
Portsmouth
Safeguarding
Children
Partnership
ANNUAL REPORT 2022 - 2023

Contents

Foreword 3
Introduction 4
What we achieved against our priorities in 2022/23 5
1. Early identification & support: 5
2. Responding to neglect: 5
3. Exploitation: 6
4. Family Safeguarding: 7
5. Safeguarding in Education: 7
About Portsmouth Safeguarding Children Partnership 9
Our Vision 9
Our Priorities for 2023-25 9
Our Partners 10
Our Structure 10
Financial contributions to support the Partnership 11
Context & Key Facts About Portsmouth 12
Education 12
Health 13
Money 13
Extra-familial contexts 14
..... 14
Learning from Monitoring, Evaluation and Scrutiny 15
Learning from Data 15
Deep Dives and Audits 18
Recommendation Tracking 23
Safeguarding & Early Help Compact Audit 24
Learning from Children & Practice 26
Workforce Development 28
Attendance on PSCP Training 28
Re-think 29

Foreword

It is my pleasure to introduce the Annual Report for Portsmouth Safeguarding Children Partnership (PSCP) for 2022/23. I joined PSCP in the latter part of this reporting year as the Independent Chair and Scrutineer.

The scrutineer part of my role is about challenging and supporting our safeguarding partners in their leadership role. It is about providing scrutiny to audits, assurance work, case reviews and partnership decision making. Thereby ensuring ours is a multi-agency safeguarding system that continues to learn, develop, and remain effective in keeping our most vulnerable children safe from harm and abuse. A partnership based on the premise of mutual respect, high support, and high challenge, working collaboratively to resolve issues.

I am very aware the year continued to be shaped by the impact of COVID-19, other world events and the cost-of-living crisis being felt across our communities. Partner agencies continued to face additional challenges as a result. Senior leaders from the statutory safeguarding partners remained visible and engaged, working collectively to ensure we effectively safeguard and promote the wellbeing of our most vulnerable children, their families, or carers. Our wide range of partners continued to maintain a clear focus on safeguarding children, continuing to deliver the partnership's priorities and active workstreams. Our priorities reflect the issues facing children and their families: neglect, sexual abuse, exploitation, and exclusion from education, with a focus on adolescents and the impact of our collective activity.

July of this year saw a significant change take place for one of the statutory safeguarding partners - the NHS Clinical Commissioning Groups were restructured to form a single Integrated Care Board across Hampshire and the Isle of Wight.

The current landscape is challenging, and this is likely to remain, impacting the children and families we work with, alongside the practitioners who provide support and services.

2023/24 will bring change as we move through consultations in response to the government's Stable Homes, Built on Love publication and a new iteration of Working Together to Safeguard Children, which we remain hopeful will strengthen the role of our education partners. I will remain resolutely focused on ensuring local multi agency safeguarding practice remains effective for our children, their families or carers during any changes that may result.

This Annual Report contains information about the work of PSCP which is a partnership of us all, of everyone who works with children and families in Portsmouth. As you read through all the work undertaken this year, you will see our collective effort and the positive impact we have made together.

Thank you.

Scott MacKechnie
Independent Chair & Scrutineer for Portsmouth Safeguarding Children Partnership

Introduction

We are pleased to present this report of the Portsmouth Children's Safeguarding Partnership which covers the period from 1 April 2022 to 31 March 2023.

As ever it has been a busy year, with the continuing repercussions of the Covid pandemic having a profound impact on children and their families. We continue to see high levels of referrals to our Multi-Agency Safeguarding Hub (MASH), alongside increased pressures in our schools, our health system and across our partnership. In addition, families in Portsmouth are having to deal with a cost of living crisis that has resulted in higher food costs, huge increases in energy costs and wider inflation. In Portsmouth, 23.9% of children under 16 years (8,870 children) were living in relative low income families in 2021/22. This was a 10.6% increase (a further 355 children) compared to 2020/21. Across the partnership our workforce has worked hard to engage with and support these families to prevent the need for them to access statutory services.

Our commitment to continuous learning is robust and supported by the work undertaken in our committees, all of which are chaired by partner members of the Executive Board. As a result of this our learning and development offer goes from strength to strength and engagement is strong across the partnership workforce.

We are all immensely proud of our workforce across the partnership and would take this opportunity to thank them for their hard work over the past year. Their commitment to the work of the PSCP and all that has been achieved is to be celebrated.

Sarah Daly, Director of Children, Families & Education
Portsmouth City Council

Superintendent Clare Jenkins, Eastern Area Commander
Hampshire Constabulary

Sarah Shore, Interim Director of Quality and Safeguarding
Hampshire & Isle of Wight Integrated Care Board

What we achieved against our priorities in 2022/23

In April 2022 five areas of concerns were set out as priority areas in the PSCP's Business Plan. Over the course of this year actions were progressed to meet the required outcomes or are still in progress. These include:

1. Early identification & support:

The PSCP Team continued to collaborate with partner agencies to complete a pilot of the re-designed Early Help Assessment. This is based on the 10 outcomes within Supporting Families and, following consultation with families in Portsmouth, has been called the Family Support Plan (FSP).

The FSP officially launched in January 2023, supported by a redesign of the multi-agency Early Help Training. It is used to support families with needs across Tiers 2 and 3 and is used by both universal settings and targeted early help services. A leaflet and a video have been designed in collaboration with the Portsmouth Parent/Carer Board to help families understand the process.

As well as training, guidance was produced for practitioners to help them explain to families how the process of creating and reviewing an FSP works, and to support them in asking questions around the 10 aspects of life. The Link Coordinators Team have supported the Partnership to put together a comprehensive guide as to the support available under each of these aspects.

The FSP, along with an intense focus on relational and restorative practice, has begun to equip the workforce with tools, processes and practice which are helpful and most importantly focus on the relationship with families, resulting in better outcomes for children.

In the first 3 months since it was launched, a total of 67 plans have been submitted and the feedback so far has been overwhelmingly positive:

> *"We've been finding the FSP so positive for families. After an FSP conversation with one mum she said she felt she was leaving the school feeling so much lighter".*
>
> *"We feel it worked incredibly well for the family. The questions worked effectively in terms of the family being able to talk openly and they are now very hopeful that the plan we have put together will be positive in moving things on".*
>
> *"The form is so much better than before. It really helped being able to show mum the 0-10 scale and they were able to first cover all the positive areas and then focus on their areas of concern. Mum reported that she felt listened to".*

A quality assurance framework is being developed in order to monitor the implementation and effectiveness of FSPs

2. Responding to neglect:

Since the PSCP concluded a deep dive into multi-agency practice in response to children experiencing neglect in 2021, the following work has been undertaken:

- A review of research of evidence-based tools and interventions for working with families where neglect is a concern;
- A review of the approach used by neighbouring LSCPs and those across England where the local authority has been graded as 'outstanding' by Ofsted;
- 2 workshops with practitioners to understand the opportunities and challenges they find in using the current practice guidance and Neglect Identification & Measurement Tool (NIMT);
- Liaison with the perinatal mental health steering group (that has since been established) to understand the work being taken forward to support maternal mental health more effectively; and
- Supporting the work being undertaken to develop a parenting pathway, as part of the Public Health Strategy, to ensure there is appropriate support for families at all tiers of need.

This work concluded that having separate strategies for specific forms of abuse or harm can be confusing for the workforce, and therefore responding to neglect will be embedded into the comprehensive Portsmouth Safeguarding Strategy when it is refreshed in April 2023.

It also found that the NIMT is not an evidence-based tool, was not widely used, and many practitioners found it unhelpful when they did attempt to use it. With the extensive work that has been undertaken to replace the Early Help Assessment with the FSP, indicators of neglectful parenting will be better identified through the Family Support Conversation. Through considering all aspects of family life practitioners will have a better understanding of the impact of neglect, as well as potential causal factors and be able to work with the family to develop an appropriate plan of support in place to address these.

In addition it was felt that a specific tool to help practitioners (especially those working in Children & Families Service) work with a family to capture a child's lived experience was need. It was agreed to adopt The Day in the Life (DIL) Tools developed by Professor Jan Horwath.

Finally it was concluded that having a supporting Practice Guide for responding to children experiencing neglect was helpful to clarify the expected response and approach in Portsmouth across all tiers of need (especially for newer and/or less experienced practitioners). So the Practice Guide has been refreshed to be clear on how and when to use the FSP and DIL tools to effectively identify and support families where children are experiencing neglect. These have been published on the PSCP website and disseminated across the children's workforce

3. Exploitation:

During 2022-23 the PSCP supported the Head of Service for Adolescents and Young Adults in working with partner agencies to develop a Multi-Agency Missing, Exploited and Trafficking (MET) Integrated Pathway. The Pathway is designed to support the understanding and response across emerging, complex, and acute need.

In response to learning by the Partnership about the need for collaborative and coherent plans to support children who go missing or are vulnerable to exploitation, we have adopted a 'Safer Plan' model. The aim of the plan is that is developed with the child and belongs to them and brings together key information about the child to share across police, health and social care to better enable them to and respond to their risks and vulnerabilities.

We recognise a child going missing is often a significant indicator of the presence of exploitation and that a missing episode may indicate a time-critical window to identify and intervene to reduce increasing vulnerability to exploitation. Op Endeavour has been introduced to ensure schools are notified by Police of children who have gone missing, so that any information the school has that may help locate them or prevent them from going missing in the future can be shared. The school can also offer appropriate support to the child when they return to education.

The Partnership understands that the risks of exploitation for some children are still ongoing when they reach their 18th birthday and can no longer be supported by Children's Services. The LSCPs across Hampshire, Isle of Wight, Portsmouth, Southampton (HIPS) have worked with the respective Local Safeguarding Adults Boards on a transitional safeguarding framework - Multi-agency framework for managing risk and safeguarding people moving into adulthood. In Portsmouth, a Transitional Safegaurding Forum meets regularly, chaired by the Head of Adolescents and Young Adults, to ensure the needs of these young people are understood and appropriate plans of support are developed with them.

Police have relaunched Hotel Watch with the hospitality industry to ensure they are aware of potential safeguarding risks and responding with appropriate actions. Within the monthly operational MET meetings areas of concern in the city are explored and a contextual approach is taken to consider how best to work with these premises.

The PSCP continues to offer a significant amount of training to the workforce on exploitation to improve the identification and response to children at risk of this form of harm. A particular focus this year has been on delivering a masterclass on supporting practitioners to consider their language and avoid victim blaming. Examples of the impact this training has had is:

> *"One thing I have been guilty of is maybe not saying but thinking "the parents could be doing more". But the training has shown me that actually maybe the parents are doing all the can, and that they are in fact at a loss and don't know what to do to help their children"*
>
> *"This has started to shape language that is more restorative and really builds a culture where children are supported as victims and not just seen by their actions on the surface."*
>
> *" When speaking to families I have always tried to choose my words carefully but perhaps hadn't been as considered when writing up documents. Following the input I try to ensure my reports do not have an underlying judgemental or blaming tone."*

4. Family Safeguarding:

During 2022-23 the PSCP has worked with other LSCPs and Local Safeguarding Adults Boards across HIPS to re-fresh the Family Approach Toolkit. This will be relaunched in 2023.

Within the tools used to complete Rapid Reviews and Deep Dives, we have included questions to consider whether decisions and/or actions are appropriately considering the impact on the child when one or more significant parental risk factors are present. This has highlighted that where parents/carers are supported by the Family Safeguarding & Support Services to address parental needs around mental health, substance misuse and/or domestic abuse, the support given by the adult workers embedded within these teams is effective.

Within the FSP and the redesigned Early Help Training, there is a renewed focus on supporting practitioners in having honest conversations with parents/carers. The aim being to identify existing strengths that can be built upon, as well as potential needs within a family, thus enabling the joint development of a plan of support that builds parental capacity to appropriately safeguard children.

5. Safeguarding in Education:

The PSCP training team continue to support schools across the city in a variety of ways of to further grow a safeguarding culture in an education setting, this includes through a diverse range of Masterclasses, bespoke and inset training, as well as coaching.

The training program offers a robust package of learning and reflective opportunities, which is continually being updated and added to in line with Keeping Children Safe in Education (KCSiE) and emerging safeguarding themes and learning from Child Safeguarding Practice Reviews. This year, sessions to cover topics such as Cyber Choices, Working Sexual Harmful Behaviour, Family Support Planning, Clare's and Sarah's Law were included. We continue to work in partnership with experts in these specific areas to ensure the content is of a high standard. 75.4% of schools across Portsmouth are engaged in PSCP Designated Safeguarding Lead (DSL) Training, alongside The City of Portsmouth College.

Intensive bespoke training was developed to support two schools who were deemed inadequate in regard to safeguarding in their OFSTED inspection. For these a project plan was developed which incorporated specific

training, reflection and coaching to enhance staff's knowledge and skills, and focus on strengthening the school's safeguarding culture. Coaching has also been offered to the Designated Safeguarding Leads (DSLs) and Leadership Teams within six schools which provides a supervision type service.

The local authority has a team of Education Link Coordinators who provide a supportive link between the Children, Families and Education Directorate and education settings, (including Early Years, Schools, and Colleges) to ensure they are aware of their vulnerable children. Children that are identified as vulnerable include those with attendance below 50%; children with 2 or more suspensions; children at risk of exploitation; children with an unmet special educational need; those open to the Youth Offending Team; and children open to the Early Help or Family Support and Safeguarding teams

The Link Coordinators have a fortnightly conversation with the education setting's designated safeguarding lead in regard to those vulnerable children who attend their setting. The aim being to provide regular advice, guidance, challenge, and support with a key focus on ensuring the right support is in place on a multi-agency basis to improve the outcomes for children and their families. The Family Support Plan is promoted for children who do not have a lead professional in place, and actions agreed where appropriate.

About Portsmouth Safeguarding Children Partnership

The Portsmouth Safeguarding Children Partnership (PSCP) is a statutory, multi-organisation partnership coordinated by a business unit, which oversees and leads upon children's safeguarding across Portsmouth. The main objective of the PSCP is to gain assurance that local safeguarding arrangements, comprised of partner organisations, are working effectively, both individually and together, to support and safeguard children who are at risk of abuse and neglect. The PSCP acts as a critical friend and a champion for best practice.

Quality assurance remains our key driver across all the committees, using frameworks that will measure the impact of activities and challenge those working in the safeguarding arena. We also continue to ensure that our policies and procedures are embedded in practice; that toolkits, guidance, and procedures draw on the knowledge of subject experts locally and nationally to inform them; and that we can demonstrate the impact of learning that has taken place.

The Partnership has an Independent Chair who provides leadership, vision, support & scrutiny and who is responsible for ensuring that all organisations contribute effectively to the work of the PSCP. Effective communication between the Business Manager and Chair ensures that there is a clear link between the committees and executive group, enabling risks, themes and opportunities to be highlighted at an executive level, which in turn provides direction to the work of the committees.

In February 2023, the Partnership met to review the impact of the previous Safeguarding Strategy 2020-2023, that had been drawn up as part of the Portsmouth Children's Trust Plan. To enable this, an analysis of the available data was provided that highlighted some of the key themes, trends and needs of families and children across Portsmouth. Agencies were also asked to review knowledge held within their own setting of the current risks, pressures and opportunities that related to the effectiveness of the multi-agency safeguarding arrangements in Portsmouth. As a result it was agreed to renew the vision and principles for the Partnership; to amalgamate the priorities within the 2022-25 into the Strategy; and to have one overarching document that set out the multi-agency priorities for safeguarding and promoting the welfare of children in Portsmouth.

Our Vision

Our children and young people within Portsmouth will grow up being and feeling safe, protected, and cared for by their families and in their community. As a multi-agency partnership, we will achieve this by working with families to enable them to keep their children safe from all types of harm by providing the right advice, support, and intervention, from the right services, at the right time.

Our Priorities for 2023-25

1. Children and family's needs will be identified at the earliest point, and they will receive effective early support and help
2. Families will receive effective and timely support when children are at risk of experiencing neglect
3. Families will receive effective and timely support when children are at risk of experiencing sexual abuse
4. Young people will be kept as safe as possible from all forms of extra-familial harm, and there will be effective transitional safeguarding arrangements in place to support vulnerable young adults
5. Children and young people have access to appropriate support that recognises the impact of trauma resulting from adverse childhood experiences (ACEs)
6. There is an effective response to safeguarding children with additional needs and those from diverse communities
7. Providing sufficient professional and organisational development to ensure there is effective response to safeguarding children within Portsmouth
8. We will ensure there is a good understanding of safeguarding risks for children within education settings and an effective response to these

More details about these priorities, how we aim to achieve these, and our principles can be found in the Portsmouth Multi-Agency Safeguarding Strategy 2023-26

Our Partners

Working Together 2018 is statutory guidance that provides children's safeguarding with a legal framework, setting out the responsibilities of local authorities and their partners. From a statutory perspective the three legally required bodies are:

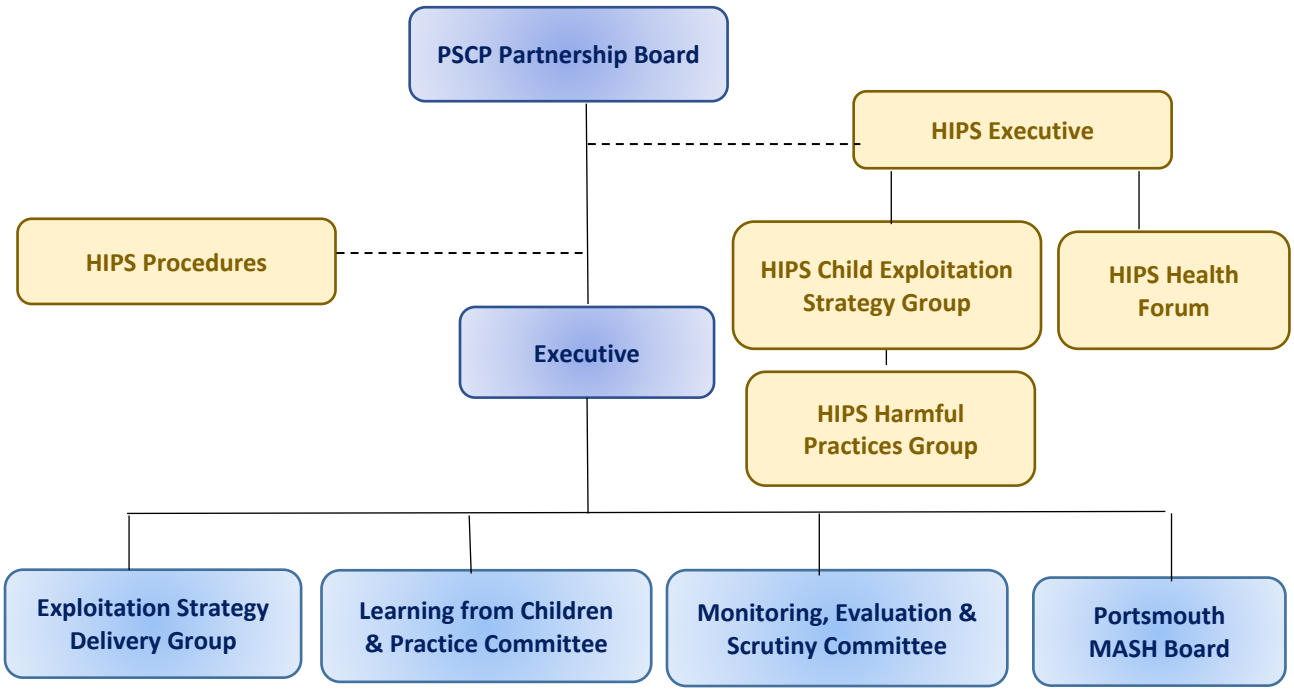
Portsmouth City Council

Hampshire & Isle of Wight Constabulary

NHS Hampshire and Isle of Wight

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. A full list of these relevant agencies can be found here within our Partnership Arrangements.

Our Structure



In addition to the Board and Executive, Portsmouth has the following sub-groups and Committees.

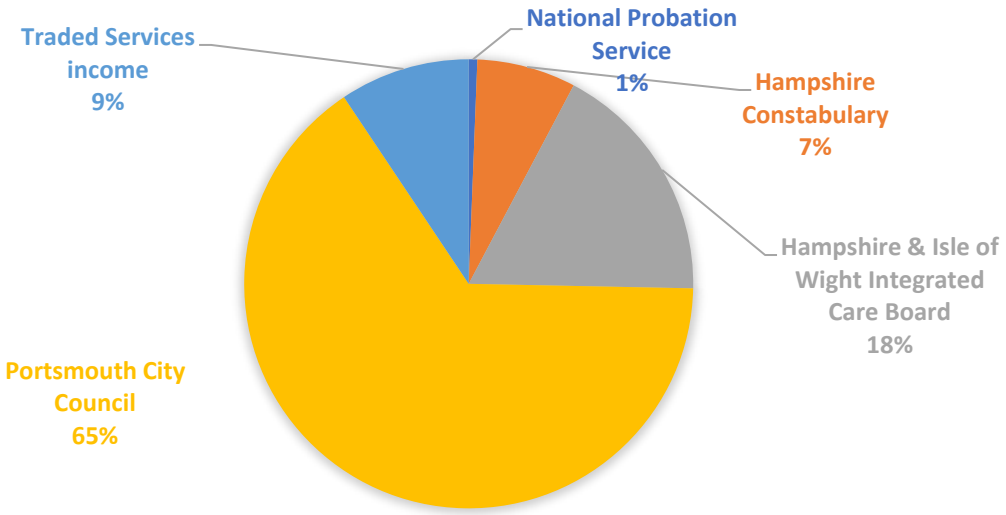
- **Learning From Children and Practice Committee** - which oversees safeguarding notifications and Child Safeguarding Practice Reviews, commissions external authors and reviews actions and learning
- **Monitoring Evaluation and Scrutiny Committee** - which oversees our comprehensive dataset and analysis, multi-agency audits of practice, recommendation tracking and compliance with safegaurding standards set out in the Portsmouth Safeguarding Compact which is completed every two years by over 200 agencies in the city.
- **Exploitation Strategy Delivery Group** - leading our strategy to tackle child exploitation
- **Portsmouth MASH Board** - ensuring effective resourcing, delivery, and quality of decision-making at the multi-agency front door

Our partnership is part of a wider HIPS safeguarding arrangement, which whilst not statutory, enables effective joint working across a wider geographical footprint - shared with the Constabulary and the Integrated Care System. The same Independent Chair covers all the local partnerships and the HIPS Executive.

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 total budget for the Partnership in 2022-23 was £324,296.



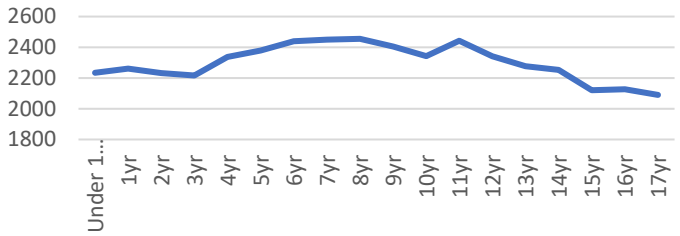
The four biggest areas of Partnership spending for this year were:

- Staffing = £284,026 (including the Business Unit, Training Team, and the Independent Chair)
- Contribution to CDOP = £12,000
- Provision of websites and online learning = £11,398
- Safeguarding Practice Reviews = £2,500

Context & Key Facts About Portsmouth[1]

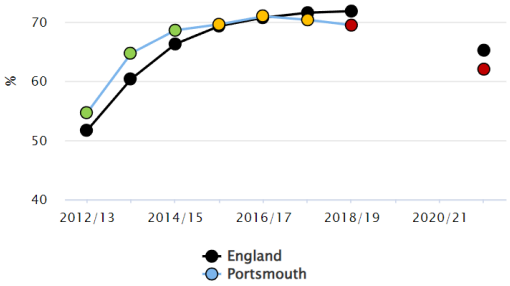
Portsmouth is a city on the south coast of England. It remains the local authority with the highest population density outside of London, with around 37 people living on each football pitch-sized area of land. According to the ONS Census completed in 2021, the population size in Portsmouth is 208,100.

Numbers of children aged 0-18yrs living in Portsmouth



Education

Within Portsmouth there is 1 all through school, 47 primary schools, 10 secondary schools, 5 special schools, 1 state-funded FE colleges and 5 independent schools.



The percentage of children in Portsmouth schools achieving a good level of development at the end of Reception has fallen to 62% in 2021-22 compared to a national average of 65.2%. This decrease from 69.4% in the previous year may be an indicator of the impact of national lockdowns as a result of Covid.

In Portsmouth, the rate of persistent absentees is higher than the national average.

Persistent absence rate	Portsmouth	England
Primary	18.2%	17%
Secondary	32.1%	27.4%
Special	51.8%	38.7%

On census day in Spring 2023, in Portsmouth there were 40 children missing education who are not registered pupils at a school and not receiving suitable education otherwise. At the same point in time there were approximately 200 children registered as receiving elective home education. Where a reason was given for choosing EHE, the top two were dissatisfaction with the school SEND provision and health concerns relating to COVID-19.

4.5% of pupils in Portsmouth have an Education, Health, and Care Plan (EHCP) which is in line with the national average of 4.3%. The rate of pupils receiving Special Educational Needs (SEN) support without an EHCP is 14.9%, slightly higher than the national average of 13%

69% of pupils in Portsmouth are from a white British ethnicity, which is lower than the national average of 62.6%.

[1] Public Health Data & Child Health Profile & Gov.UK Education Statistics

Percent of pupils by ethnicity	Portsmouth	South East	England
Any other ethnic group	2.1	1.3	2.3
Asian - Any other Asian background	1.9	2.2	2.1
Asian - Bangladeshi	3.4	0.6	1.8
Asian - Chinese	0.7	0.7	0.7
Asian - Indian	1.7	3.6	3.7
Asian - Pakistani	0.4	2.7	4.5
Black - Any other Black background	0.4	0.4	0.8
Black - Black African	4.9	3.0	4.3
Black - Black Caribbean	0.3	0.3	0.9
Mixed - Any other Mixed background	1.7	2.7	2.7
Mixed - White and Asian	1.5	2.0	1.6
Mixed - White and Black African	1.5	1.0	0.9
Mixed - White and Black Caribbean	0.8	1.3	1.6
Unclassified	1.9	1.6	1.7
White - Any other White background	7.5	7.2	7.2
White - Gypsy/Roma	0.1	0.4	0.3
White - Irish	0.1	0.3	0.2
White - Traveller of Irish heritage	0.0	0.1	0.1
White - White British	69.0	68.6	62.6

Young people aged 16-17 who are not in education, employment, or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression, or early parenthood. In 2021-22 the percentage NEET in Portsmouth is 5.1%, a reduction from 5.6% in the previous year and close to the national average of 4.7%.

Health

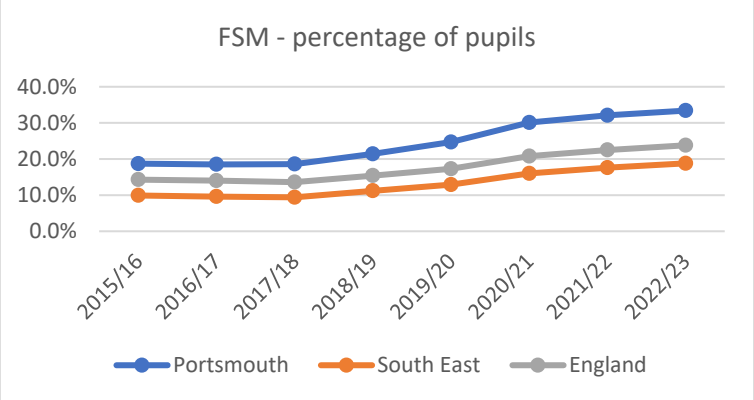
The infant mortality rate is 3 per 1,000 and the child mortality rate is 8.1 per 100,000. Both of these are below the national average of 3.9 per 1,000 and 10.3 per 100,000 respectively, and are the lowest rates amongst Portsmouth's statistical neighbours

Money

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. There is also a wide variety of evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health

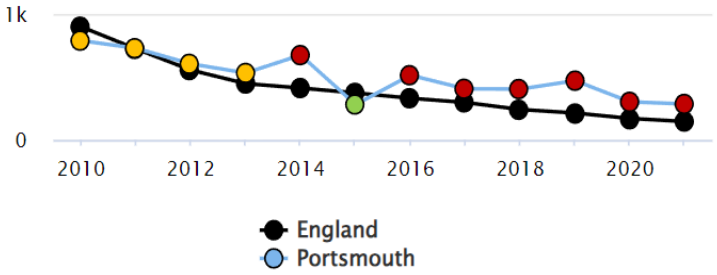
Portsmouth is ranked 59th of 326 local authorities for deprivation, where 1 is the most deprived. 8,870 children, which equates to 23.9% of all under 16's, are in relative low-income families. Of all the households owed a duty under the Homelessness Reduction Act, 21.4 per 1,000 include dependent children. This is the highest rate compared to Portsmouth's statistical neighbours and is higher than the national average of 14.4.

The percentage of pupils in Portsmouth that are eligible for free school meals (FSM) is 33.4%, which is higher than both the national and regional average and has increased significantly over the past 7 years.



Extra-familial contexts

The rate of first-time entrants to the youth justice system is 286.7 per 100,000, which is almost double that of the national average of 146.9 and is the highest amongst Portsmouth's statistical neighbours. However this does continue the downward trend over the last 11 years.



Learning from Monitoring, Evaluation and Scrutiny

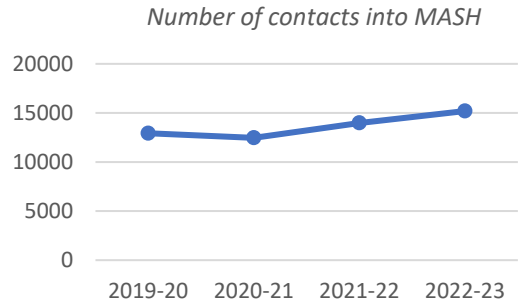
Learning from Data

The Partnership's dataset framework provides performance information to the PSCP to inform the assessment of the effectiveness of the support being provided to children and families. Data relating to key safeguarding and early help processes, and particularly vulnerable groups of children, is provided by partner agencies each quarter. This is reviewed by the Monitoring, Evaluation and Scrutiny Committee (MESC) who provides the Executive Committee with an analysis of any trends and areas for consideration.

Contacts into the Multi-Agency Safeguarding Hub (MASH)

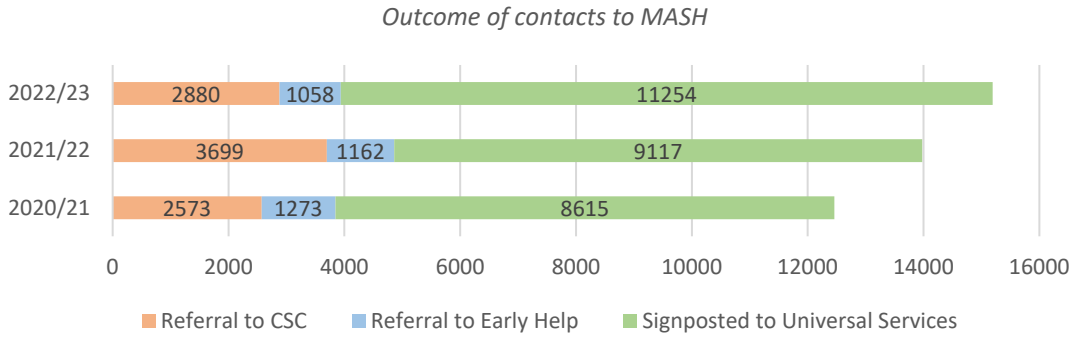
The Portsmouth MASH was established in November 2015. It is the multi-agency front door that manages child safeguarding concerns and determines an appropriate response. The services represented within MASH are Family Safeguarding and Support, Early Help and Prevention, Hampshire Constabulary, Solent NHS Trust, Youth Offending Team, Youth Service and Education.

The MASH process continues to allow for a manager to oversee the allocation of all work and to endorse the recommendations from the multi-agency team for response. When a contact is received by the MASH an initial decision is made by a manager in accordance with the information provided and the PSCP thresholds for services document.



Since 2019-20 there has been a 43% increase in the number of contacts made to MASH. It has risen from 12,924 contacts in 2019-20, to there being **15,192** contacts in 2022-23.

These contacts across the year related to 11,055 individual children, which represents a significant increase of 40.6% increase from 2021-21.



Of these contacts there was a 22% reduction in those that met the threshold for a referral to Childrens Social Care, and a 9% reduction in those that met the threshold for a referral to Early Help when compared to the numbers from the previous year.

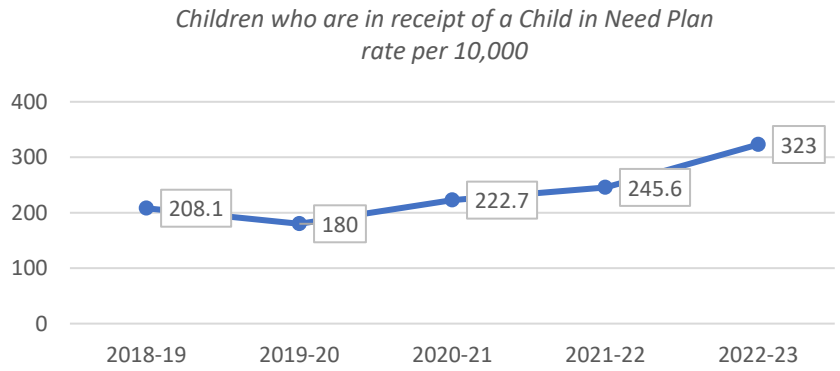
Agency	Number of Contacts	% of overall contacts	% that met Tier 4 threshold	% that met Tier 3 threshold
Police	4,171	27.5%	18.6%	1.3%
Schools	2,400	15.8%	25.1%	26.4%
Health[2]	2442	16.1%	17.1%	6.5%

[2] This includes hospital, GPs, Health Visitors, School Nurses etc

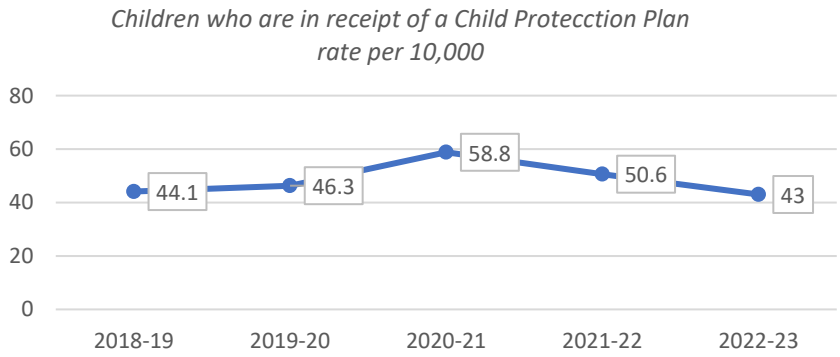
When considering the source of the contacts made to MASH, it is clear that the police make the largest number of contacts. However in terms of whether these contacts result in a referral to either the Family Support and Safeguarding Service or the Early Help Service, it is schools that make the greatest percentage of referrals that meet either the Tier 3 or Tier 4 threshold.

Child in Need, Child Protection and Looked After Children

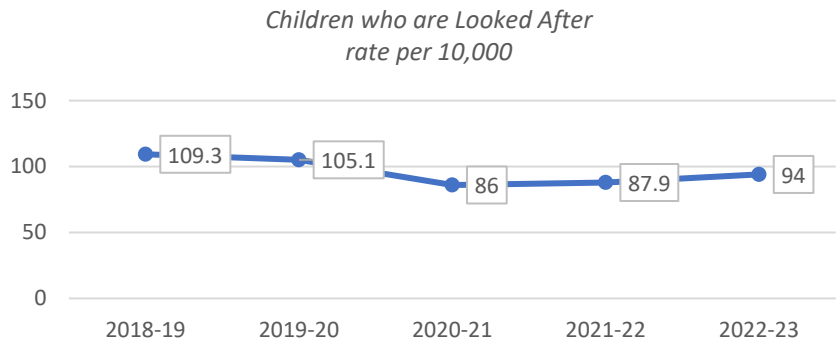
The rate of children in receipt of a Child in Need Plan in 2022-23 has increased by 31.5% from 2021-22.



Whereas the rate of children on a Child Protection Plan in 2022-23 has decreased for the second year by 15% from 2021-22.



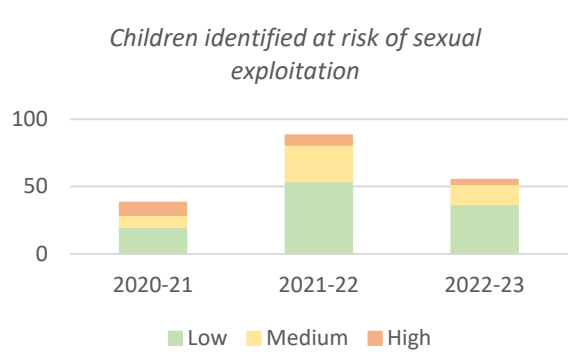
There has been a 6.5% reduction in the rate of children who are looked after in 2022-23.

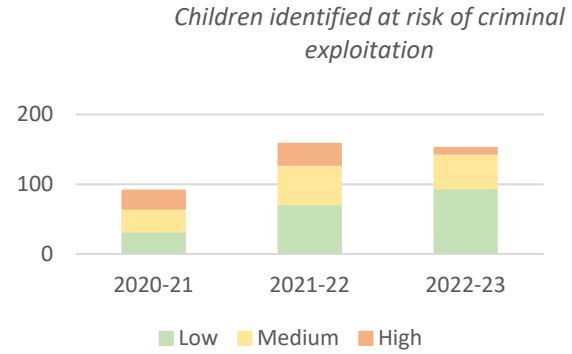


This overall picture indicates that whilst there are more concerns about children's safety and wellbeing notified into MASH, proportionally their needs are being managed at a lower tier of support than in previous years.

Extra-familial Harm

In 2022-23 there has been a 31.8% decrease in the number of children identified at risk of sexual exploitation from the previous year; and a 9.5% increase in those identified at risk of criminal exploitation.

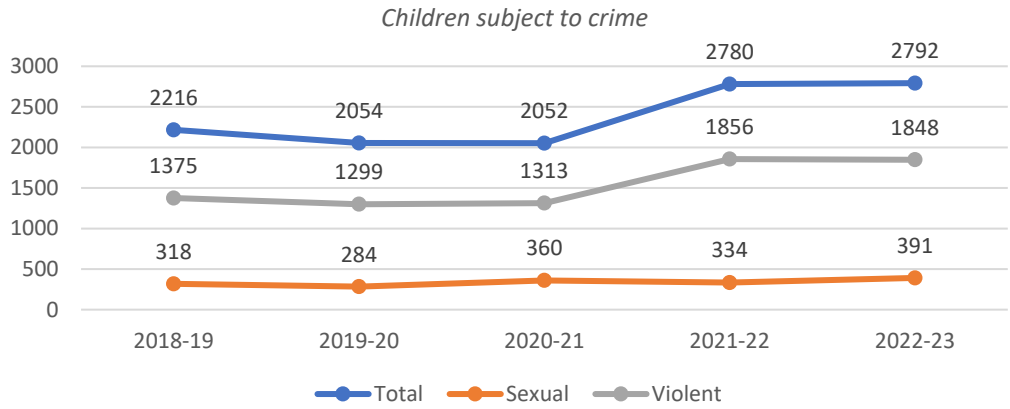




Within the last three years the percentage of children identified at low risk of exploitation compared to high risk has increased. This is a positive indication that the workforce is now better equipped to identify an emerging risk, so that support can be provided to the child sooner before they experience more significant harm.

The youth offending police team have noted that between 1 in 4 and 1 in 3 children referred have been identified as at risk of exploitation. This indicates that children at risk of exploitation are more likely to come to police attention for criminal behaviour than their peers. This is why in response to the strategic priority to keep young people as safe as possible from extra-familial harm in the revised Safeguarding Strategy, a Youth Forum is being developed. The aim is that by bringing together specialist knowledge and expertise from the Youth Offending Team, Violence Reduction Unit and child exploitation teams, we will develop a more effective response to the prevention and disruption of exploitation and be better able to divert young people from becoming involved in criminality.

There also continues to be a steady increase in the number of children subject to crime over the last 4 years. Since 2018-19 reported sexual crimes have increased by 18.7%, violent crimes have increased by 25.6% and the total number of crimes have increased by 20.6%



Neglect

Following last year's Annual Report, in response to the 305% increase in the number of crimes recorded for neglect noted from 2017 to 2022 Hampshire Constabulary completed an analysis of their cruelty and neglect profile. They concluded that the Force had seen an increase in these occurrences over the last 5 years and that there were multiple contributing factors identified for this.

There has been an upward trend seen nationally, with the NSPCC reporting a 25% increase in cruelty and neglect during 2021/2022. It is predicated that volumes will continue to increase over the next few years in line with all child abuse offences.

Although Hampshire Constabulary are recording significantly higher volumes than other forces within the region, they felt that this does not necessarily equate to increased risk being seen. Crime Data Integrity (CDI) accounts for approximately a third of all cruelty and neglect occurrences recorded within Hampshire over the last 5 years. The forces approach to crime recording as a whole has changed and progress has been made year on year. It is recognised that when neglect is reported and there are multiple children within a household, each child will be recorded as a victim on a separate occurrence. These recording improvements will likely account for some of the increase, particularly in areas where there are larger families with multiple children.

Despite the impact of CDI, in 2019 cruelty and neglect offences increased disproportionately compared to all crimes across the force and, more specifically, to all child abuse crimes. This coincides with a large amount of training and emphasis across Police to ensure that incidents of neglect are reported. This remains a strategic priority for all agencies and it is likely the improved identification and recording have contributed to the increases in recorded cruelty and neglect during this time.

MASH demand analysis has shown that the total number of all Public Protection Notice (PPN1) volumes have increased over the last few years. Safeguarding teams (predominantly MASH) are recording the greatest proportion of cruelty and neglect and this has increased by 94% (from 297 in 2017 to 577 in 2021). The rise in MASH volumes coupled with a confidence in the team's data recording accuracy suggests that there is an increased understanding of what constitutes cruelty and neglect within Hampshire.

Concerns were also raised that despite an increase seen in commission rates the arrest rate remained relatively stable for these offences. It is acknowledged that an arrest is not always the best course of action and analysis confirms that there were multiple occasions where a series of crimes were investigated under the one arrest record. Therefore an arrest may fall within that of a linked offence and will not be reflected in the arrest data for cruelty and neglect, but positive action was still taken.

Additionally, those neglect occurrences resulting in Formal Action Taken (FAT) have increased to higher levels than all other child abuse crimes, suggesting that there are more positive outcomes for children who are victims of cruelty and neglect. Community Resolutions (CR) account for the greatest proportion of FAT outcomes, and these have increased since 2019 whilst arrests and charges have remained relatively stable. Since 2018, all neglect offences recorded by MASH are automatically referred to CAIT who are specially trained in working with partners to support a positive safeguarding outcome for children. Analysis has confirmed that the Child Abuse Investigation Team's (CAIT) use of Out of Court Disposals (OOCD) was positive and effective, particularly in cases of neglect where it is a positive early intervention tool.

Deep Dives and Audits

Multi-Agency Safeguarding Hub (MASH) Audits

Every quarter representatives from the PSCPs three statutory partners undertake an audit of contacts into the MASH, to consider:

- Quality of information provided,
- Use of parental consent, and
- Application of threshold

Each quarter the MASH Board agrees a focus or thematic aspect for the audit which is informed by either learning from performance data or agency requests. (Please note that where any contacts are considered to be inadequate, feedback is provided to the individuals to support their learning and any remedial action to ensure the child is appropriately safeguarded is taken.) In 202223 the audits undertaken were as follows:

Quarter 1: Application of threshold and consent

17 contacts were reviewed that had varying outcomes in order to assess the application of threshold and the appropriateness of the decision making. Within this we also considered whether consent had been appropriately sought and recorded.

In terms of the application of threshold we were confident that the decision making and outcomes were appropriate in all 17 cases. There was clear recording of the rationale for the outcome in all instances, noted within a 24-hour time period. There is clear strong management oversight at point of contact and throughout. It was felt that 4 of the contacts were unnecessary and this was fed back as learning to each of these agencies.

Quarter 2: Contacts into MASH that do not progress to contact and referral

In this audit 10 contacts that came into the MASH that then did not progress to being a formal contact, and so were not recorded on MOSAIC (Children Social Care - Computerised Record System), as it was deemed as not being proportionate to record them.

The question of management oversight on these was considered. However, whilst there is a process in place that each contact will be seen by either a Service or Team Leader and the decision not to record will be made by them, as these contacts are not recorded, we were unable to review whether this process had been followed.

Of the 10 children where contacts made into the MASH in August were not recorded on a contact and referral record on MOSAIC, these were made up of 5 from police, 4 from health and 1 from a nursery. Of these the decision made in 9 of the 10 instances was agreed to be appropriate and proportionate.

Quarter 3: Contacts into MASH where the Single Assessment Framework (SAF) is completed, but the child was not seen as part of the assessment

This audit considered 6 contacts that were assessed by MASH as meeting Threshold at Tier 4 and an assessment was completed, but the child was not seen as part of this process.

The initial assessments where the child was not seen as part of process were reviewed, with hypothesis that these would show assessments closed down by management agreement prior to completion. This was borne out in the sample considered and there were 3 themes that ran strongly through the sample:

- A lack of curiosity in the assessment
- Assumptions about consent and lack of engagement
- How robust and assertive are we in our engagement with families

On more than one occasion visits and work were undertaken with the family, but then deemed that a full assessment was not needed. So the start and finish of the assessment was completed with a rationale given for this. It was felt that this rationale lacked curiosity and challenge and often involved taking the families' word for something, regardless of the information contained in referral.

Quarter 4: Application of thresholds

14 contacts were selected from March that had varying outcomes in order to assess the application of threshold and the appropriateness of the decision making.

The audit found confidence with 13 of the 14 threshold decisions. 1 was challenged which involved a child who had disclosed historical sexual abuse. This was referred back to MASH who reviewed the findings and held a strategy discussion post audit.

Child Protection Plan Audit

In October 2020, the PSCP published a serious case review of Child H. One of the recommendations was that "*The Safeguarding Partnership commission a multi-agency audit of Child Protection Plans to gain assurance that information taken in to Initial Child Protection Conferences via single agency reports accurately captures and analyses known and knowable risks to the child, that the record from the ICPC reflect such risks and these*

are translated into the Child Protection Plan". This was undertaken in 2021-22 and the findings reported to the Partnership in July 2022.

Areas of strength:

- Assessments were consistently comprehensive and detailed. They provided clear summaries of risks to children.
- Appropriate and broad multi-agency attendance at Strategy Meetings
- The Chairs were consistently restorative, empathetic, and caring.
- The use of motivational interviewing was strong. Discussions were strengths based and there was open ended questioning and positive affirmations.
- Families had always been well briefed in advance of the meeting by the Chair, and the purpose was well explained again within the meeting.
- Families were well supported throughout conferences and the process in general. Professionals demonstrated high levels of empathy and consideration.
- The Chairs made sure that each professional had multiple opportunities to provide updates, feed into the meeting and raise any comments/questions throughout.
- All professionals had provided a report in each of the conferences.
- Families were usually given frequent opportunities to share their views and feed into the creation of the plan.
- A Family Safeguarding Approach had been considered where appropriate, with Adult's workers involved in several cases.

Areas for development:

- Risks were not consistently followed through from referral and assessment to the plan. If the risk identified in an assessment is unsubstantiated, it should be recorded in the ICPC minutes/ on the plan that this is no longer a risk.
- There were examples were there seemed to be a focus on one parent, especially if they were more engaged.
- Due to the pandemic, conferences were being held virtually or as hybrid meetings. Unfortunately, many of the conferences were hindered by IT issues. This was always managed well by the Chair but not an ideal scenario for these types of meetings.
- Although professionals had consistently had sight of reports, the family often had not seen them in advance of the meeting.
- Inclusion of the child's views was not consistent. The voice of the child and family was not always strong in both conferences and plans, it was broadly felt that the lived experience could have been clearer.
- There were some examples of professional language being used that families may not understand e.g. 'Toxic Stress', 'Restorative Approach'
- Outcomes on plans and timescales for those were not always achievable e.g. school attendance going from 25% to 97% in a period of less than two months. Contingency plans were also not measurable and would benefit from clear timescales.
- There were some examples of partner agencies not feeling like their views had been incorporated into the assessment or resultant plan.
- There were a number of cases where there had been limited inclusion or attempts to include the father/ partner.

What has been done as a result:

- A dip sample of current child protection plans was undertaken in May 2022 that demonstrated an increased expectation within Childrens Social Care relating to the quality of child protection plans, and a significant shift in outcome focussed plans.
- Continued focus remains within the Rapid Improvement Group relating to Care Planning. There is specific focus on SMART planning, outcome focussed plans, and the voice of the child.
- Hybrid technology has now been installed in the Civic Centre, with all conferences now being offered with hybrid capacity.
- Information relating to the sharing of agency reports is now included in the Child Protection Advisor's audit form that is completed as part of the record of the meeting.
- A 'One Minute Guide' was published regarding Our Model of Conferencing in November 2021. This includes clear guidance for professionals about expectations for sharing reports in advance of meetings
- Improvements have been made to the electronic recording system to ensure that the most recent plan is reviewed as part of all Review Child Protection Conferences - informed by the progress of the Core Group.
- 'Mind of My Own' is promoted within the service. Information regarding MOMO, a digital tool enabling children to give their views, is included with all invitations to CPC's. All children age over 4 years subject to CPC's are also referred for Advocacy support.
- Child Protection Advisors have been offered development work around analytical recording. Specific workshops have been delivered and this is an ongoing element within the Service Quality Team business plan

Transition Deep Dive

This was done in response to the Learning Review of Child G and the Safeguarding Adults Review of Mr D both undertaken in 2019. These both concluded there should be a joint exploration with the Portsmouth Safeguarding Adults Board (PSAB) of the effectiveness of transition arrangements for young people with significant learning difficulties and/or disabilities; and to consider the impact of the revised Transition Protocol that was revised a result of these reviews.

This was undertaken in 2021-22 and the findings reported to the Partnership in June 2022.

Areas of strength:

- Referrals to Adult Social Care (ASC) are made from Children's Social Care (CSC) when the child reaches 14yrs old in line with the Protocol and Care Act 2014 duties
- The staff within special schools and the child's social workers engage early with families to explain transition and the process that will be undertaken
- There were timely health transition and Continuing Health Care assessments. Child Paediatric Medical Services continue providing support until the young person reaches 19 years of age, and so (where they are open to CPMS) the Paediatrician is able to offer consistency in care during the young person's transition to ASC
- For children who are looked after, their Independent Reviewing Officer provided additional scrutiny by checking that a transition plan was in place and managed effectively by their 18th birthday.

Areas for development:

- Quality of practice was reliant on the workers supporting the child - there was inconsistent practice evident seen with some particularly good practice from individual workers, but we need to improve the consistency of practice to make sure all young people have a good transition
- ASC were not adding young people to their recording system before their 18th birthday. When CSC referred a child aged 14yrs, it was therefore unclear where this information was stored and how ASC were monitoring these to ensure effective planning for transition was occurring

- Some children were not referred to ASC as CSC believed their needs meant they would not meet the threshold for receiving services. However, all children whose needs will continue to make them vulnerable into adulthood should be referred, as even if they are not eligible for services ASC will be able to signpost them to other appropriate sources of support
- There was limited understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards within the children's workforce and the impact these have upon including children and their families withing transition planning, including consent for referrals and information sharing
- There needs to be an improvement in the information available to families regarding services and support available preparing for & during transition, and into adulthood. This information should also be supplied in accessible formats.

What has been done as a result:

- Adult Social Care has employed a Transition Lead who works closely with Childrens Services and the Inclusion Service, to ensure that there is now strong oversight of the transition planning for young people
- A member of staff has been recruited with responsibility for maintaining the Local Offer website, to improve the information available to families and across the workforce regarding services and support available.
- Within the Preparing for Adulthood core group, transition champions across the partner agencies have been identified.

Obesity Deep Dive

Data from the National Child Measurement Programme (NCMP) for the school year 2021/22 showed that:

- Portsmouth is the only upper tier local authority in the region that has a percentage of Reception children living with obesity that is statistically significantly worse than the England average.
- Portsmouth is one of 3 UTLAs in the region that are statistically significantly worse than the England average for Year 6 children living with obesity.

Childhood obesity can be associated with various diseases (often called co-morbidities) such as sleep apnoea, type 2 diabetes, liver disease and orthopaedic problems. However, being overweight as a child can affect more than their health. It can also impact self-esteem, ability to participate in activities, mental health, and quality of life. All of which can last into adulthood.

This was undertaken in 2022-23 and the findings reported to the Partnership in January 2023.

Areas of strength:

- In the majority of the children reviewed their GP had been proactive in identifying that the child's weight was rapidly increasing and that they were overweight or obese. This was even the case when it was the child's first appointment at that practice, or the child had attended for another reason other than related to measuring their weight. In all instances there was evidence of the GPs making appropriate referrals to other health services to help the family with their child's weight management.
- The Complications from Excess Weight (CEW) Clinic appears to be effective in helping children reduce their weight. For the children who had been receiving support from the CEW Clinic they had all managed to reduce their weight.
- There was evidence of health professionals recognising the child's reluctance/fear of attending the hospital to receive interventions from the CEW Clinic. Examples of how there were overcome were nurses going out to complete weight measurements or blood tests in the community; or supporting attendance by providing transport and accompanying them from home to the hospital.

Areas for development:

- Children not being brought to appointments meant that in many of these instances the child was either discharged from the service or opportunities to identify concerns earlier and offer support were missed.
- For many of the families additional needs were identified that included bereavement, parental ill-health, domestic abuse, social isolation and/or poor parental mental health. Where these were identified, there was limited evidence of exploration of how these potentially impacted on the family's ability to engage in the support and advice being offered. However, this consideration was consistently apparent once a family was supported by the CEW Clinic.
- There was reference in the records to parents' lack of awareness of the complications upon their child's physical and emotional health and wellbeing from them being obese.
- There was limited evidence of the use of the Obesity Pathway and the Thresholds Document in helping practitioners consider an appropriate response.
- Practitioners need to ensure that there are no assumptions made about other services knowledge of the impact the child's weight might be having upon them. As such references to weight or BMI may not be meaningful to practitioners not familiar with what a healthy weight range should be for that child.
- There were examples of schools not recognising concerns about the child's excess weight or not being confident as to how to appropriately respond.

What has been done as a result:

- The PSCP has engaged with Public Health to advise them of the findings of this audit. Until now they have utilised national resources in their public campaigns regarding childhood obesity. They now aim to review these and consider how these can be better targeted. They are also leading on a review of the Obesity Pathway.
- The PSCP Training Team has collaborated with the Consultant Paediatrician from the CEW Clinic to develop a multi-agency workshop ' Working Together to Effectively Safeguard Obese Children' that will become part of the core offer from September 2023.
- The learning from this audit has been shared with education and early years settings, and examples given of how they can use the FSP to support early intervention when a child's weight is increasing. These messages are being shared within the PSCP Early Help training.

Recommendation Tracking

The PSCP has evolved a method of tracking the recommendations made to the multi-agency safeguarding system in Portsmouth (from case reviews, data analysis, audits, and inspections) whereby 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	New, added in year	Completed in year	Outstanding at end of year
Children's Social Care	14	17	30	1
Adult Social Care	0	1	0	1
Education Service	1	0	0	1
General Practices	0	1	1	0
Hants & IoW ICB - Portsmouth place	0	1	0	1
Hampshire Constabulary	0	1	0	1
Portsmouth Hospital University Trust	4	0	3	1
PSCP	19	13	14	18

Solent NHS Trust	0	3	2	1
University Hospital Southampton Foundation Trust	4	0	4	0
Total	**42**	**37**	**54**	**25**

Safeguarding & Early Help Compact Audit

The Partnership is collectively responsible for the strategic oversight of local safeguarding arrangements, to ensure that organisations working with children and families in Portsmouth are compliant with their statutory duties to safeguard and promote the welfare of children

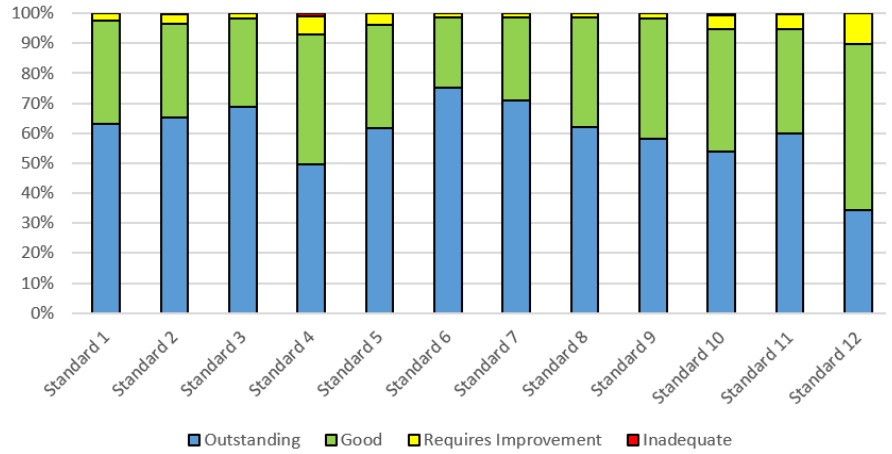
Part of the way in which the PSCP does this is to require all services that work with (or regularly come into contact with) children and families, to complete a self-assessment once every two years against 12 standards with varying indicators to reflect the varying statutory requirements. This is referred to as the Compact Audit and more details of this can be found here on the PSCP website[3].

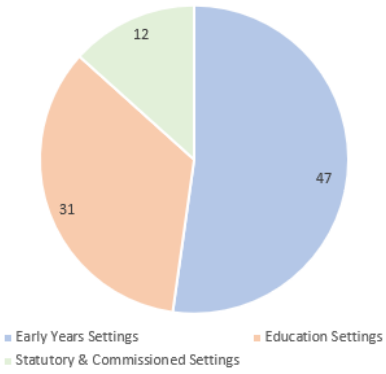
1. Senior management commitment	5. Induction, training & appraisal	9. Information sharing
2. Staff responsibilities & competencies	6. Recruitment	10. Equality of opportunity
3. A clear line of accountability	7. Allegation management	11. Disabled children
4. Service development	8. Effective inter-agency working	12. Commissioning

For each standard there are a set of indicators, which describes the behaviours, processes and policies that would be expected. Settings are then asked to assess themselves against these as to whether they feel their current practice is outstanding, good, requiring improvement or inadequate and to provide the evidence which they believe demonstrates this. Where this is less than good, they are asked to develop an action plan describing what they will do to improve practice.

There is a quality assurance process in place overseen by the Monitoring, Evaluation & Scrutiny Committee to review the individual returns and progress against the action plans. By reviewing all the returns, it allows us to engage both at a setting and sector level to address any gaps in knowledge and/or practice. Briefings are produced summarising the learning at a sector level, and the learning is used to inform future PSCP training and support development.

This year a total of 89 returns were received:





The overall analysis of the returns submitted this year indicates that there are 4 areas of practice where there is a significant need for improvement, these are:

[3] https://www.portsmouthscp.org.uk/10-learning-from-practice/10-2-portsmouth-safeguarding-and-early-help-compact-audit/

Standard 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 = 6.12% RI and 1.05% inadequate

Standard 10. Equality of opportunity = 4.76% RI and 0.56% inadequate

Standard 11. Special Educational Needs & Disabilities (SEND) = 4.97% RI and 0.17% inadequate

Standard 12. Additional specific requirements for commissioning bodies = 10.29% RI and 0% inadequate

What is noticeable is that the areas requiring the most improvement are the same as last year, with the addition of the areas in relation to Standard 11. This demonstrates that more needs to be done to work with settings across Portsmouth to communicate effectively how they can improve their safeguarding arrangements in these areas.

The PSCP requests that settings who completed the Compact Audit last year and marked any indicators as requiring improvement or as inadequate submit an update on the progress and impact of these actions. Some of the examples given are:

- *Completion of the Compact Audit has helped to highlight the importance of what we do and how, if things are not done correctly, the consequences of this.*
- *The focus on safeguarding from point of induction and safer recruitment training for managers has promoted a positive safeguarding culture.*
- *All staff understand that safeguarding is everybody's responsibility and a culture of it could happen here. Safeguarding procedures in school are secure and staff are more vigilant around the nuances of change for the children.*
- *The work completed alongside the children has been particularly beneficial and empowered the children in their knowledge also.*
- *Ensuring that any future changes are assessed, ensures that the impact upon all children and other stakeholders are considered and not unfairly discriminated against.*
- *Implementing Safeguarding Board Meetings where every term the DSL, Safeguarding Link Governor, and Senior Safeguarding Officers meet. These allow the team to review patterns and trends on a termly basis, including making comparisons to previous years.*
- *Contactors are challenged when coming onto school site if no DBS or accompanied by school staff at all times so that children are not exposed to adults without DBS.*

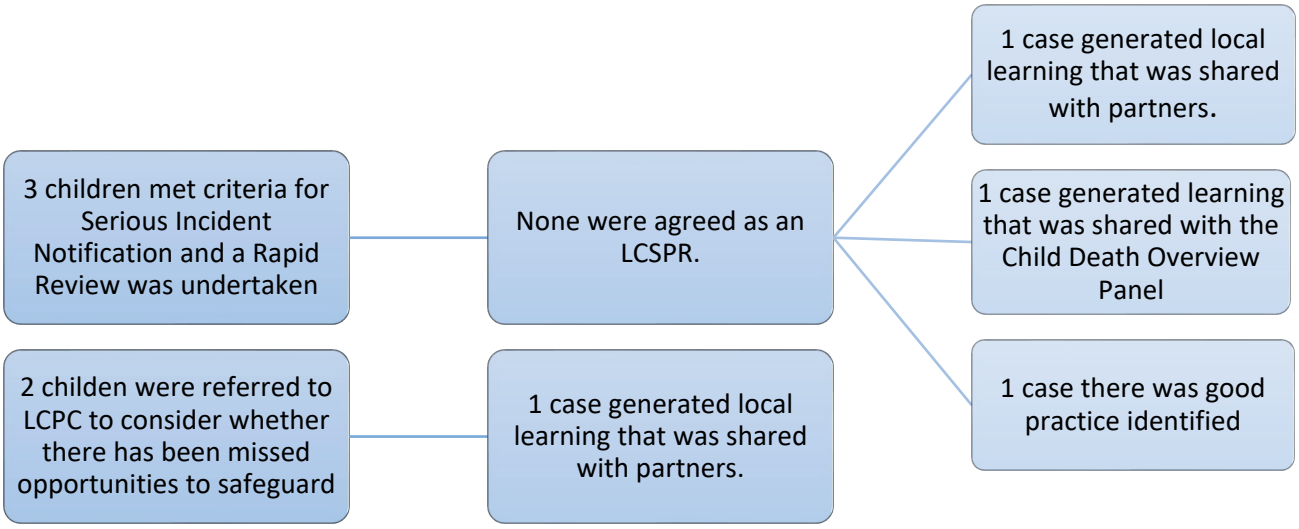
Learning from Children & Practice

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 conduct a Rapid Review and make a formal decision regarding any further review. All decisions are agreed by the Learning from Children & Practice Committee (LCPC), the Safeguarding Partners, and the Independent Chair.



LCSPR Reports are published on our Safeguarding Children Partnership website in our learning from practice section. During the period April 2022 to March 2023 the PSCP has not published any Child Safeguarding Practice Reviews. However it has completed the following:

Thematic Review into availability of Tier 4 beds - The instances of 3 young people were referred to the LCPC between Oct/Nov 2021 that had common concerns as they been placed on paediatric wards with significant mental health and/or 'behaviour' issues where the local hospital is deemed a 'place of safety' because no other option was available. Whilst there were no concerns that met the threshold for a LCSPR, it did highlight what is both a local and national challenge of placement bed availability. The Head of Integrated Commissioning for the local authority and Portsmouth Clinical Commissioning Group undertook a thematic review into this issue. This considered the journey of 13 young people to their admission to hospital. 6 actions were developed in response to this review, which were:

1. Investment was made into the Paediatric Psychiatric Liaison Service at the hospital and will be monitored through the quarterly Child and Adolescent Mental Health Services (CAMHS) Performance Review.
2. The CAMHS Closer to Home Service started to take cases during March 2022 which should support more young people at home and avoid admission.

3. Portsmouth CCG have committed to investing in 3 new mental health roles to support the 'Team around the Worker', to be hosted in the Integrated Targeted Early Help Service as part of a new approach to chronic absence.
4. Portsmouth CCG have committed to investing in an additional role in the CAMHS LD team to provide greater capacity for crisis support.
5. A multi-agency bid to the DfE respite programme has been submitted, jointly with Southampton, for out of school activity.
6. Engaged with Hampshire Childrens Social Care to develop system-wide mechanisms to support young people in avoiding hospital admission or to speed up discharge.

'Henry' was a 2-month-old baby who was suspected of being physically harmed by his parent, resulting in substantial injuries. This incident was notified to Ofsted by the Local Authority and a Rapid Review was completed. Whilst the case met the criteria for a LCSPR, there were similarities in learning to those identified in Child E, Child I, Freya and Skylar. Instead, the learning identified in the Rapid Review will be shared with relevant agencies, appropriate recommendations developed and consideration of the appropriateness of the response built into the Deep-Dive on the Unborn Baby Protocol being undertaken in 2023. This will include consideration of what the barriers may have been in effectively implementing the recommendations from the previous reviews. The National Panel has agreed with our decision.

Workforce Development

The PSCP training programme has grown in strength and depth over the past year. Following the significant changes made to adapt to the consequences of Covid19, the team have reformed the offer again to meet the growing need for connection. Through extensive feedback gained from across the workforce, it was clear that learning 'in person' is of far greater benefit and the networking gained in being together improves relationships resulting in more effective safeguarding practices. However shorter courses remain on-line as this supports easier access to them, and has the benefit that delegates are off-site from their place of work for a shorter period of time

The PSCP training offer has strengthened its focus the importance of growing a safeguarding culture in line with Keeping Children Safe in Education (KCSiE) and other statutory guidance, research and evidence. Underpinning much of this work is the focus on language and how it reflects our values. Building on the relational and restorative work, language forms an essential part of how we develop practice which is inclusive, accessible and kind. An essential element of all of the taught sessions on the PSCP training programme, is that delegates are given time and support to consider application of their learning in practice. The feedback from attendees is overwhelmingly positive, that in particular this has enabled their practice to improve and strengthened how they work together across the multi-agency network and how they connect with children and families.

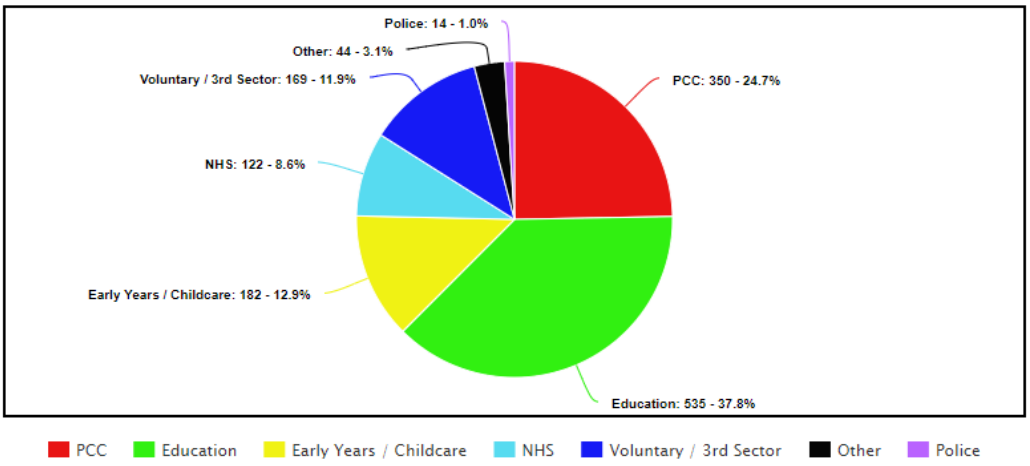
Another key focus this year has been to strengthen how we embed learning from both our audit and scrutiny activity and from learning from children and practice into training. In combination with the feedback from delegates through evaluation of the courses they have attended, this allows for adaptations to be made to the programme throughout the year to ensure the training remains meaningful and current.

Going forward the priority is to continue to strengthen the PSCP training in line with local and national learning. The training team will respond to bespoke work in line with the growing momentum around language development and relational practice. Re-think will be a central strategy in supporting the workforce to improve outcomes for children and their families. And finally the team will work together with the PSCP Business Manager to ensure effective improvement activity is designed in line with learning gained from the Partnership's activity.

Attendance on PSCP Training

Despite there being a 5.2% decrease in the number of multi-agency training courses available in 2022-23 compared to the previous year, there was a 7% increase in bookings and a 5.6% increase in attendance.

Multi-agency training data	2020-21	2021-22	2022-23
Number of courses run	129	134	127
Number of bookings	1,972	1,636	1,766
Number of attendances	1,556	1,337	1,416
Booking attendance %	79%	81.72%	80%



As can be seen in the chart above, the majority of attendees on these courses come from education settings and Portsmouth City Council

However, caution needs to be applied when making a comparison to the preceding years for both single and multi-agency training, due to many of these courses being impacted by restrictions applied following the Covid19 pandemic.

The requests for single agency (bespoke) training grew significantly in 2022-23 with a 133% increase in the number of courses ran. Throughout the year, as well as the inset training delivered to education settings, there has been considerable work carried out on a single agency basis with Hampshire Constabulary, and teams within Solent NHS and Portsmouth City Council.

Single Agency Data	2020-21	2021-22	2022-23
Number of courses run	17	27	63
Booking Attendances	408	1,220	1,506

A contributing factor for this high growth in single agency training is how practitioners and managers experience the multi-agency training programme. Following reports of positive learning experiences, managers often contact the team for further input, wanting to have a more specific and targeted training input delivered to their team. Equally those who have had bespoke training previously have come back again for further input.

Re-think

In the PSCP 2021-22 Annual Report, the development of the Re-think approach was described in relation to the learning from the Skylar LCSPR. Over the past year Re-think has grown in strength and momentum, and a growing number of sessions have been facilitated in order to support the workforce in relation to their safeguarding work with children and families to:

- Address and repair professional disagreement and / conflict
- Find creative solutions to 'stuckness'
- Define roles and responsibilities to ensure effective multi-agency collaboration

Giving and receiving honest challenge about our work with families can be difficult and taking time to ‘slow down’ and consider how to go about hearing challenge is vital to ensure children and their families are kept at the centre of our work. Resolving concerns is beginning to be seen as an integral part of how we advocate for children and their families in Portsmouth. Re-think is beginning to support the workforce to address such challenges.

Further work in evaluating the impact of Re-think is being prioritised over the coming year and will build on the existing evidence showing impact on practice.