions on the MESC tracker.
   1.2. Supporting and championing development of a new multi-agency approach to encourage better multi agency escalation and/or peer review of casework. We were acutely aware of a key finding from the Child G SCR around the need for stronger escalation to senior leaders where disagreement or the failure of plans was stalling progress for children. Workshops with front line staff and managers led by the PSCP team identified cultural barriers and a need for a fresh approach which led to the development of the re-think process. While CFE leadership has strongly championed this new process within our services it is not yet embedded and continued focus will be needed this year.
   1.3. Restructuring the Children and Families senior leadership to strengthen our contribution to tackling exploitation. As part of our response to the PSCP deep dive into exploitation we developed proposals for the creation of a new service focusing on vulnerable adolescents, bringing care leaving services together with adolescent edge of care and youth offending, with an ambition to develop a stronger transitional safeguarding response to meet the needs of older young people, working with colleagues in adult services. The new service will be established in 2021-2022.
   1.4. New "link coordinator" arrangements to strengthen oversight of vulnerable children during the pandemic. Early in the pandemic, in spring 2020, the Directorate redeployed staff into a number of link coordinator roles to liaise with schools and services to track as well as possible the wellbeing of vulnerable children, both those open to Children and Families and those identified by schools. In autumn 2021 as staff went back to their previous duties we recruited three permanent posts to carry on this work, which has been well received by schools.
   1.5. Appointment of a more senior Principal Social Worker to drive improved practice. We restructured in order to create a Head of Service level PSW post, and the current post holder started work in January 2021. She has played a significant role in supporting improvement work across Children and Families.

1.6. Oversight over the implementation of the Family Safeguarding model. The Directorate leadership has taken a close interest in the implementation of family safeguarding through chairing and attending quarterly meetings of the multi-agency Excellent Family Practice group and arranging a peer review of the implementation by leaders in the field, Hertfordshire County Council.

1.7. Championing and facilitating review of options for better integrated more effective multi agency support for looked after children and care leavers. This key strand of the multi-agency corporate parenting strategy was delayed by the commitments of health partners at the height of the pandemic but was restarted and is an important strand of work in the current year.

1.8. With NHS colleagues, ensuring effective early help support for families with young children. Workshops with key managers led to the recruitment of additional staff to support health visitors working with families at the tier 3 level of need, and an additional post to support vulnerable pregnant women.

2. In 2021-22 key safeguarding leadership priorities for us include:

2.1. Working with schools to support and facilitate wider implementation of restorative practice approaches designed among other things (including higher attainment) to reduce significantly school days lost through poor attendance and/or exclusion and the safeguarding risks that these create for children and young people.

2.2. With Police colleagues, implementing our new youth justice strategy including reducing first time entrants by more use of alternative diversion and support offers.

2.3. Implementing the Children and Families restructure to strengthen response to exploitation.

2.4. Implementing more effective approaches to integrated support, including safeguarding support, for looked after children. We are making progress in identifying the key barriers and potential helpful ways forward.

2.5. Extending the Family Safeguarding model as far as resources allow, including preparing families for reunification and supporting women who have lost children into care. Overseeing the delivery of training across the children and families workforce in motivational interviewing will be a priority in this area.

2.6. Supporting the wider system to hold risk appropriately, including through a redesign of the early help assessment and plan tool.

2.7. Leading multi-agency work on the Portsmouth Insight Hub bringing together key data sets to identify earlier children and families who may need support.

2.8. Continuing to strengthen the line of sight on vulnerability and risk, particularly for the statutory DCS, in ways which do not cut across effective front line operations. This will include regular review of the MESC tracker by the leadership team.

Alison Jeffery, PCC Director, Children, Families and Education

As the Portsmouth district commander I work on a daily basis with the statutory partners in the city. This report outlines the commitment from each partner to improve the lives and outcomes for the children and young people of Portsmouth. The data supports some of the challenges we face and demonstrates how safeguarding arrangements are at the heart of other key partnership strategies such as Health and Wellbeing and our City Vision. As a team we provide healthy challenge to one another's practices but this does not prohibit transparent dialogue when we recognise that work needs to improve.

I welcome the scrutiny being applied to the police submissions to the MASH. This is a key area of development which is at the heart of the child Centred policing approach. We are aspiring to create a workforce that is not only trauma aware but trauma informed, who can articulate effectively not only what has happened but apply professional curiosity to the home health and happiness of children and young people. The MASH manager is a participant at the police daily management meeting enabling live time information sharing to take place which assists in dynamic safeguarding.

Our commitment to Early Help is demonstrated by embedding a PCSO within the team, who is making a difference to children and their families, where there has been domestic abuse, crime or antisocial behaviour in the family, working as part of the multi -disciplinary team.

I look forward to the further development of the safeguarding improvement hub, the transition deep dive and continued improvement of our services.

Superintendent Clare Jenkins, Portsmouth District Commander, Hampshire Constabulary

It is obviously no surprise that this past year has been the most challenging year in the history of the NHS. Health staff working within the community were relocated to support frontline staff and the majority of office-based workers were sent home to work, with no idea of when they would return. Staff embraced the virtual world of working and quickly adapted; providing health consultations, GP appointments and new-born visits (to name just a few) via video links. At the start of the pandemic weekly multi-agency meetings were set-up to ensure safeguarding our children within the city remained a priority and safeguarding needs were identified and responded to quickly. The last year has seen an increase in children requiring support with their mental health and as a partnership we have ensured additional services have been commissioned to support our children, including an online service. Throughout the year a new health issues developed we worked with our partners to ensure that safeguarding remained at the fore front of everyone's minds. We maintained health involvement in the MASH due to the work done historically to ensure all primary and community health acre used one electronic patient record. We also took opportunities to raise awareness of issues such as domestic abuse by ensuring that there were materials to support victims available at Covid Testing sites. We also developed a more integrated approach to safeguarding in health across what will soon be the Hampshire and IOW ICS putting in the building blocks for future changes in the NHS. During the past year I feel as a partnership we have worked more collectively than I thought was possible, resulting in a workforce that is even more resilient and committed, to safeguarding children and their families.

The NHS will continue to face significant challenges over the coming year, but the resilience developed through the pandemic will help to drive forward improvements in safeguarding practice going forward. We are looking forward to working ever more closely with our safeguarding partners.

Tina Scarborough, Director of Quality and Safeguarding

The last year has presented safeguarding partnerships across the country with a series of unprecedented challenges linked to the pandemic. Partner agencies had to adjust long established ways of working, both as individual agencies, and in terms of how they shared information, acted effectively together and collectively maintained a 'line of sight' to those children and families most in need of support. That need can be acute in what we might describe as normal times but the onset of lockdown and the associated social, financial and emotional pressures magnified the necessity for multi-agency safeguarding.

The partnership in Portsmouth was, and remains strong. It has become even stronger over the last year. As Independent Chair of the PSCP I saw a reaffirmation of the commitment to protect and safeguard our children with strategic and operational engagement, innovation and an extraordinary effort to deliver and flex services as required. I had regular and open access to senior leaders from the Safeguarding Partners who led their respective organisations with drive, determination and a willingness to not only maintain service provision but improve wherever possible.

The PSCP is determined to learn from the pandemic, taking forward improved practices and identifying where further developments can be made. My role requires that I hold the partners to account and to seek assurance that safeguarding is recognised as being everyone's responsibility. The nature of the partnership in Portsmouth, the quality of leadership I have seen and the shared commitment to the city's children gives me optimism for the year ahead.

Our audit programme and the learning reviews we have published tell us that there can never be room for complacency, and the PSCP will continue to hold to account those tasked with safeguarding and promoting the wellbeing of our children.

Derek Benson, Independent Chair of Portsmouth Safeguarding Children Partnership

Context and Key Facts about Portsmouth

Portsmouth is a city on the south coast of England. It is the only city with a population density greater than that of London. 212,761[1] people live in Portsmouth, which covers 15.54 square miles.

41,491 (19.5%) are aged between 0-17 years - 21,193 are male and 20,298 are female

Age	Number
0-4	11,621
5-9	12,491
10-14	11,444
15-17	5,935

75% of Yr. R to Yr. 11 children are White British.

25% of children are from a wide ranging number of ethnic backgrounds, including Black African, Chinese, White and Asian, Indian, Bangladeshi and Pakistani.

15.6% of pupils do not have English as a first language. First languages spoken include Bengali, Arabic, Kurdish, Polish, Romanian and French.

Children eligible for free school meals:

- In a special school = 60.1%
- In a secondary school = 34.6%
- In a primary school = 30.7%

In Portsmouth 31% of children are living in poverty - a rise of 0.6% since 2015. This is in line with the national average, but higher than the average for the south east of England which is 24%

There were 572 households in 2019-20 (a rate of 22.8 per 1,000) with dependent children owed a duty under the Homelessness reduction Act.

This compare to a rate of 14.9 per 1,000 for England and 13.7 for the south east region

Education[2]

Portsmouth has:

- 45 primary schools
- 1 all-through school
- 11 secondary schools
- 4 special schools
- 5 independent schools
- 2 FE colleges

69.4% of children achieve a good level of development at the end of Reception, compared to a national average of 71.8%

58% of children in Portsmouth meet the expected standard at the end of key stage, compared to a national average of 65%

Absence & Rates in State-Funded Schools[3]

	Overall Rate of Absence	Persistent Absence	Fixed period exclusion [4]	Permanent exclusion
Portsmouth secondary schools	6.7	17.9	17.94	0.15
England secondary schools	5.5	13.7	10.75	0.20
Portsmouth primary schools	4.1	8.7	1.58	0.01
England primary schools	4	8.2	1.41	0.02

Because of the impact Covid had upon the taking of exams in 2019-20 and in school attendance, the Government has announced that it will not publish any school performance data for this academic

[1] https://www.hants.gov.uk/landplanningandenvironment/facts-figures/population/estimates-forecasts http://www.endchildpoverty.org.uk/local-child-poverty-data-2014-15-2019-20/

[2] https://www.compare-school-performance.service.gov.uk/

[3] Figures are for 2018/19, the most recently published figures

[4] https://explore-education-statistics.service.gov.uk/data-tables/fast-track/764f3fc5-eb9f-4b19-b112-2ffe38ab7684

year. Therefore the attainment at GCSE level and the absence & exclusion data for 2019-20 has not been published

5% of 16 & 17 year olds are not in education, employment or training, compared to a national average of 5.5%

Within primary schools 2.4% of pupils have an Education, Health & Care Plan (EHCP) and 12.7% have Special Educational Needs (SEN) support. In secondary schools 1.8% of pupils have an EHCP and 12.4% have SEN support.

Health[5]

For substance misuse the hospital admission rate for 15-24 year old is 71 per 100,000 compared to a national average of 84.7

The rate of children 0-5 year olds having a hospital admission for dental caries has increased to 32.6 per 100,000 compared to 21.2 in the previous year

Prevalence of obesity children in Yr. R is 11% for 2019-20, compared to 12.5% in the previous year. Whereas the rate of obesity in Yr. 6 has increased slightly to 22.1%, compared to 21.6% in the previous year

The rate for hospital admission episodes for alcohol specific conditions decreased to 26.5 per 100,000 in 2019-20, compared to 34 per 100,000 in the previous year

Hospital admissions for mental health conditions was 57.1 per 100,000 and as a result of self-harm in 10-24 year olds is 532.4 per 100,000 compared to a national rate of 439.2

Safeguarding

The Multi-Agency Safeguarding Hub (MASH) received 12,515 contacts in relation to 9,749 individual children.

It is difficult to compare this to numbers from previous years, as there was a change in recording systems in April 2020. The previous recording mechanisms wouldn't allow for a differential in the types of contacts for open and closed cases therefore historical contact numbers appear higher because of this.

259 children have a Child Protection Plan, compared to 204 children in 2019-20.

222.7 children per 10,000 have a CIN plan. This is in comparison to 180 in 2019-20.

379 children are Looked After in comparison to 463 during the same period in 2019-20.

COVID-19 and the impact on safeguarding

In response to the global pandemic the UK government announced in March 2020 national restrictions on movement, working arrangements and the closure of education and early years provision for a number of children and young people. These initial restrictions spanned a period of four months with localised restrictions being instated and then a further period of full lockdown being seen in January 2021.

The PSCP worked with partner agencies to understand these impacts and gain assurance in relation to how children and young people were being supported, and how services were adapting to ensure that children, young people and families continued to be seen. For the first four months the PSCP Executive increased the frequency of its meetings to offer an opportunity to review the pressures upon critical safeguarding arrangements caused by the pandemic, and to respond accordingly to any

[5] Public Health England - Child and Maternal Health

potential impact upon children and families in Portsmouth. What we saw was a quick adaptation to new ways of remote working during this period, with a sharp focus on retaining services for those children and families considered to potentially be at most significant risk of harm. However, this has led to some pressures and delays in other parts of the system, such as:

- A rise in mental health issues and self-harm stemming from isolation caused by the lack of social interaction;
- A delay to permanency for some looked after children with no adoption orders being processed for a period of a few months

To try and mitigate some of these concerns, the following was put in place:

Link Coordinators - In March 2020, as soon as the closure of schools was announced in the first lockdown, a range of professionals from across the PSCP Business Team, Children & Families Services and the Education Department came together to act as Link Coordinators with schools. The aim of this work was to liaise at least fortnightly with schools regarding their pupils who were either recognised as vulnerable due to being currently open to Children & Families Services, had an EHCP or that the school were concerned about because their vulnerability was increasing due to additional pressures brought about on the family due to lockdown restrictions.

The feedback from schools was that it had helped to improve multi-agency working by ensuring there was a good flow of information between the school and the Lead Professional. Schools also found that their Link Co-ordinators provided critical support to their work by providing both robust support and challenge in their consideration of vulnerabilities and determining the appropriate response. As a result funding was provided from the Local Authority to employ a permanent team of 3 Link Coordinators whose role will be expanded in order to:

- To encourage schools to identify emerging concerns about children and put in place a robust offer of support through an Early Help Assessment and Plan, to prevent these from escalating;
- Have focused discussions regarding children with chronic non-attendance;
- To engage in exclusions prevention work, by offering support in maintaining placements within schools ; and
- To ensure there is a proactive approach to children at risk of becoming NEET (not in education, employment or training), by identifying them early and actively engaging with the Post-16 Team to put in place appropriate support

Childrens Hub - providing a coordinated link to the support available from statutory services and the voluntary & community sector. To ensure that where support needs arising from Covid19 specific issues such as the need for food parcels, benefit information, welfare checks etc. could be directed to families in a timely manner. The Hub was stepped down in autumn 2020

Safe & Curious Conversations - initially some professionals, especially in universal services, reported some challenges in maintaining a sharp oversight of vulnerable children whilst working remotely and having to conduct safeguarding conversation via telephone rather than in person. In response, the PSCP produced guidance and delivered workshops to services (especially schools) where needed. This focused on the types of questions to ask and the responses to listen for.

PSCP Multi-Agency Training - Prior to the restrictions put in place by the Covid19 pandemic, the PSCP had always delivered the majority of its training face-to-face. In March 2020 in line with Government guidance, all PSCP face to face training had to cease. However the work to safeguard children did not stop, therefore it was our commitment to ensure we could provide them with the training to support practice and keep children safer.

In the interim period of April 2020 to August 2020 the training team worked to adapt practice, the content of courses and the method of delivery. By September 2020 all PSCP safegaurding children training was adapted to be delivered online via Zoom and the updated programme was made available to the workforce. More details of this can be found in the workforce development section.

Evidence of Impact - Many agencies have reported and identified the adoption of different and innovative ways of working which could continue in the future. Professionals have reported greater

involvement in multi-agency meetings held online as practitioners have not had to factor in travel and family involvement in some instances also increased due to the online approach.

However, the impact in working in such an intensive, but potentially isolated way has been recognised and agencies are considering how to achieve the right balance. There remains a good will to build on the positive ways of engaging with professionals and families which this report will report on next year.

Progress against last year's priorities

The priorities as outlined in last year's annual report were agreed as:

1. Learning from Cases - Publication of completed Child Safeguarding Practice Reviews, and to ensure our training and communications work is fully informed by the learning from Cases

2. Monitoring, Evaluation and Scrutiny - Ensure recommendation tracking process is robust. Carry out annual Compact audit self-assessments and continue with programme of deep dives

3. Workforce Development - Develop socially distanced training. Strengthen the programme for DSLs, managers and the exploitation offer. Support agencies to improve practice in priority areas.

4. Organisational Development - Create an effective Organisational Development model including the Leadership Coaching skills and Action Learning Set facilitation. Provide capacity for the Team Around the School model. Review the Partnership's understanding and proactivity around diversity and inclusion

5. Partnership and Process - Develop and promote clear guidance for 'stuck cases'. Provide greater clarity on all assessment and practice toolkits for the workforce

6. Communications and Campaigns - Relaunch of Trolls Campaign. Deliver all appropriate campaigning following case reviews.

7. Work effectively with sub-regional LSCPs - in Hampshire, Southampton and Isle of Wight

Learning from Cases

As well as our Local Child Safeguarding Practice Reviews (LCSPRs) being sent to the National Panel and published on the NSPCC repository; all of the PSCP LCSPRs are published on our own website and for each a 2 page briefing is produced to give practitioners a succinct overview of the case and to highlight the expected response as a result of the recommendations made.

Progress on the recommendations is tracked via the Monitoring, Evaluation & Scrutiny Committee and where insufficient or inappropriate action is taken against these, this is escalated to the PSCP Executive for a challenge to be raised with the respective services. Where necessary, task & finish groups are established to consider the production of additional policy, toolkits or development of resources as necessary.

The PSCP Training Team are now standing members of the PSCP Learning from Cases Committee so that all relevant learning about good and effective safeguarding is immediately embedded within the PSCP Training Programme. This includes learning from all cases referred to the committee, regardless of whether or not they meet the threshold for a formal LCSPR or not.

Child H - was published in October 2020 and involved a 10 year old child who died as a result of respiratory illness, alongside a background of complex disabilities including epilepsy. At the time of their death they were on a Child Protection Plan as a result of concerns involving neglect.

Child I - was published in July 2020 and involved the death of a 9 week old infant, whose cause of death was unascertained. However at the time of their death they were found in an unsafe sleeping position, co-sleeping on a sofa with a parent who had consumed alcohol.

Monitoring, Evaluation and Scrutiny

All recommendations made in relation to any work undertaken by the PSCP is now tracked centrally by the Monitoring, Evaluation & Scrutiny Committee (MESC). This has meant there is a much sharper focus on reviewing the progress against these, and by regularly reporting this to the PSCP Executive, timely challenge can be provided where necessary.

By centralising the process it has also enabled the consideration of recurring themes that are impacting good and effective safeguarding, such that these can then be prioritised for consideration of a robust response by partner agencies.

The annual Early Help & Safeguarding Compact audit self-assessment was completed by organisations that work with children and families in Portsmouth and the findings reviewed by MESC. The PSCP worked with the Partnerships in Hampshire, Isle of Wight and Southampton to complete a similar process for agencies that work across 2 or more of these LSCP areas, and the findings were reviewed by the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Executive.

Due to the impact the pandemic had upon primary care, a decision was made by the PSCP to not include GP Practices in this year's audit. However, safeguarding arrangements within Practices continued to be overseen by the CCG and arrangements were made that any concerns (of which there were none) would be reported to the PSCP Executive.

Due to the impact on capacity caused by the pandemic, and the need to embed other learning and improvement first, we have only been able to achieve one of the two planned deep dive audits. Priority was given to completing the deep-dive on the multi-agency response to children experiencing neglect, and the deep-dive on transition has been deferred until 2021-22.

Training and Workforce Development

All of the priorities identified last year have been achieved. These were to:

- Develop more learning for socially distanced training
- Develop exploitation offer including the launch of the new Child Exploitation Risk Assessment Framework (CERAF) tool
- Strengthen Designated Safeguarding Lead (DSL) induction, support and certification

More details on these can be found in the Workforce Development Section of this report.

Organisational Development

In response to the need to create an effective Organisational Development model, the training for Designated Safeguarding Leads (DSLs) and managers has been restructured. See the section on Workforce Development for more details.

Work has been undertaken in order to develop a multi-agency group of practitioners who can provide Leadership Coaching and Action Learning Set facilitation to the workforce.

The work to provide capacity into the Team Around the School model has been put on hold this year due to the pandemic and is hoped to be re-established in the 2021-22 academic year

Work has been started to improve the PSCP's dataset in order to have a better understanding of the needs of Black, Asian and Minority Ethnic residents in Portsmouth and the impact our current safeguarding system has upon these members of the community. The PSCP has considered partners' policies on diversity and inclusion to ensure they are appropriate to the needs as they are currently understood.

Partnership and Process

Following on from learning from cases last year, it was agreed as a priority to develop and promote clear guidance for 'stuck cases', using reflective practice and escalation. In response, following consultation with the workforce the PSCP has developed a new 'Re-think' approach. Whereby professionals come together to reflect on a case either virtually, on the telephone or face-to-face to explore current concerns with a child's case and find resolutions. This guidance has been produced to

help practitioners and managers across the Portsmouth Safeguarding Children Partnership resolve disagreements or concerns in a constructive, restorative way, which keeps children safe. This was launched in February 2021 and will be continually evaluated to assess impact and effectiveness.

In response to learning from practice and feedback from practitioners, the PSCP have been working on providing greater clarity on all procedures, assessments, toolkits and resources for practitioners. Key to this has been distinguishing what **must** be done/followed, as opposed to those which are provided to be helpful but there is no obligation to use. In order to achieve this all identified resources have been reviewed and updated where necessary, as have the One Minute Guides that accompany these and give context and explanation as to how and when to use them. This has been a lengthy process, supported by practitioners from across many services. This work is now complete and the PSCP website is currently being re-written to give more clarity in response to various safeguarding concerns, what is available and how to use them. This work is due to be completed by July 2021, and the impact this has on practitioners understanding and confidence in the resources available will be evaluated 6 months after launch.

Communications and Campaigns

The Lurking Trolls campaign was originally designed in 2013 to support children in key stage 2 with developing more awareness of online safety. In 2018 the Home Office approached the PSCP to see if the campaign could be re-designed to build digital resilience in this age group to new and emerging online safety concerns such as fake news and radicalisation. The PSCP secured the support of the LSCPs in Hampshire, Isle of Wight and Southampton with this redesign and work is almost completed. The new Lurking Trolls campaign - The Peril of the Possessed Pets - is due to launch in June 2021.

Following the launch of the Safer Sleep and ICON campaigns last year, the PSCP has continued to promote these messages to practitioners and embed these in all relevant training. Since this there have been no serious incident notifications of infants suffering abusive head trauma, though tragically there has been the death of 1 infant whilst in a co-sleeping situation. The PSCP is currently working with its partner agencies in health to develop a training course that will focus on safeguarding unborn babies to infants aged 3 years and incorporate messages from the Unborn/Newborn Baby Protocol, the Bruising Protocol for Non-mobile Infants, Safer Sleep Procedure and ICON.

The PSCP uses a range of methods to communicate on our safeguarding priorities with the workforce - through briefing notes, items in services' newsletters, monthly reports on activity to senior managers of partner agencies, through our training programme and a twitter account. All of the communication provides links to the PSCP's website which is the central repository of information for the workforce. What we have seen as a result is a 46.9% increase in the number of unique page views on the PSCP website, from 7,211 in 2019-20 to 10,593 in 2020-21.

Work Effectively with the LSCPs in Hampshire, Isle of Wight and Southampton

The PSCP continues to support the HIPS Executive Committee and its Exploitation Strategy and Procedures sub-committees. All recommendations and learning from the work undertaken is actively considered as to whether it is more appropriate to develop in conjunction with the other 3 LSCPs and, where it makes sense to do so, this is recommended to the HIPS Executive Committee for consideration.

This year the key initiative developed across HIPS are:

- The completion of the Exploitation Strategy
- The re-design and launch of the Unborn/Newborn Baby Procedure
- Completion of the Section 11 Safeguarding and Early Help assessments for services that operate in 2 or more of the LSCP areas.

Whilst working across HIPS is beneficial for services that operate in 2 or more areas, as it provides more consistency in the procedures and processes that practitioners have to follow, it does potentially lead to delay in the completion of some work.

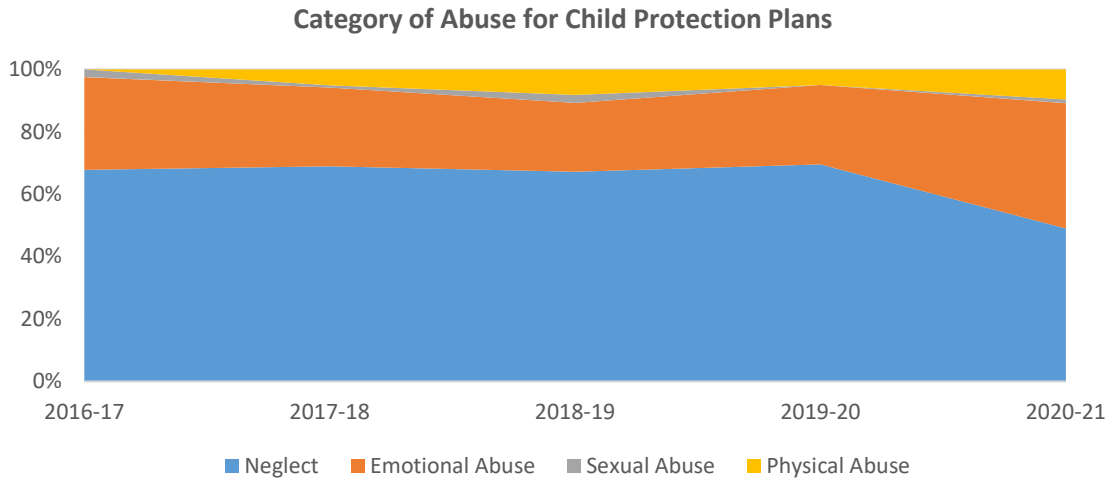
The Effectiveness of Safeguarding Arrangements

PSCP Dataset

Since 2010, the PSCP (formally the Portsmouth Safeguarding Children Board) has maintained a multi-agency dataset. This currently consists of 196 indicators, broken into 9 blocks to consider:

1. **Child Protection Processes -** the rate of children per 10,000 on a Child Protection (CP) Plan has remained consistent over the last 5 years (55.25 in 2016-17 and 58.8 in 2020-21), but we have seen a decrease in the percentage of children requiring a second or subsequent plan ever (20.3 in 2016-17 and 13.85 in 2020-21). This decrease will need monitoring to see if it can be maintained.

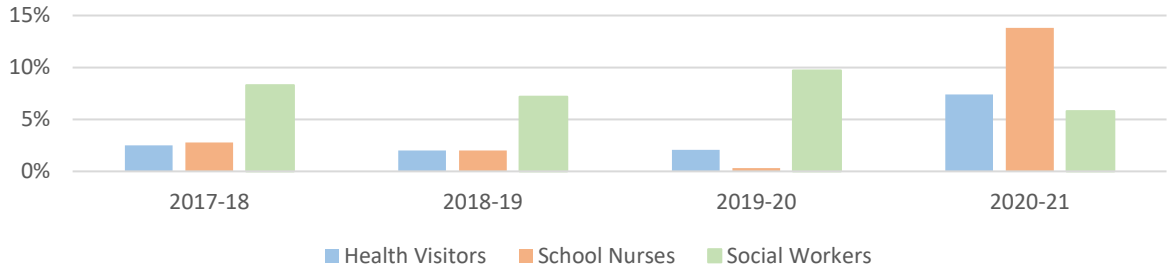
   What has changed significantly this year is the categorisation of CP Plans. Whilst neglect remains the most frequent reason for a child being on a CP Plan, the percentage of plans under this category has significantly reduced and there has been an increase in emotional abuse being the reason cited for the CP Plan. This is likely to be as a direct result of a recommendation made to Children & Families Service following the findings from the Deep-Dive into neglect undertaken during quarter 3 of this year. It was found that when reviewing CP Plans under the category of neglect, that this focus on the resultant neglectful parenting a child was experiencing was failing to sufficiently focus the plan on the causal factors in the parent's ability to adequately meet their child's needs. Often in the examples reviewed the neglect experienced was as direct result on the parent's lived experience of domestic abuse or criminality within the family. The concern was that by naming neglect as the primary issue this led the plan to not sufficiently address the issues within a family that needed to change in order to improve the parenting capacity. The impact this has upon families will be monitored throughout the year by reviewing whether it reduces the amount of time before a child can be stepped down from a CP Plan, and whether we see a reduction in the number of children requiring a second or subsequent plan.



2. **Child in Need -** the rate of children on a Child in Need Plan per 10,000 has increased by 23.7% from last year - from a rate of 180.02 in 2019-20 to 222.7 in 2020-21. However despite this increase, for the first time since 2015-16 throughout the year 100% of children have, had an allocated Social Worker.

3. **Early Help -** as has been noted at the beginning of this report, Children & Family Services changed its recording system in April 2020. As a result the number of Early Help Assessments being completed across tiers 2 and 3 are no longer being records. The PSCP is currently working with partner agencies to find a suitable solution to this.

4. **Workforce -** The vacancy rate in both Health Visiting and School Nursing is at the highest rate it has been since we routinely started to record these figures in 2017. However, these are small teams and so the rate can easily be affected by a small number of vacancies.



5. **Child Deaths -** Sadly there were 8 deaths of Portsmouth children this year, these all occurred after the 1st July as there were no child deaths reported during the first period of the national lockdown in Portsmouth. No adults were arrested or charged in connection to any of these deaths.

6. **Wider Safeguarding Issues**

   a. **Neglect -** Despite there being 132 crimes recorded for neglect with 95 suspects linked to these, only 17 people were arrested for neglect offences and these led to only 5 people being charged in connection to these.

   b. **Missing, Exploited and Trafficked (MET) Children -** The number of episodes of children reported as missing was the lowest it has been since 2016. There has been a promising downward trend over the past 4 years, but this year's decrease is most likely to be as a direct result of the lockdown measures brought in as a response to the pandemic.

Total episodes of missing children

2016-17	2017-18	2018-19	2019-20	2020-21
1577	1512	1376	1060	970

There was a 40% reduction in the total number of children flagged at risk of sexual exploitation (CSE) who were discussed at the MET Operational Group this year. Aside from the lockdown being a preventative measure to the risk of CSE, the group also spent some time this year reviewing all of the children on the list and removing any where the risk had been reduced sufficiently.

Number of children at risk of CSE

	Low risk	Medium risk	High risk	Total
2019-20	9	15	38	62
2020-21	20	9	9	38

A revised risk assessment tool was also introduced in September and there was a large number of staff trained in its use. So the decrease in the total number is unlikely to be as a result in professionals not being familiar with the tool, but may possibly explain the change in the identified level of risk. This will be closely monitored throughout 2021-22.

However, the number of children linked to CSE crimes occurring online rose this year to its highest level. This reflects the national concern that during lockdown more children spent time unsupervised online and were potentially more vulnerable to online harm.

Number of CSE online crimes

2016-17	2017-18	2018-19	2019-20	2020-21
35	18	17	18	36

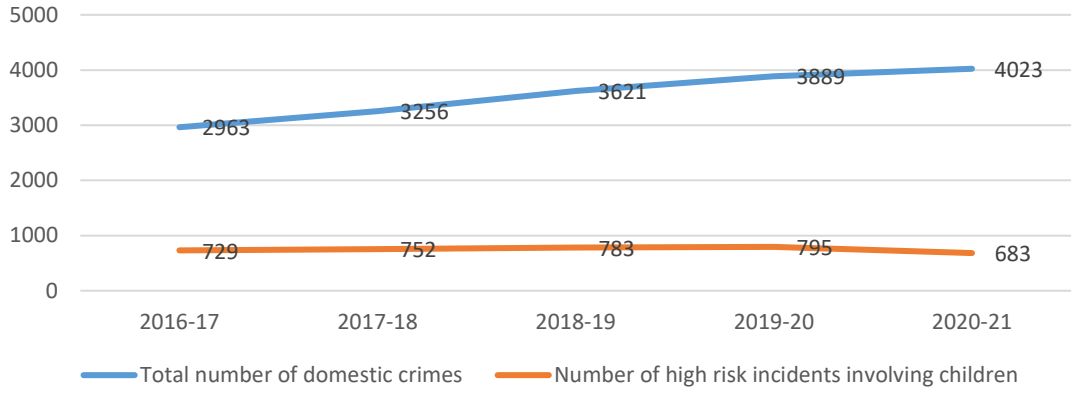
The number of children identified at risk of criminal exploitation is a new indicator for this year and so no comparisons can be drawn.

Number of children at risk of CCE

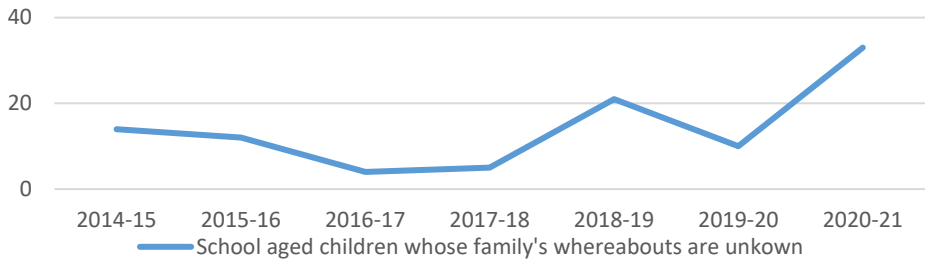
	Low risk	Medium risk	High risk	Total
2020-21	32	33	26	91

There were 9 children reported as being victims of trafficking offences during 2020-21.

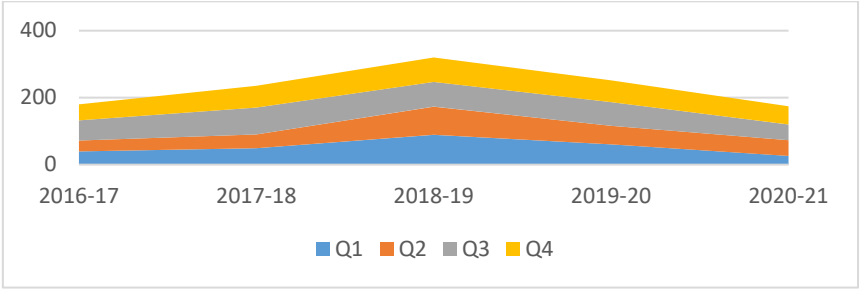
c. **Domestic Abuse** - the number of domestic crimes in Portsmouth continues to increase, however the number of high risk domestic incidents occurring in households where children were present has decreased by 14% in 2020-21



d. **Young People at Risk** - the number of school aged pupils whose family whereabouts are unknown and have been removed from a school roll, increased significantly in 2020-21. This is due to a marked increase in referrals from schools of pupils who left during the closure of schools in the spring or summer term, without saying they were going or never returned from where they said they were going. These children's details have been passed to the MASH who will work with the police to locate the family and check on the child's welfare.



7. **Allegations -** The number of allegations received by the Local Authority Designate Officer had been steadily increasing between 2016 and 2019, however the last two years have shown a significant decline. Whilst the decrease this year can be accounted for due to the lockdown restrictions meaning that not as many staff were working directly with children, this does not account for the decrease in 2019-20. The PSCP will want to understand what work the LADO is doing to communicate the allegations process to the workforce and to ensure that incidents are being appropriately reported.



8. **Looked After Children** - The number of children who are looked after reduced by 18% from 463 in 2019-20 to 379 in 2020-21. This decrease is due to two factors:

a. Targeted work was undertaken with the National Transfer Scheme during October to March to support appropriate moves in other other local authority areas for Unaccompanied Asylum Seeking Children who were being looked after in Portsmouth; and
b. Some is due to the positive impact from the implementation of the Family Safeguarding Model, which has enabled us to work with parents to address need and to build resilience to enable them to continue caring for their children.

9. **Partnership Engagement -** Despite the challenges the pandemic has had upon capacity in the PSCP partner agencies, their commitment to supporting the work of the Partnership has not been affected. In fact attendance at the full Partnership meeting has actually increased in 2020-21 to 72% from 56% in the previous year. Attendance at MESC has also risen from 67.5% in 2019-20 to 75% this year, and attendance at the Learning from Cases Committee has been at 84%. No PSCP meetings have had to be cancelled due to inquoracy.

Multi-Agency Safeguarding Hub (MASH) Audits

The MASH Strategic Board has overseen quarterly multi-agency audits that have an overall focus on quality, consent and threshold. Every quarter the Board agrees the thematic aspect of the audit informed by key lines of inquiry from performance data and agency requests. In 2020/21 the audits undertaken were as follows:

Quarter 1: Quality of referrals - Health
Quarter 2: Quality of response to referrer
Quarter 3: Quality of referrals - Schools
Quarter 4: Repeat contacts

Q1: Quality of referrals received from Health - the Joint Targeted Area Inspection (JTAI) undertaken in December 2019 identified that, 'while referrals to the MASH are timely, the quality of referrals by partners is not consistently good'.

The audit found that in too many cases referrals into the MASH lacked critical information and it was left to the MASH practitioners to do additional information gathering to support their decision making. The audit evidenced that consent had not been sought and that agreement for the referral to be made was not evidenced.

An action plan was developed to support targeted learning and development focusing on an improved understanding of consent and supporting health partners to understand what a good referral looked like. A review audit undertaken in quarter 1 2021/22 evidenced significant improvements in the quality of referrals and timely decision making.

Q2: Quality of the MASH response - this was an area of practice development that had been highlighted in the JTAI, where Inspectors found that '*Referrers and key agencies are not always informed of outcomes of referrals or notifications sent to the MASH'.*

Following the JTAI Children's Social Care had reviewed processes within the new IT system (Mosaic) and a responses to referrer step was introduced to support improved communication. The audit reassured the partnership that concerns were addressed and in all cases requiring a response this was evident on the child's record.

Q3: Quality of referrals received from schools - in the majority of cases reviewed the school had provided information that enabled MASH to make a timely and informed decision. In 90% of cases threshold for Tier 4 services was met and consent was appropriately sought. It was demonstrated that schools engagement with the PSCP training offer is supporting their understanding of 'what a good referral looks like'.

As a result of the audit, two masterclasses were delivered to DSLs and Safeguarding Leads in January 2021 focusing on thresholds and quality of contacts. We plan to revisit this audit in the 2021/22 schedule, but performance data from our MASH evidences that schools have a good understanding of threshold with the majority of cases referred in sitting appropriately at Tier 3 and 4.

Q4: Cases where there had been a number of repeat contacts in the previous 6 months - the audit process found that a number of the cases related to private law matters and that contact for fathers was a specific issue that resulted in high levels of contact with the MASH (this was exacerbated by COVD 19 restrictions). In other cases there were multiple contacts (from different sources) relating to the same incident. The partnership was reassured that the audit did not identify concerns relating to threshold decision making.

Evidence of impact - these audits demonstrate that we have a good and effective MASH, which is routinely ensuring that families receive the right support based on their level of need. The quality of contacts from schools appears to be improving and their understanding of the thresholds in Portsmouth appears sound. A target for next year, to be taken forward by the Portsmouth Safeguarding Improvement Hub, will be to consider how the quality of contacts can similarly be improved in other partner agencies.

Safeguarding & Early Help Compact Audit

Section 11 of the Children Act provides the PSCP with an opportunity and a framework to undertake an analysis of safeguarding arrangements within statutory organisations. In order to understand children and families experience of safeguarding and early help across all services in Portsmouth - the PSCP has a much more extensive approach and has developed a self-assessment tool that in addition to Section 11, considers the duties placed upon those voluntary & community organisations, education settings under Section 175/157 of the Education Act 2002 and upon early years settings under section 40 of the Childcare Act 2006. This tool is referred to as the Portsmouth Safeguarding & Early Help Compact and it is currently used with 169 organisations that work with children in Portsmouth.

There are differing versions of the Compact for the different types of settings, and whilst there are different indicators to reflect their differing duties they are measured against the same 12 Standards. This enables the PSCP to analyse any areas where gaps in knowledge or understanding relating to safeguarding and early help for all settings across the city. The 12 standards are:

1. Senior management commitment to the importance of safeguarding and promoting the welfare of children
2. Staff responsibilities and competencies (the term staff also refers to volunteers)
3. A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
4. Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families
5. Induction, training and appraisal for staff and volunteers on safeguarding and promoting the welfare of children
6. Recruitment
7. Allegation management
8. Effective inter-agency working for early help and to safeguard children and promote the welfare of children
9. Information sharing
10. Equality of opportunity
11. Disabled children
12. Additional specific requirements for commissioning bodies

An aligned version of the tool overseen by the HIPS Executive is used for twelve organisations that have duties under Section 11 and operate in Southampton, Isle of Wight and Hampshire as well as Portsmouth. The number of questions in the HIPS version of the tool was reduced this year, in order to decrease the amount of time it took for them to complete it (in recognition of the impact the pandemic has had upon capacity in services such as the police, hospitals etc.)

Organisations are required to submit their completed return to the PSCP once every two years, but we strongly encourage services to use the tool more regularly in order to assist a culture of continuous

improvement. To ensure the proper accountability for safeguarding arrangements, the Compact audit tool must be signed off by the senior manager, headteacher or owner of the organisation.

The learning from this year's returns highlighted that all organisations considered themselves to have effective safeguarding and early help arrangements in place. Where any service indicated an area of practice which they assessed required improvement, then an action plan has been put in place. The PSCP has reviewed these plans and will require an update on progress within 6 months.

For the returns from statutory organisations and early years settings there was no one standard that was consistently identified by them as requiring improvement. For education settings standard 4 was the only area where a significant number (17%) felt that their practice could be improved.

To ensure that the learning opportunity from this process is maximised, a sector specific report is circulated to all settings in the city. This includes advice, guidance and examples of how practice can be improved for all indicators where over 9% of services reported that practice required improvement.

In recognition of the impact the pandemic has had upon capacity in primary care, GP Practices were not required to submit a Compact Audit this year. Work is underway with the CCG to look at merging their safeguarding assurance tool with the Compact for next year's audit, in order to reduce duplication.

Evidence of impact - The grades given for the Compact continue to improve year-on-year, demonstrating services increased confidence in their understanding of safeguarding and early help arrangements in Portsmouth. However, for this model of self-assessment to be effective it is reliant on services fully understanding its purpose, being rigorous in their self-assessment and willing to be transparent about the strength of their current safeguarding arrangements. The PSCP has recognised that some services are not as robust in their assessment as they could be. Issues have been identified in safeguarding arrangements by external inspections by statutory regulators (e.g. Ofsted) conducted not long after completion of the Compact, that weren't identified by the service themselves. In response to this we emphasise in the learning summaries circulated to services this variance that has been noted and encourage them to see the Compact as a diagnostic tool, to apply more rigour in their assessments and to avoid being overly optimistic of their practice. This message is also reinforced in the ' Developing a safegaurding culture - The Portsmouth Compact' workshop for DSLs and managers that has been developed. We are also working more closely with the Education Service in the local authority to triangulate the Compact returns with the education or early years settings most recent Ofsted inspection outcomes and performance data, so that the PSCP can challenge where appropriate any assessments that still appear overly optimistic.

Recommendation Tracking

Over time the Portsmouth Safeguarding Children Board tried many methods of tracking the recommendations made to the multi-agency safeguarding system in Portsmouth resulting from case reviews, data analysis, audits and inspections. The PSCP has evolved a method by which they are all centrally recorded by the PSCP Business Unit and once every 2 months relevant agencies are sent a request to update their progress against these. The returns are presented to the Monitoring, Evaluation & Scrutiny Committee whose role is to consider whether the action fully meets the ambition as set out in the recommendation; and whether there is sufficient evidence of the robustness of its implementation and/or impact on the effectiveness of improving safeguarding arrangements.

	Number at start of year	Completed in year	New, added in year	Outstanding at end of year
Adult Services	3	3	0	0
Portsmouth CCG	2	1	2	3
Fertility Clinic	2	2	0	0
Hampshire Constabulary	7	1	3	9
Children's Social Care	37	6	4	35

Children's Trust	5	3	0	2
Early Help & Prevention	2	2	0	0
Education Service	4	3	0	1
Portsmouth Hospital University Trust	3	0	1	4
PSCP	7	4	33	36
Solent NHS Trust	6	5	2	3
Total	78	30	45	**93**

Evidence of impact - For some of the recommendations, agencies have chosen to split these into multiple actions to support their implementation. This means that whilst there appears to still be 48 recommendations from 2019-20 outstanding, closer analysis of these would show that either considerable activity has occurred and they are awaiting completion; or the actions are all complete and MESC are awaiting an evaluation of their implementation before considering it completed. MESC is rigorous on not signing off any recommendation until there is evidence that it is embedded into practice and/or there has been an evaluation to demonstrate it is having the desired impact. So this often extends time taken to sign off some of these recommendations by 6-9 months, as it may take this long to allow the work to be embedded before an evaluation of its impact can be undertaken.

Deep Dive - Children experiencing neglect

The primary purpose of the Deep Dive methodology is to assess the quality in a chosen area of practice and includes the following components:

- Multi-agency case audit
- Voice of the family
- Learning from case review findings
- Multi-agency data
- Practitioner survey
- Workshop event

Neglect was prioritised for this deep-dive by the Partnership as it still is the main reason given as to why approximately two thirds of children are on a Child Protection Plan. The PSCP has completed previous audits on the theme of neglect in 2014 and 2017. This activity generated actions and recommendations, including the development of a new strategy, toolkit and practice guidance. Within the strategy, there are identified measures for success including a reduction in the number of cases open on a CP Plan for neglect and a decrease in the number of repeat referrals for neglect. It is apparent when reviewing these measures that the desired outcomes from previous recommendations have not been achieved and the same issues remain. So this deep dive was done to try and better understand why these previous measures have not been as effective as we'd hoped.

What we've learnt - The findings of this 2020 Deep Dive appear to fall into two categories, those that are specific to neglect and others that more broadly relate to good and effective safeguarding practice.

Practice to support children experiencing neglect	
What's working well?	**What are we worried about?**
• In families where neglect had been identified, the parents clearly understood what the concerns were and which of their children's needs they were not meeting. This is crucial in empowering parents to improve the care they give.	• There was limited evidence of practitioners' awareness and use of effective, evidence based interventions to address neglect.
• Those who had used the Neglect Identification & Measurement Tool (NIMT) described its benefits as being "a useful way	• The NIMT is not widely used and is considered to be too lengthy to be routinely used

to focus your thinking when you 'know' something isn't right but haven't worked out why you 'know' that"	
• GPs have also put a Safeguarding Processes in place so that when there has been 3x missed appointments or vaccinations missed, they raise their concerns with other appropriate health colleagues	• Medical neglect is often not recognised until the child is experiencing significant harm as a result
• In all cases there was evidence of consistency with the Portsmouth Model of Family Practice, with all family members being included in the plans.	• In some cases the categorisation of neglect is being used too broadly and failing to recognise other harm as well as the causal factors that are leading to the child being at risk of significant harm
Good & effective safeguarding practice	
What's working well?	**What are we worried about?**
• Local Authority Link Co-ordinators have been employed to work with schools using a restorative approach, being curious in their communication when discussing individual children & families, keeping the child's needs at the centre of the conversation	• Contacts into MASH being made without there ever having been an Early Help Assessment and an attempt to provide support early in order to prevent the escalation of concerns
• All of the schools involved in the cases reviewed showed a good understanding of the safeguarding concerns in the family and how these were impacting on children. There were some good examples of schools advocating for the need for services for families.	• Whist improvements have been made, there is still more to do to ensure we are consistently exploring and recording the child's voice and lived experience
• Health Visitors were described by families as being very good at ensuring both parents were equally included in the service provided for their child, even when they are separated and not living together. Parents also told us that they felt the social workers built good relationships with the children	• There needs to be better awareness of the HIPS Escalation Protocol, to highlight the importance of professional challenge. Also to embed the new 're-think' practice to provide practitioners with the facility and support to review stuck cases
• Home Start's parenting courses were valued, by helping unpick the parent's experience so they are empowered to improve their parenting skills which in turn improves the outcomes for their children	• We need to see that in all cases there's been a robust assessment of a parent's capacity to change that is shared across relevant practitioners and used to inform planning and decision making with the family.

Evidence of impact - the change in the categorisations of Child Protection Plans (as reported in the dataset) appears to be as a result of this deep-dive. It is too early to demonstrate any other change. However, since the learning has been shared with the PSCP the partner agencies have committed to the following next steps:

1. Hold workshops with the workforce to understand what types of support and interventions they currently use with families where neglect is identified as an issue. Use the information from these to identify any current gaps in resources or provision, to inform updating the neglect strategy, toolkit and practice guidance.

2. Set up a working group to review the current Early Help Assessment and Plan to make it easier for universal services to identify risks and strengths and to plan and deliver change accordingly.
3. Work with partner agencies to raise awareness of the Escalation Protocol and Re-Think Process and support them with embedding this into practice.
4. Review our practice on assessment of parental capacity to change at early help and child protection levels
5. We will offer more tailored restorative practice training to services that work with families, to support the development of more effective, relational based working with parents, carers and children

Tackling Child Exploitation

Last year the PSCP completed a deep dive into the experience of children vulnerable to criminal exploitation. As a result of this we said we would:

1. refresh the Portsmouth Missing Exploited and Trafficked (MET) Strategy;
2. work with Research in Practice and The University of Bedfordshire on our successful on 'Tackling Child Exploitation' (TCE) bid;
3. review our approach to identifying risk for individual and groups of young people and responding at the earliest opportunity considering both the risk assessment framework and the training available to support the workforce; and
4. Provide greater clarity on joint working arrangements at the local, operational level

1. Exploitation Strategy - As Hampshire Constabulary and many of our health partners and voluntary sector organisations work with children vulnerable to exploitation in Hampshire, Isle of Wight and/or Southampton as well as Portsmouth, it was agreed that we would work with the HIPS Exploitation Group and develop a strategy that covers all 4 areas. However, to reflect local need and service delivery each area is responsible for their own delivery plan with the PSCP have responsibility and oversight of Portsmouth's. This strategy was finalised in July 2020 and its delivery is overseen by the PSCP Exploitation Strategy Delivery Group with membership from strategic leaders and managers from relevant services across the city.

2. Tackling Child Exploitation Support Programme - unfortunately this work was impacted by the restrictions in place due to Covid19. It meant the start was delayed until June and that all work had to be done virtually. As part of the scoping and consideration of what could be achieved the overall goal of the project was amended to how multi-agency data could be used to identify places and spaces in Portsmouth where children were most vulnerable to exploitation. The aim being that this map of 'hot-spots' could then drive disruption activities by better identifying perpetrators and bringing them to justice; and providing targeted youth work and positive activities for the children to engage in as an alternative to engaging in the exploitation. During the course of the project workshops were held with strategic leads and data analysts and a number of core reflections and themes were identified:

- This work isn't just about data, we also need to think about how response shaped by intelligence may need to shift.
- There is a need to think about capacity before embarking on any further activity. For work to be meaningful it should be ongoing and embedded throughout the partnership approach.
- There is a need to be clear about the parameters and limitations of this work at both strategic and operational levels.
- Consider what is within the gift of the partnership and promote and share current tools/approaches which already exist rather than looking to start from scratch with entirely new ways of working.

These outcomes are to be presented to the Partnership to consider how best to take them forward.

3. Child Exploitation Risk Assessment Framework and exploitation training - prior to this year, Portsmouth was using a different risk assessment framework to identify children potentially vulnerable to exploitation than the other 3 LSCP areas. In order to improve consistency of practice and

reduce the risk of confusion amongst the workforce, the PSCP agreed to work with the HIPS Exploitation Group on the development of a new Child Exploitation Risk Assessment Framework (CERAF) that was also launched in September 2020.

There have been many changes made to the training offer this year, and more details of these are given in the Workforce Development section of this report. Below is a summary of the courses held this year and the attendance from partner agencies.

	Children & Family Services	**Health**	**Police**	**Education**	**Voluntary sector**	**Other** (Incl. Youth & Play Services, Early Years, Armed Services)
Exploitation - multi-agency	12	8	0	4	6	1
Exploitation - bespoke, single agency	25	0	0	50	0	25
CERAF	58	9	n/a	26	10	7
CEOP - online safety	10	7	2	19	3	1
Victim blaming[6]	11	0	0	0	0	1

4. Greater clarity on joint working arrangements - All of the One Minute Guides relating to missing, exploitation and trafficking have been reviewed and updated accordingly. The PSCP website is being re-written to make information more accessible to practitioners, to that it is clearer as to what is statutory guidance and legislation; what are the toolkits to be used to help assess and identify risk; and what is helpful information. The Exploitation Strategy Delivery Group has also undertaken a scoping exercise. This has identified all of the various groups and meetings held within Portsmouth to identify children at risk to provide greater clarity about their purpose, reduce unnecessary duplication and to ensure there is robust communication between these. The services that can support children at risk from missing, exploitation and/or trafficking have also been scoped to include details of what they do, who they can support, when and how to contact them - this directory has been shared with agencies and will also be available for practitioners on the PSCP website.

In addition to this multi-agency work, below are some examples of targeted work that has been undertaken this year by agencies working within Portsmouth:

Hampshire Constabulary - launched its Child-Centred Policing (CCP) strategy with the aims of

- Working together in partnership to recognise children who are vulnerable or at risk and respond effectively to protect them
- Identifying and bringing to justice those who seek to exploit vulnerable children or do them harm
- Ensuring a coherent youth offending approach, which has a clear focus on intervening early to prevent young people being drawn into the criminal justice system but which also is effective in managing the small number of serious young offenders who cause, or who would cause, the highest harm to others
- Building stronger relationships with children and young people by improving engagement

The operational response has included the following 2020/21:

- Op Salvus – High risk missing child pilot in Hampshire Constabulary aimed at improving focus on high risk missing children at risk of exploitation. To reduce the risk of harm, reduce number of missing episodes, reduce length of time missing. (evaluation awaited)
- Missing People charity commissioned to "help identify further areas of improvement, specifically linked to the accuracy, value and quality of 'Safe and Well Check' reports in safeguarding children

[6] This is a new course and so only 1 workshop has been held so far in March 2021

Areas for improvement identified and being addressed through child centred policing delivery plan

- Work with PSCP trainer Kelly Huggett around developing a workshop on the use of inappropriate language, victim blaming and unconscious bias, which is now being used to train 50 CCP champions in Hampshire Constabulary.
- Trauma-informed training being rolled out across the constabulary and with partners through 2020/21
- Deliveries in schools around exploitation, gang violence, county lines and knife crime took place during 2020 and planned during 2021
- Operation Keepsake – a prioritisation assessment tool focusing on inappropriate relationships between children and older males used in Portsmouth (which is being rolled out across HIPS once model revised for other districts)

Children & Family Services:

- Have facilitated group work with a targeted group of girls who were vulnerable to exploitation. This work was successful in reducing the risk and a group programme will be developed based on the learning from this
- Have commissioned the St Giles Trust (in partnership with the OPCC and VRU network) to work with year 6 and 7 in 10 schools on highlighting risks of gang and knife crime.

Early Help & Prevention (EH&P) Service:

- Created an additional 3 exploitation specialist roles and created a Preventing Youth Offending role within the service. These specialists offer a Team around the Worker model to provide advice and guidance to workers within the early help 0-19 provision.
- Created a training programme for Early Help Workers on preventing youth offending and the use of Risk of Anti-Social Behaviour and/or Offending (RASBO) tool to identify children early on that are vulnerable
- Embedded a Police Community Support Officer within EH&P for a year carrying out direct work with young people identified using the RASBO as potentially vulnerable to youth offending

Play & Youth Services:

- Has ensured that all training relevant to identifying and safeguarding children vulnerable to exploitation is embedded within their services training schedule.
- Have promoted the 'Is This Love?' campaign in youth centres to encourage conversations with young people about potential forms of abuse in their relationships
- The service has worked on strengthening their relationships with the local police teams, and regular visits have provided a visual confidence that police are here and paying attention to the community issues. As a result the children have police officers that they know by name and are happy to engage with when they see them, and parents speak positively about the their children engaging with police

Crime Prevention Community Coordinator - In response funding from the Home Office has been used to employ a Crime Prevention Community Coordinator. Two of the specific initiatives they're involved in that seek to address this rise are:

1. The creation of an interactive resource for delivery in schools, as well as youth and community settings, called 'Your Choice Matters'. The resource depicts a fictional hate & knife crime incident in Portsmouth which young people need to view from the perspectives of different communities, improving understanding and empathy and deterring involvement in hate crime and knife crime. The resource will be trialled over the summer and ready for the autumn term.
2. The creation of a network of spaces of safety or sanctuary, not just for women and girls but also for boys/men who need safety from abuse, harassment, domestic violence and other forms of harm including exploitation. The aspiration is to create a city-wide network of venues but will initially launch in the south of Portsmouth.

Learning from Child Safeguarding Practice Reviews

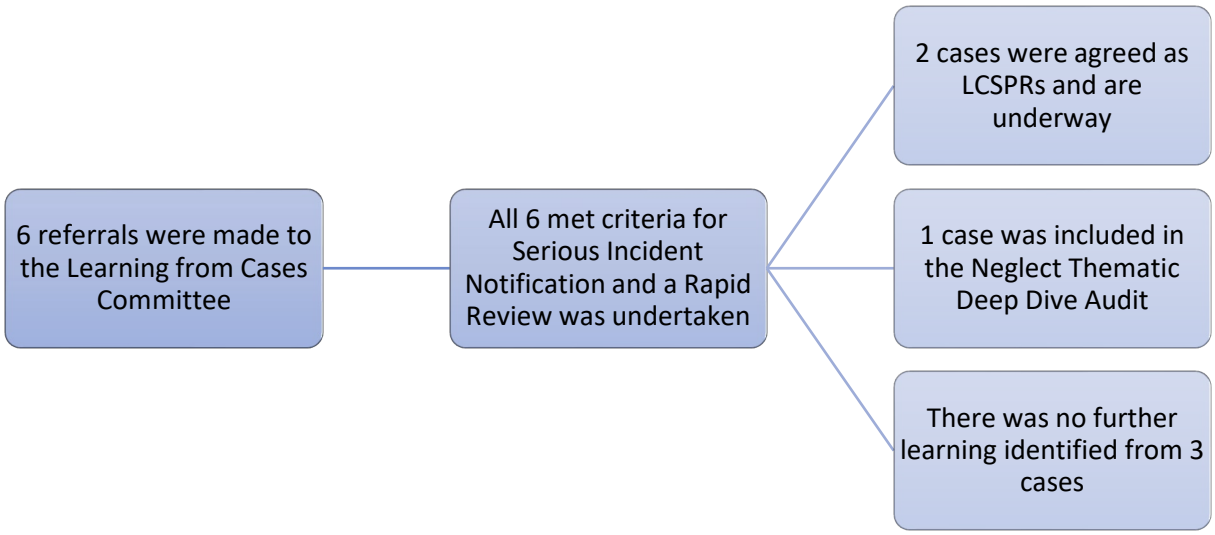
In accordance with Working Together 2018, a Local Safeguarding Partnership should consider undertaking a Local Child Safeguarding Practice Review (LCSPR) when it is thought that the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

If a case meets the above criteria it does not mean that a LCSPR must be agreed. It is for the local area to determine the relevance and opportunity for local learning and development.

Where a case meets criteria for a Serious Incident Notification as per Working Together 2018, the Local Authority is required to notify Ofsted. The Partnership then has 15 days to carry out a Rapid Review and make a formal decision regarding any further review. All decisions are agreed by the Learning from Cases Committee, the Safeguarding Partners and the Independent Chair.

During 2020-21:



Child I - published July 2020

Child I died in August 2018 aged 9 weeks having had no previously identified health concerns. The cause of death was unascertained; however Child I was found in an unsafe sleeping position co-sleeping with a parent. They were not known to Children's Social Care prior to the incident. The full findings of this Serious Case Review (SCR) are set out in the Overview Report that has been published on the PSCP Website.

What we have done as a result of learning from the Child I's review:

In the case of Child I the parents had been provided with clear guidance on the dangers of co-sleeping. However, awareness raising on this important issue is necessary on an on-going basis. A HIPS wide campaign took place during the week 9 - 15 March 2020 to coincide with National Safe Sleep week. A campaign launch event was organised for 9 March at the Portsmouth Central Library with representatives attending from all 4 LSCP areas. Workshops on safe sleeping took place over the remainder of the week with attendees from a variety of organisations within the city to ensure the right messages were delivered.

In efforts to ensure that new parents are consistently given safe sleep messaging, The Family Nurse Partnership and Health Visitor leads have developed a template to prompt discussion about safe sleeping during out of routine events. Key messages have also been disseminated widely across agencies through leaflets, laminated posters in public areas and further discussion in team meetings and supervisions. The PSCP Training Team made adaptions to their current training programme to ensure that those messages are integrated. The Team are also working with Solent NHS and Portsmouth CCG to develop a workshop combining Safer Sleep, ICON and the Unborn Baby Protocol into a course looking at safeguarding unborn babies through to 2yr old infants. This is work in progress.

Portsmouth Hospital NHS Trust created a 'Supporting Staff Involved in an Incident, Complaint or Claim' policy. This policy guides and supports managers in the supervision of difficult or upsetting cases and contains a staff support checklist. When used in conjunction with ongoing pastoral support from their team leader, this will ensure that all available support is offered to them following an adverse incident.

Solent NHS, Hampshire Constabulary and Southern Health have worked together within a task and finish group to review universal process and paperwork for the JAR (Joint Agency Response) process across the 3 organisations. It is agreed that the new JAR 1 meeting agenda paperwork will include a prompt to discuss if there are additional known services/ agencies that need to be included. This is to ensure that no key organisation are left out from the JAR process in future.

In July 2020, the National Panel published their report in to Sudden Unexpected Death in Infants (SUDI). Portsmouth were visited as part of the methodology for this review. Key learning from this report includes the strong link between alcohol and substance misuse and sudden infant death. It recommends that professionals tailor their safe sleeping key messages to the needs of the family's background and history. It also highlights the importance of planning for 'out of routine' events where a child's normal sleeping arrangements may be changed, especially when this involves alcohol. This learning was used to inform the action plan from this review. Safe Sleep is an ongoing key theme across the HIPS area and there is further work underway with HIPS CDOP to establish why messaging to parents/carers doesn't always have the desired impact. The PSCP will be a part of this work during 2021/22.

Child H - October 2020

Child H tragically died aged 10 as a result of a respiratory illness alongside complex disabilities including epilepsy. Child H was on a child protection plan at the time of his death as a result of concerns around neglect. The full report has been published on the PSCP Website.

What we have done as a result of learning from Child H:

The PSCP also published its response document which outlined the action that had already been taken; and commented upon what more would be done. This document can be found on the PSCP website.

The PSCP training programme has been reviewed in response to this review. Details of thresholds and the various stages of Early Help and Social Care are incorporated in multi-agency training. This will work to ensure that both the professional team around the child and the families themselves will be clear on their current status within the system and what that means.

The PSCP developed a series of masterclasses for Designated Safeguarding Leads of schools within the City. This includes sessions on decision making, escalation and contacts to MASH. These sessions will be reviewed on a regular basis to ensure that the most up to date messages are being given.

In response to a recommendation regarding professional knowledge of escalation, the PSCP carried out a number of workshops to understand this further. Barriers to escalating effectively were often cultural and behavioural rather than an issue with the process. The PSCP therefore developed a new approach to dealing with conflict or challenges within cases, called Re-think. This allows professionals to pause and reflect on the case as a group and promotes multi-agency working in order to find a resolution. This was launched in February 2021.

Social Care has reviewed their internal Child in Need policy and has strengthened it to reflect the fact that the social worker is the lead professional and is responsible for oversight and coordination of the case. The review highlighted this as an issue, particularly in cases of children with disabilities. The

policy now makes explicit reference to the allocated Social Worker being the named lead professional and request that this be stated at the beginning of every Child in Need review meeting.

The report recommended that Solent NHS Trust and Portsmouth Hospitals NHS Trust review their policy and procedure about recognising and responding to medical neglect. Solent NHS Trust developed an overarching Was Not Brought and Did Not Attend Policy. The policy aims to ensure that practitioners are aware of the importance of attempting to build a therapeutic relationship with clients and/or parents that appear to be difficult to engage with, do not attend appointments, (DNA), or do not bring children to appointments, to ensure that the Trust is able to offer an appropriate service to such individuals and families. Portsmouth Hospital NHS Trust also updated their Was Not Brought Policy, disseminated it widely across the hospital and embedded it in to their Level 3 safeguarding training.

Hampshire Constabulary was asked to ensure that information and intelligence that is relevant to keeping children safe is always shared with relevant statutory partners in a timely way. In response, the Intelligence and Tasking Directorate (ITD) adjusted their processes to ensure that intelligence processors send intelligence logs around holistic risks on the lifestyle of the child and this has resulted in more intelligence to the MASH. They also held workshops with MASH, Children's Social Care, Hampshire Constabulary's intelligence department and the Missing, Exploited and Trafficked team which has resulted in the intelligence department giving the MASH training as to how to manage and disseminate intelligence.

All case review actions are monitored by the PSCP Monitoring Evaluation and Scrutiny Committee and the Executive Committee on a quarterly basis.

Further actions we've taken to improve safeguarding

Portsmouth Safeguarding Strategy

The PSCP has oversight of a newly produced Safeguarding Strategy. This document outlines the safeguarding vision for the Partnership:

> *Children and young people should grow up feeling safe, protected and cared for by their families. Our role as a multi-agency partnership is to work with families to enable them to keep their children safe from harm by providing the right advice, guidance and intervention from the right services at the right time.*

To deliver the vision above, and based on previous learning of what works locally and atonally, the PSCP has identified 10 Strategic Objectives for 2020-2023:

SO1. Ensure universal settings provide high quality preventative and early help support including the youth offer

SO2. Deliver an effective integrated prevention and early help service

SO3. Ensure an effective MASH function

SO4. Develop and embed family safeguarding practice

SO5. Reduce the prevalence and impact of offending, serious violence and custody

SO6. Keeping young people safe from exploitation including disruption activity

SO7. Reduce the prevalence of domestic abuse

SO8. Improve the identification and multi-agency response to neglect

SO9. Enable learning, quality assurance and practice development across the system

SO10. Intelligence-led safeguarding - using our data across the system to identify and respond to need.

Each objective has its own action plan with a greater level of detail which is owned by professionals across the Partnership. The PSCP Executive oversees the Portsmouth Safeguarding Children strategy, providing a co-ordination and scrutiny role in its delivery.

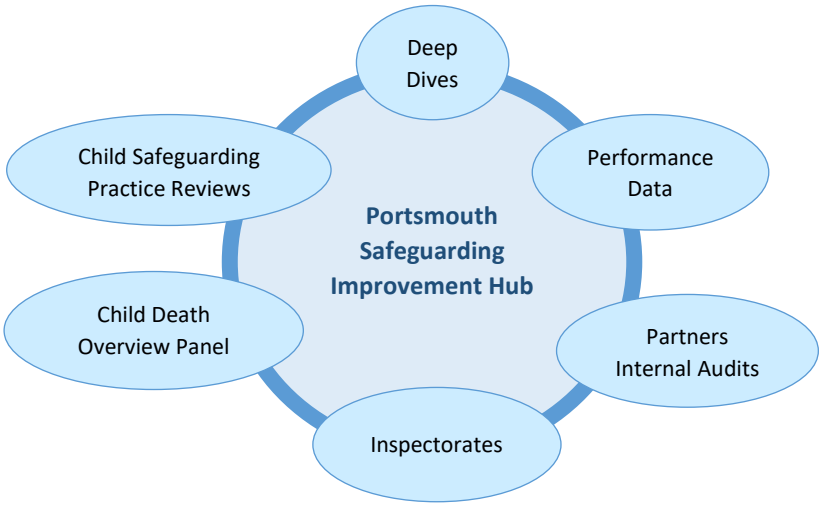
Portsmouth Safeguarding Improvement Hub

The PSCP has a range of responsibilities with regard to multi-agency working to keep children safe from harm. Recent discussions within the Partnership have considered whether we currently have the balance right between 'learning' and 'improving'.

We have a very comprehensive set of arrangements in place for learning about the quality of safeguarding practice in the city. Our learning activity over the past couple of years has highlighted a number of common themes where we appear to be struggling to make improvements either fast enough or across the system. These include:

a) Relational-based practice built upon restorative principles
b) Quality of contacts into the MASH
c) Assessments of need and risk - e.g. use of sociograms and chronologies; embedded use of the Early Help Assessment
d) Quality of plans - SMART planning
e) Voice and lived experience of the child and family
f) Whole family safeguarding practice - siblings and the needs of parenting adults which become a barrier to safe care at home
g) Escalation and response to 'stuck cases'
h) Leadership and management to drive a safe safeguarding organisational culture

We believe we could better join-up and align our work on improving in order to address these themes. Rather than develop another Committee, the PSCP Executive has agreed that we set up a 'Safeguarding Improvement Hub' in 2021-22.



Working closely with the PSCP Monitoring, Evaluation & Scrutiny Committee (MESC), the Portsmouth Safeguarding Improvement Hub will provide a structure that ensures learning from the partnership activities is used to make real, sustainable improvements to services to reduce the risk of future harm. This learning will also be used to understand what we do well, with a focus on learning from success that is turned into tangible outcomes to improve practice in the city.

It is not proposed that the Hub be any form of structural change. But rather an arrangement which brings together improvement leads and workforce leads across the local authority, NHS commissioners and providers, the police and education services to work together to develop practice in their sectors and in the system.

The Hub will be a supportive space to work on a shared improvement agenda under the auspices of the PSCP. The Hub will have a work programme to tackle priority issues, designed to create an effective safeguarding culture in every organisation in Portsmouth - with specific deliverables around areas of improvement and linked to our new Safeguarding Children Strategy.

Response to Mental Health Joint Targeted Area Inspection (JTAI), December 2019

In December 2019, Ofsted, the Care Quality Commission, HMI Constabulary and Fire & Rescue Services and HMI Probation carried out a JTAI focussed on agencies' responses in Portsmouth to children living with mental ill health. Please see the full published letter for further details.

The inspection found 56 areas of good practice and 26 areas for improvement. In response to this the Partnership developed an action plan to address the key issues raised. Below is a summary of the response to these by partner agencies during this year:

Multi-Agency Safeguarding Hub

To improve the quality of contacts to MASH there is multi-agency quarterly auditing programme and the learning is shared with partners. This issue has also been identified as the first priority for the newly developed Portsmouth Safeguarding Improvement Hub. The audits also monitor that referrers are being informed of the outcome of their contacts. Similarly, Hampshire Constabulary has established a multi-agency panel to scrutinise the quality of notifications submitted by officers (PPN1S) to MASH. Learning from this is shared directly with the relevant team and also escalated where necessary to inform policy and training development.

The backlog of police notifications in the MASH has been addressed, a plan of action has cleared this and additional capacity is being sought in order to prevent this from reoccurring

To ensure that strategy discussions are bringing key agencies together, especially during the forced home working during lockdown, the use of MS Teams has been introduced to make it easier for professionals to engage. The audits show that the majority of strategy discussions are good and there has been an increase in partners' attendance. There is an ongoing improvement plan and a weekly dip-sample is undertaken to monitor its impact by the Head of Service, and any concerns identified are immediately followed up through discussion with the relevant partner agency.

Child protection

There was some evidence of drift and delay, with delays in the appropriate threshold being applied for a considerable period for some children. In response a review of the step-up decision making process was completed with Targeted Early Help, Children's Social Care and MASH. In addition The Head of Service has developed a pro-forma to support monthly dip-sampling of cases where a child has been on a CIN plan 6 months+ and CP Plan 18 months+ , and going forward 6 cases will be reviewed monthly in order to respond appropriately in a timely manner.

It was found that not all GP Practices were aware of which children were on a CP Plan or were Looked After. The CCG supported a data cleanse with Practices to ensure they had up to date records. Ongoing monitoring of how well they maintain these records will form part of the CCGs annual safeguarding conversation with Practices in 2021-22.

There were a few examples of decisions to convene an Initial CP Conference being overturned by team managers. Clear practice instructions have been given to team managers to ensure that this is only done in exceptional circumstances and that the rationale for such decisions is clearly recorded. There is evidence that since this, that Service Leaders are no longer overturning multi-agency decisions made at strategy meetings

To ensure there is robust monitoring of management oversight, there is a weekly meeting with CSC, YOT and Police to review high risk cases and CSE/CCE cases to support a shared understanding of risk, sharing of intelligence and timely identification of cases for escalation.

To ensure a consistency in the quality of plans children have, one to one sessions have been offered to all practitioners and managers, followed by audits to review the impact of these. These are now targeted at those identified through audit as needing additional support.

Impact of the child's lived experience

In response to the JTAI finding that there was not consistent recognition of family's cultural heritage, a reflective discussion in social workers' supervision now takes place to the impact on the family and

explore if there is any unconscious bias in the worker. There is also a plan to roll out Social Graces training across Children & Family Services.

The audit tool used by Children & Family Services has been reviewed to ensure that lived experience of the child and parent is explicitly considered. The implementation of the Family Safeguarding Model in Portsmouth is supporting an improved understanding of the impact of parental experiences. Care plans are co-produced with children and their parents/carers to ensure their voice is captured within these.

To ensure that there is sufficient focus to evaluate whether children are getting the right help at the right time by providing a thorough analysis of a child's needs and the impact of previous experience on their emotional wellbeing and mental health, training on assessment and analysis was delivered in November 2020. Action Learning Sets have then been convened to support the translation of this into practice. There has also been sharing of good assessments to support an understanding of 'what good looks like'. There is evidence of impact in the LAC service with targeted involvement of the Family Safeguarding Service supporting the restoration of relationships with family members. This is supporting an improved understanding of parental mental health and resilience.

To ensure the level of risk associated with children missing from home is also always recognised, a weekly operational meeting to review all children at risk of exploitation is held to support a shared understanding of risk, sharing of intelligence and timely identification of cases for escalation. A high risk missing pilot (OP SALVUS) has now been started to consider the risk associated with children being missing.

To promote greater consistency in recording of the recognition of the vulnerability of children who come into contact with the police, training packages were planned but delayed due to Covid19. A review with Call Management of incidents not deployed to which may contain details of children who need further assessment of potential harm or wider partnership information sharing took place. This review confirmed processes are in place to achieve this if a physical deployment does not take place.

Workforce development

PSCP Training Programme

A key part of making sure we have an effective safeguarding response in Portsmouth is by making sure we have effective multi-agency safeguarding training. The PSCP has always delivered its training face to face primarily due to the fact that in person learning offers the opportunity to learn together to work together, which is as important to improving multi-agency safeguarding arrangements as the core content of the course. Also we appreciate that many of the attendees on our programmes would not have the IT arrangements either in their workplace to allow them to participate fully in a virtual learning environment.

However, following the restrictions put in place following the pandemic meant that this had to stop with immediate effect and all training had to move to being online. To accommodate this the main changes that have been made to the programme include:

- In addition to our core training offer of basic safeguarding, early help and child protection courses, we have added workshops on the following -
    - Understanding adverse childhood experiences (ACES) and their impact
    - Safeguarding for out of school settings
    - Bruising protocol for non-mobile infants
    - Safeguarding medical examinations
    - Medical examinations for suspected child sexual abuse
    - Safeguarding children with disabilities
- Replacing the full day training course for Designated Safeguarding Leads and managers with five 1.5 hour masterclasses -
    - National & local context for safeguarding children
    - Safegaurding decision making
    - Resources for effective safeguarding conversations

    - Contacting MASH
    - Escalation and Re-Think
    - Developing a safeguarding culture - The Portsmouth Compact
- Supplementing the exploitation training offer so as well as the full day training there are now 4 additional masterclasses -
    - Avoiding the use of victim blaming language
    - National Referral Mechanism (NRM)
    - Preventing online child sexual exploitation
    - Assessing exploitation and sharing information (use of the CERAF & CPI forms)
- The 2 day Restorative Practice (RP) training has been replaced with the following half-day workshops -
    - RP introduction
    - RP development
    - RP circles and meetings
    - Bespoke Offer - drawing from the three sessions above the content is specifically curated to enable whole teams/groups to understand and embed RP

Many attendees were unfamiliar with accessing a virtual learning environment and so a training agreement was developed detailing the expectations. We were mindful that we would be delivering potentially emotive material to attendees outside of their usual work place (e.g. whilst they were working at home) and so we needed to ensure they knew how to access support if needed. Similarly this created other challenges, such as having their children and other family members around. So it was made clear that where possible they should be in another room with the door shut or wear headphones.

It has been challenging to encourage an interactive learning environment, as initially practitioners were used to attending online meetings or webinars where they were encouraged to turn their cameras off and remain on mute. This also increases the temptation for training attendees to multi-task, by responding to emails etc. and just listening to the training rather than fully engaging in it. We have attempted to overcome this by making the expectations of full engagement explicit and ensuring there are activities built into all sessions at regular intervals to encourage full participation.

	04/2020 to 03/2021	04/2019 to 03/2020
Number of courses available	129	75
Number of people booked	1,972	1,188
Number and percentage of people attended	1,556 = 79%	1,062 = 89%

Evidence of Impact

As you can see from the figures above there has been a:

- 72% increase in the number of courses available
- 10% decrease in the conversion rate of people booking and then actually attending
- 66% increase in the number of people attending PSCP training

The increase in courses available is partly due to offering more, shorter masterclasses and workshops as opposed to full or half day training. There has been a decrease in the conversion rate of those booking onto courses and then actually attending. However much of this has been due to capacity issues within services caused by the pandemic, meaning that participants have had to withdraw from training at short notice in order to be available to work.

The shorter, more focused courses have proved very popular and have received very positive feedback. In particular attendees appreciate a more 'pick & mix' approach where they are able to choose the topics most relevant to their work. The shorter length of the masterclasses has meant that more people are able to fit them around their work commitments. This is shown in the increase in the number of people attending the PSCP training

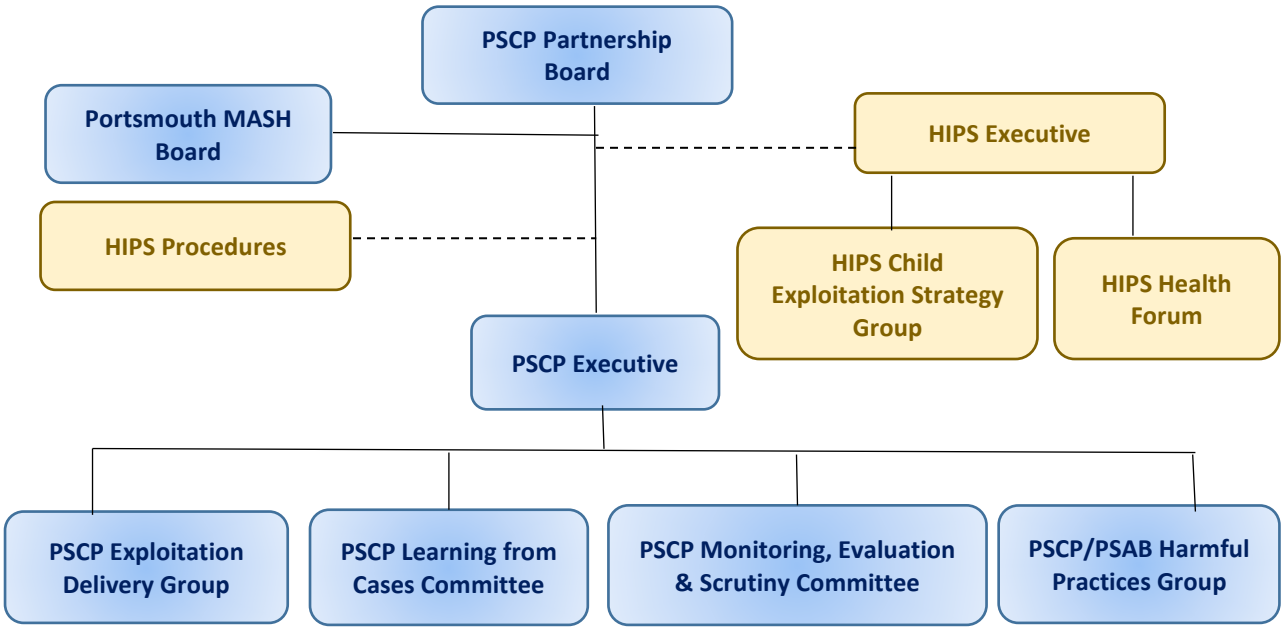
Going forward, once we are able to resume our face to face training, we will be adopting a blended approach to our offer. Such that all full day and some of the half day courses will be offered in real life, so that participants get the benefit of the multi-agency approach of being able to learn together. We will keep the shorter workshops and masterclasses as a virtual learning offer, and will re-examine the impact of the uptake of this and the impact it has on professional development in order to inform our training offer for 2022-23.

Governance and accountability arrangements

The full details of the PSCP Partnership Arrangements can be found on our website. The strength of local partnership working is built upon the safeguarding partners working collaboratively together with all other relevant agencies and services in Portsmouth who come into contact with children and families.

The PSCP has a range of committees in place to help identify emerging issues and respond to agreed priority areas. The PSCP also commissions task and finish groups as necessary to deliver actions.

In recognition of the fact that many of the organisations we work with cover a larger geographical area, we also work closely with the Local Safeguarding Children Partnerships in Hampshire, Isle of Wight and Southampton. You can see this reflected in our current structure chart.



The four LSCPs work collaboratively to produce the Safeguarding Children Procedures Manual that all those working (in a paid or voluntary position) with children and families in Hampshire, Isle of Wight, Portsmouth and/or Southampton should have due regard of.

The PSCP also works closely with the HIPS Child Death Overview Panel to ensure that any matters relating to the death, or deaths, which are relevant to the welfare of children in Portsmouth are considered and acted upon where appropriate.

Financial contributions to support the Partnership

The previous funding arrangements have remained for this year of the safeguarding arrangements. This includes the three statutory partners providing all of the funding as follows:

- Portsmouth Local Authority 82.7%
- Portsmouth Clinical Commissioning Group (CCG) 11.61%
- Hampshire Constabulary 5.64%

It is also important to note the significant contributions from all our partners within their safeguarding roles, which accounts for a significant 'in-kind' contribution to the work of the Partnership. Furthermore, the 'in-kind' contribution of partners to the LSCP Training Pool.

Our priorities for next year

1. To deliver against the 10 objectives as set out in the Safeguarding Strategy
2. To drive through continued improvement in the quality of contacts into the MASH through the Safeguarding Improvement Hub
3. To deliver against the recommendations from the deep-dive into children experiencing neglect
4. To work with the Portsmouth Safeguarding Adults Board to complete a deep-dive into transition arrangements for young people in Portsmouth
5. To complete an equalities assessment to consider the impact of current multi-agency safeguarding arrangements on Black, Asian & Minority Ethnic members of the community in Portsmouth
6. To deliver the Beware of Lurking Trolls project to primary schools to improve children's digital resilience to online harm