Hampshire Safeguarding Children Partnership

ANNUAL REPORT

2019/2020

Foreword

Welcome to the first Annual Report of the Hampshire Safeguarding Children Partnership (HSCP).

On 30 September 2019, the previous Hampshire Safeguarding Children Board (HSCB) transitioned into the Hampshire Safeguarding Children Partnership (HSCP). The HSCP is established in accordance with the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 statutory guidance. The HSCP provides the safeguarding arrangements under which the safeguarding partners and relevant agencies work together to coordinate their safeguarding services, identify and respond to the needs of children in Hampshire, commission and publish local child safeguarding practice reviews and provide scrutiny to ensure the effectiveness of the arrangements.

This report covers the last six months of the previous HSCB arrangements and the first six months of the HSCP arrangements.

Helping and protecting children through a coordinated approach to safeguarding children is everyone's responsibility. Through collaborative working across organisations and agencies who work with children, young people and families, including those who work with parents/carers, the ambition of our arrangements is that everyone can recognise, respond and fulfil their responsibilities to ensure that children, young people and families are effectively safeguarded and supported.

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At the heart of the arrangements is a commitment from us, as safeguarding partners, to work together effectively, constructively challenge where needed, and to foster a culture of professional curiosity and continual learning to drive improvement.

Steve Crocker
Director of Children's Services
Hampshire County Council

Ellen McNicholas
Director of Quality & Nursing
On behalf of the 5 Clinical Commissioning Groups

Rachel Farrell
Chief Superintendent
Hampshire Constabulary

Welcome from Derek Benson

It is my pleasure to introduce the Hampshire Safeguarding Children Partnership's Annual Report for 2019/2020, and although the report covers the performance year that ended in March it would be wrong not to take stock of where we find ourselves in light of the unprecedented situation caused by the coronavirus (COVID-19).

Like every individual, agency and indeed the country as a whole, the HSCP had to adjust how we work, operate and think, with well-established processes and practices coming under intense pressure. The Partners from both the statutory and voluntary sectors responded quickly and effectively, adjusting how they operate and critically, how they maintained line of sight to those children and young people with whom we work.

Safeguarding is critically important and is best approached through agencies coming together with shared ambition, shared information and co-ordinated programmes of action. I would like to place on record my appreciation for the efforts, commitment and professionalism of all those agencies and individuals who safeguard the county's children and young people. More detail will be provided in the annual report for 2020/21 but the strength of the Partnership in Hampshire has been apparent during the crisis.

This report provides information and assessment of the activity that has taken place, the progress that was made in delivering the Partnership's objectives, how learning was identified and applied in practice and some of the challenges we continue to address as a partnership.

I would like to highlight the launch of the Family Approach protocol and toolkit, which was done in conjunction with the Hampshire Safeguarding Adults Board and the other pan-Hampshire LSCPs, the ongoing ICON programme and the Safe Sleep campaign. These initiatives, alongside the broad range of safeguarding activity detailed in the report, help to keep the children and young people in Hampshire safe and well.

I firmly believe that a collective approach is most effective in safeguarding and promoting the wellbeing of children, and the HSCP will remain committed to maintaining a strong and inclusive partnership in Hampshire.

Derek Benson
Independent Chair
HSCP

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About the Annual Report

To bring transparency for children, families and professionals, Safeguarding Children Partnerships publish an annual report that sets out what agencies have done to improve outcomes for children and their families and how effective programmes of work have been in practice.

This annual report includes:

- Evidence of the impact of the work of the three safeguarding partners (Hampshire County Council, West Hampshire Clinical Commissioning Group, on behalf of Hampshire's 5CCGs, Hampshire Constabulary) and relevant agencies, including training, on outcomes for children and families.
- 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.

Snapshot of Key Demographics

Hampshire County Council is the third largest county in the country (based on population) with 1.32 million people including 309,462 children and young people aged 0-19 (ONS Census, 2011). The population of Hampshire is forecast to increase to 1.47 million people by 2024 (Small Area Population Forecasts 2017). The population of children aged 0-17 is forecast to increase from 282,750 to 307,350 over the same period.

Hampshire has a predominantly white ethnic population with 91% of children of compulsory school age and above of white ethnicity (DfE sfr/28/2017). 94% of children in Hampshire of compulsory school age and above have English as their first language (DfE sfr/28/2017).

The county is a mix of urban and rural populations, with areas of affluence and areas of significant deprivation. There are six areas in Hampshire that are listed in the 20% most deprived in England, including Eastleigh, Gosport, Havant, New Forest, Rushmoor and Test Valley (Index of Multiple Deprivation, 2015).

I. THE PARTNERSHIP AND SUBGROUP FUNCTIONS

How the partnership works

Hampshire Safeguarding Children Partnership (HSCP) is the key statutory body overseeing multi-agency child safeguarding arrangements across the Hampshire local authority area. The work of the Partnership in 2019/20 was governed by the statutory guidance Working Together to Safeguard Children (2018).

Section 14 of the Children Act 2004 set out the statutory objectives of Local Safeguarding Children Boards, which are:

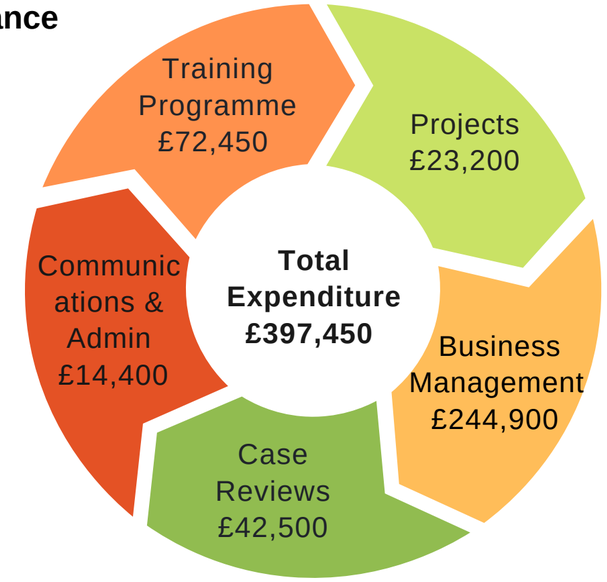
- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in their area.
- To ensure the effectiveness of what is done by each such person or body for those purposes.

Everything we do is underpinned by two key principles:

Safeguarding is everybody's responsibility -
For services to be effective each professional and organisation should play their full part.

A child centred approach -
For services to be effective they should be based on a clear understanding of the needs and views of the individual children whilst recognising the support parents and carers may require.

Finance



The gross budget for HSCB in 2019/20 was **£428,587** which included a carry forward underspend of £98,237.

This has included an 'in kind' contribution from the Diocese of Winchester who have supported us via free use of their venues. For 2019 the total was worth £4,610.

I. THE PARTNERSHIP AND SUBGROUP FUNCTIONS

Key Priorities

HSCP has an Independent Chair and members who are leaders from a range of agencies. The Partnership is collectively responsible for the strategic oversight of local safeguarding arrangements. It does this by leading, coordinating, challenging, and monitoring the delivery of safeguarding practice by all agencies across the county.

Day to day, the work of HSCP includes:

- Undertaking multi-agency thematic audits and partnership reviews into the effectiveness of services.
- Scrutinising quarterly data and producing a partnership analysis so that HSCP is clear on the needs of children and the challenges in relation to safeguarding.
- Commissioning, designing, and delivering training and learning opportunities that are available for the children's workforce and reviewing the effectiveness of these through evaluations, observations, and longer-term impact audits.
- Managing completion and publication of Serious Case Reviews (SCRs), Local Safeguarding Practice Reviews (from September 2019) and other reviews ensuring that the learning from these improves services for children.
- Checking partners are fulfilling their statutory obligations in relation to safeguarding and promoting the welfare of children within their organisations through audits, visits, and challenge days.
- Coordinating complex multi-agency working in respect of emerging safeguarding themes.

To ensure that the children of Hampshire are safeguarded, and their welfare promoted, the HSCP will:

Listen and respond to children and young people, and adult victims/survivors of child abuse to inform how services are delivered.

Facilitate collaborative working beyond organisational boundaries and agency constraints to deliver best outcomes for children and families.

Work and share information proactively, to enable the early identification and response to new areas of safeguarding and emerging themes.

Build working relationships between partners which support continuous improvement, professional curiosity, constructive challenge, and enable partners to hold each other to account for the outcomes we deliver for children.

Work and share information proactively, to enable the early identification and response to new areas of safeguarding and emerging themes.

Work effectively and collaboratively towards shared priorities to achieve improved outcomes for our children.

Ensure services for children and families in Hampshire support parents and carers to provide the best possible care for their children and enable families to live together where possible.

Embed the learning from local and national safeguarding reviews, and local scrutiny and assurance practices, to improve the way children are safeguarded.

I. THE PARTNERSHIP AND SUBGROUP FUNCTIONS

Safeguarding arrangements

The new safeguarding arrangements have been developed to build on the strengths of the previous arrangements under the Hampshire Safeguarding Children Board. More information on the new HSCP can be found in our 'new arrangements' document.

The multi-agency partnership in Hampshire is robust and effective, with clear commitment from senior leaders. The changes to the partnership arrangement have strengthened the already strong partnerships we have in Hampshire. The development of the new partnership arrangements has given us the opportunity to review and change some of our ways of working; building on strengths within the good partnership relationships that already exist and focusing on how we can make a real difference to multi-agency frontline practice to improve outcomes for Hampshire children, young people and their families.

There are many agencies in Hampshire supporting children and young people, and they all work together as a partnership to ensure they are keeping children safe. As leaders we recognise that safeguarding children cannot be achieved in isolation from other partnerships or our communities. This has been an area of strength in Hampshire in recent years.

Working Together 2018 explains that there are three safeguarding partners who have overall responsibility to establish the Local Safeguarding Children Partnership, and assure themselves on the effectiveness of the arrangements. These partners are:

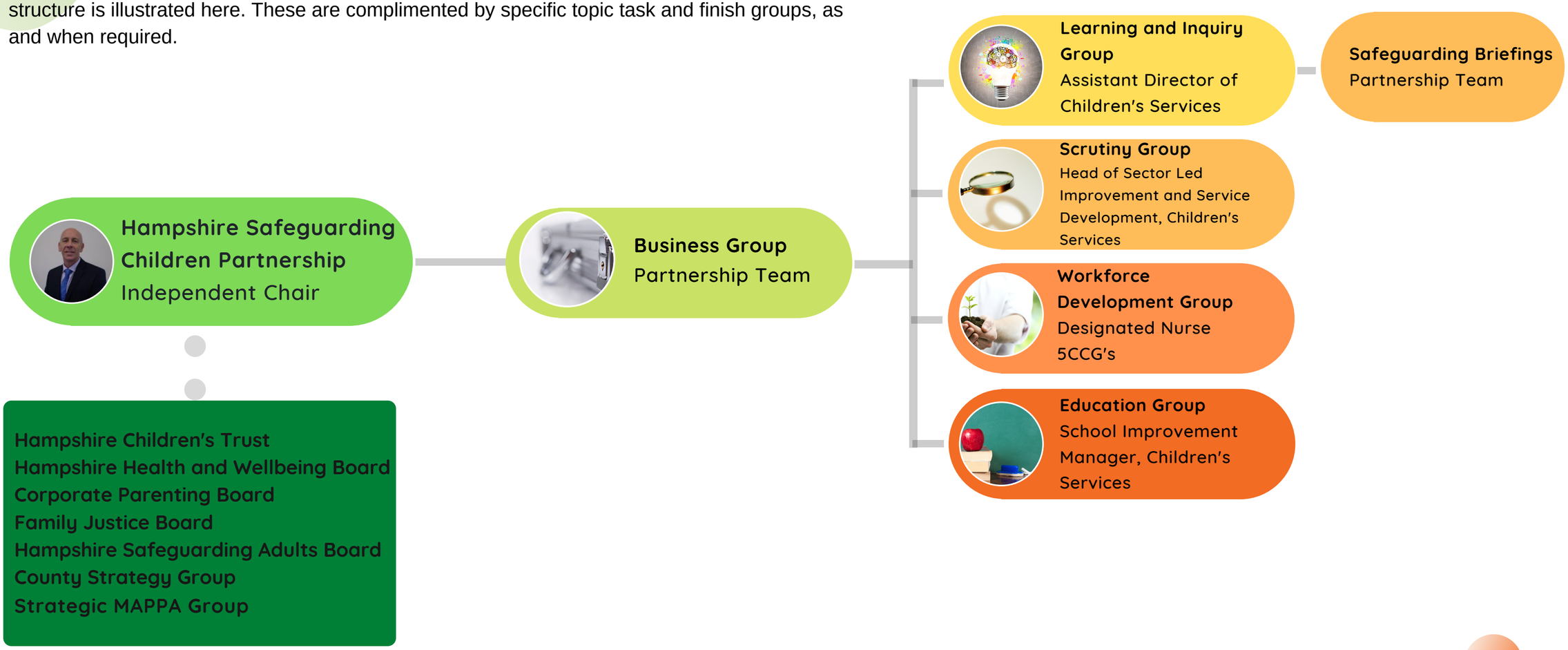
As well as the three Safeguarding Partners, the HSCP is made up of a number of 'Relevant Agencies' who are required to work as part of the local partnership arrangements. A full list of the HSCP Relevant Agencies is included as an Appendix to this report.

**on behalf of the five Hampshire Clinical Commissioning Groups*

II. THE PARTNERSHIP AND SUBGROUP FUNCTIONS

Structure 2019/20

The Partnership is supported by a range of subgroups that enable its functioning. The overall structure is illustrated here. These are complimented by specific topic task and finish groups, as and when required.



I. THE PARTNERSHIP AND SUBGROUP FUNCTIONS

Lay Members

HSCB had two lay members on its Board throughout 2019/20. These lay members played an important role in challenging, supporting and holding partners to account in the way they met their safeguarding duties. They also assist in developing stronger public engagement and awareness of children's safeguarding issues. Lay members help the Board stay in touch with local issues so that its work is relevant to local communities.

Claire Cox
Lay Member

'I was appointed as a lay member of the HSCB in 2017. I am a retired healthcare professional and it has been a real privilege to witness the constructive relationships that exist in Hampshire between health, social services, education and police. These multidisciplinary teams work tirelessly to listen to the voice of the child and to safeguard them. The culture of the HSCP is one of openness and reflection. Practice is audited and reviewed – aiming for a cycle of continued improvement in the lived experience of children.

The Partnership Team has made considerable efforts to engage with me and to explain the background to issues covered. I have been encouraged to question and critically review supporting documents prior to Board meetings and the Chair has facilitated my participation. Every effort has been made to answer any queries or concerns that I have raised – either at the Board meeting, or through meetings with individual Partnership members. This year, I was invited to join a Scrutiny visit to the Child and Adolescent Mental Health Service (CAMHS), which was a fascinating experience. I was inspired to witness the hard work, care and concern of the CAMHS team, and their openness in discussing their areas of challenge.

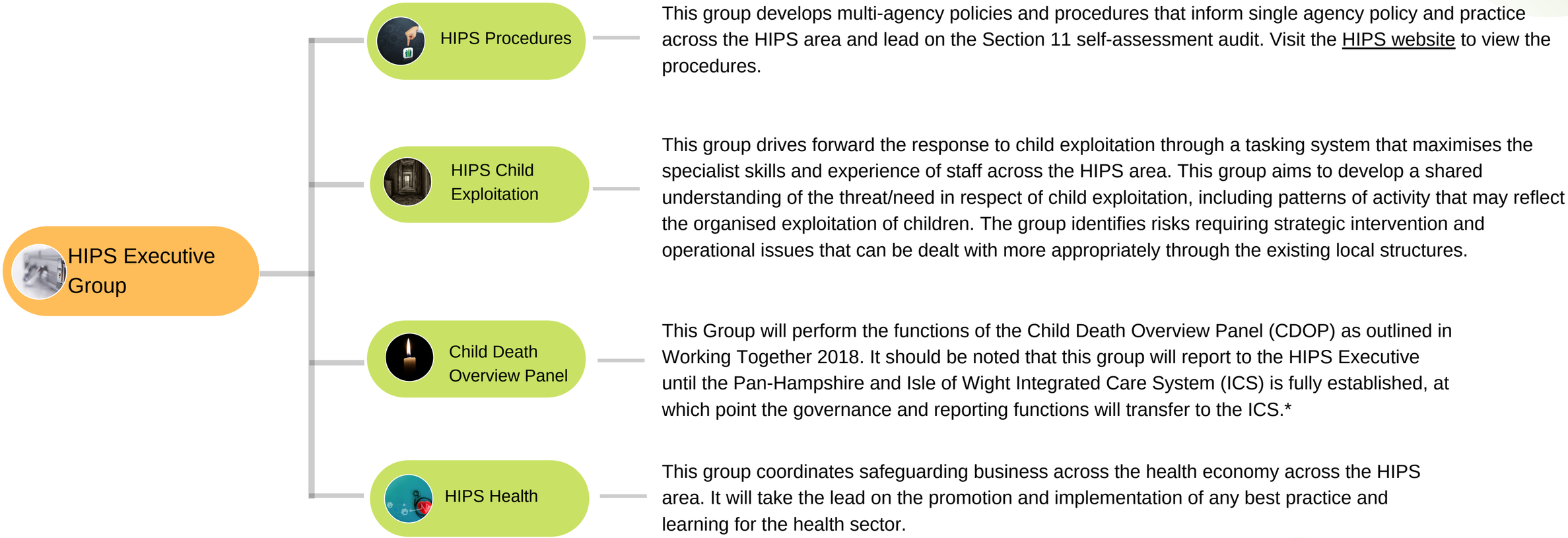
I have been very impressed with the educational initiatives that the Partnership has developed – including Safe Sleep, ICON and the Neglect Toolkit. These have the potential to significantly impact upon the safety of Hampshire children. There have been relentless efforts to embed these programmes successfully into the practice of Safeguarding Teams.'

I. THE PARTNERSHIP AND SUBGROUP FUNCTIONS

HIPS working

The Hampshire statutory safeguarding partners have agreed to work in partnership with the statutory safeguarding partners for Isle of Wight, Portsmouth and Southampton, to ensure coherence in safeguarding arrangements across the wider geographical area. The arrangements for this collaboration are known locally as ‘HIPS’.

It is acknowledged that for many agencies and professionals who work across more than one of the local authority areas, there would be benefit in greater joined-up working on strategic issues and common themes. Given that each local area was keen to retain some degree of local arrangement, partners agreed to form a new Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Executive Group, supported by some specific four-area subgroups, to work alongside the four local partnerships.



Other workstreams, for example, quality assurance, workforce development, and specific areas of business will be undertaken via task and finish or project focussed groups. The partners remain committed to undertaking the Section 11 audit process on a HIPS wide basis.

**Child Death Overview Panel (CDOP) responsibilities transferred in September 2019 and all CDOP activity undertaken since that time will be reported in the new HIPS CDOP Annual Report.*

II. PROGRESS ON BUSINESS PLAN PRIORITIES

This section of the report sets out how the Safeguarding Partners and Relevant Agencies worked to deliver improvements against the above priorities between 1 April 2019 and 31 March 2020. This includes key projects and programmes of work that have been undertaken, including the evidence the positive impact these have had for children and their families. This section also highlights key areas of focus that will deliver continued progress against the above priorities throughout 2020/21 and beyond.

Priority 1: Further embed and evaluate HSCP initiatives

Relevant agencies have worked hard to embed HSCP initiatives. Examples include:

- The 11 District/Borough Councils within Hampshire are represented on the HSCP. All initiatives are cascaded across council departments via dissemination in newsletters and staff safeguarding pages.
- Following publication of the Business Plan, Hampshire Fire and Rescue Service (HFRS) issued communications to all relevant HFRS personnel. Associated resources and training packages were uploaded to HFRS Safeguarding E-Learning platform (Moodle).
- All Hampshire initiatives have been promulgated to key stakeholders across Defence within Hampshire, including military medical centres and service police.
- The Child and Adolescent Mental Health Service (CAMHS) issue a monthly newsletter. This includes a section dedicated to HSCP developments. Key strategies and toolkits are referred to in safeguarding training.

1a – Formally launch the Family Approach Protocol and Toolkit with the other LSCBs and Local Safeguarding Adults Boards (LSABs) in the Pan-Hampshire area. Run a programme of multi-agency briefings and agree evaluation criteria for an end of year evaluation.

The Adopting a Family Approach Protocol and Toolkit was launched to the multi-agency workforce in May 2019. The toolkit contains a range of resources and information to assist frontline professionals to embed the principles and ways of working outlined in the Protocol. The HSCP and HSAB delivered a series of multi-agency workshops on the Family Approach during 2019-2020. Five sessions were run in 2019-20 with a total of 213 delegates in attendance.

Dissemination

- West Hampshire Clinical Commissioning Group (CCG), on behalf of the five Hampshire CCGs, has supported the roll-out of the Family Approach Protocol and Toolkit across the Hampshire area, via training and development sessions and within information and newsletters which have been circulated by the CCGs.
- The Family Approach featured in Designated Safeguarding Leads (DSL) conferences for school and colleges in 2019. There was Family Approach input at the Education subgroup which was then disseminated through school and college representatives.
- Hampshire Constabulary have attended and shared training across teams. The Family Approach remains a strand of the training strategy being developed by their Public Protection Department and Learning and Development Team, and has been woven into the safeguarding training delivered to new recruits.
- Family Approach Protocol and Toolkit are embedded into training and included in Hampshire Children's Services online social care toolkit.
- The Hampshire Hospitals Foundation Trust safeguarding team, in collaboration with the Emergency Department, have promoted a family approach to care delivery via the development of new training and guidance. This includes the need for multi-agency assessment when an adult presentation might indicate transferrable risks to the safety and wellbeing of children in their care.

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1b - Develop and embed the ICON programme, completing the public launch of the programme. Undertake first stage professional and public evaluation of impact of the programme to date.

The Designated Nurse for West Hampshire CCG, on behalf of the five Hampshire CCGs, and in collaboration with the HSCP, has led on the implementation of the ICON programme across Hampshire. During 2019/20 a series of audits have taken place across a number of multi-agency settings to establish if the ICON programme is embedded into practice and as part of the evaluation of the impact of the programme. The audit and evaluation report was presented to the HSCP Board in June 2020, however the individual audits were undertaken within the reporting year. The audits, which were undertaken by a number of health and social care settings, demonstrated favourable results. The headline results include:

- Within the Health Visiting and Family Nurse Partnership service, 95% of cases showed evidence that the health practitioner had had the ICON conversation with the family, 87% of families were aware of the ICON message, and when asked, 95% of parents/carers were able to confirm that they had received and remembered the messages.
- Within Primary Care services across Hampshire, the audit demonstrated overall that there has been a considerable improvement within Primary Care practice, especially regarding asking about coping with crying. The pilot in 2018 indicated that only 10% of GPs routinely asked about crying, however the 2019 audit indicated that overall 95% of practices in Hampshire (who submitted a return) discuss coping with crying at the six week check. It is also a fantastic achievement that 84% of GP practices are fully aware of the ICON programme.
- To date, over 2,000 professionals across Hampshire have received ICON training directly from the HSCP and members of the ICON Working Group.
- The HSCP in collaboration with partners, delivered eight 'ICON Train the Trainer' sessions in 2019 in addition to an 'ICON – 12 months on' update which was presented at the HSCP 'Every Sleep Counts' launch in January 2020. This reached over 400 professionals.

An example of disseminating the learning from the Train the Trainer sessions would be from the Services for Children and Young People (SfCYP). The SfCYP nominated 13 professionals to attend the ICON Train the Trainer events. In turn, during 2019, those who had received the training via the HSCP ICON Train the Trainer, formally trained a further 343 practitioners working with children and families. This equates to 26 practitioners per one person trained in delivering the ICON messages. The evidence from the SfCYP service provides good evidence that the 'Train the Trainer' model works in spreading key messages across large staff cohorts.

Practitioner Quote:

'After attending the Train the Trainer session, our staff have felt passionately about communicating the ICON message to families and expectant parents. We have used the resources provided by ICON in one-to-one sessions and group workshops to raise awareness of infant crying, and to help parents plan for how to manage and cope when it gets tricky. Young Families Coordinator, Shelly, says: "I love using the ICON resources with all of our clients. By taking the time to complete a plan and have a meaningful conversation about infant crying, we have the chance to encourage expectant parents to have those difficult conversations with each other, and with family/friends who may look after baby too. Many parents of newborns have found the 'crying curve' particularly reassuring, and we use this to spark conversations around coping strategies and speaking out when it can feel like a bit too much.' Thank you ICON!

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1b - Develop and embed the ICON programme, completing the public launch of the programme. Undertake first stage professional and public evaluation of impact of the programme to date continued...

One of the aims of the ICON programme is to try to reduce the incidence of abusive head trauma (AHT) and the origins of its development within Hampshire stems from a Serious Case Review. Whilst numbers of babies and children who have suffered AHT is as measurable indicator of whether or not the programme has been successful, there is no way to measure how many cases have been avoided due to the implementation of the programme and successful delivery of the information.

We are able to evidence that parents and carers are receptive to the ICON messages, and have had information shared from a Hampshire social worker regarding one new mothers use of the ICON message when she was suffering from intrusive thoughts about harming her baby. She recalled the information provided by health professionals, which enabled her to place her baby down, reach out and seek help – the outcome from this case is positive, in that both her and her baby received the additional support required; they were able to bond and no harm occurred to the baby.

Below are some examples of the work which the HCSP and ICON Working Group members have completed to engage, spread and promote the ICON programme:

- NHS Parliamentary Award - West Hampshire CCG, won the South East Region Parliamentary Award for the ICON programme.
- National Paediatric Trauma Network - The Designated Nurse (West and North Hampshire CCGs) and the HSCP Partnerships Manager presented ICON to the Paediatric Trauma Network (PTN) on 8 October 2019. An official endorsement has now been offered to the ICON programme.
- Royal College of General Practitioners (RCGPs) - West Hampshire CCG and HSCP officially presented ICON to the RCGP, with a request for endorsement. The RCGP fully endorsed the programme and therefore the Maternal Postnatal Template, which was developed by the Hampshire Named GPs for the six to eight week check, is fully endorsed and is included in the RCGPs Safeguarding Children online toolkit.
- Pharmacy Resources - West Hampshire CCG supported the roll out of ICON to 94 pharmacies across Hampshire to support pharmacists in delivering the ICON message. DadPad posters are also displayed within all pharmacies.
- NHS England Grab Guide - 'Prevention of Abusive Head Trauma in Babies' was developed and promoted by NHS England as a quick reference guide to AHT and ICON.
- DadPad - has been re-commissioned for across Hampshire, Isle of Wight, Portsmouth and Southampton. This is being promoted by professionals such as health visitors and a localised version is in development.
- Schools and colleges - ICON campaigns promoted through Services for Young Children to pre-school and early years settings, alongside additional services working with families, such as the Primary Behaviour Service.
- The National Probation Service (NPS) have posters on display in waiting rooms and leaflets are made available to service users.

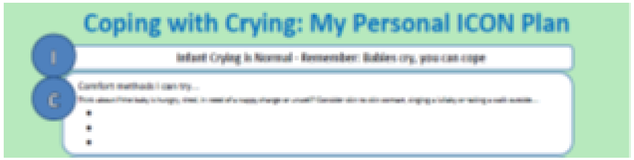
II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1b - Develop and embed the ICON programme, completing the public launch of the programme. Undertake first stage professional and public evaluation of impact of the programme to date continued...

The Hampshire ICON Working Group has supported the development of a number of ICON films including:

- Fixers Film: A film has been produced by three young people, specifically regarding the management of a crying infant. This film has been utilised within the ICON E-Learning Programme which has been developed by HSCP for professionals working across Hampshire.
- Ellis' Story: Mae Pleydell-Pearce (Ellis' mother) kindly produced Ellis' Story which has allowed her family's story to be shared in professional training sessions and at launch events. Ellis' Story can be accessed via this link: Ellis' Story - told by Mae.
- Parent Film: The film describes the ICON programme in more detail and discusses how to handle a baby safely, which can be used in settings to educate parents and carers.



Following the presentation of ICON 'Train the Trainer' to Hampshire professionals, a recommendation was made for there to be the development of a 'Coping with Crying: My Personal ICON Plan'. This plan has been developed and is now part of the antenatal/postnatal contact by the midwife and health visitor. However, the plan is available to all partners and can be used by any professional who has contact with the family.

Hampshire's current ICON work and next steps:

- HSCP has developed an ICON E-learning programme which will be available to Hampshire practitioners and is due to be launched imminently.
- A HSCP safeguarding webinar is scheduled for professionals across Hampshire regarding the vulnerability of babies and will include AHT/ICON/Every Sleep Counts and bruising.
- Public Health promote ICON routinely as part of the universal Healthy Child Programme, providing additional support and advice to families where required.
- Hampshire police are leading 'Beat' surgeries, which are scheduled across the county (including Isle of Wight, Portsmouth and Southampton), consisting of promotional stands in prominent places such as supermarkets. ICON, alongside other key safeguarding topics, such as domestic abuse, will be promoted.
- Across Hampshire, all antenatal education programmes for pregnant women and partners will include ICON information.
- There has been an agreement to further develop the HSCP and Isle of Wight Safeguarding Children Partnership (IOWSCP) ICON Toolkit to reflect the requests from parents for a 'one stop shop' for all key information. Therefore, this will include ICON and the HSCP and IOWSCP Every Sleep Counts information.
- The Named Midwife has continued to be a member of the Hampshire Steering Group for ICON, having piloted the programme at Hampshire Hospitals Foundation Trust, staff continue to deliver the message across Maternity, Child Health and Unscheduled Care. This includes its incorporation into Level 3 Safeguarding Children Training.

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1c - Launch the 'Safe Sleep' campaign with the other LSCBs and Child Death Overview Panels (CDOPs) in the Pan-Hampshire and Isle of Wight area by Summer 2019. Conduct a first phase evaluation by the end of the reporting period.

The Every Sleep Counts programme was launched in Hampshire in January 2020. The programme was developed as a result of the Child K Serious Case Review published in 2018/19 and a number of Child Death Reviews where unsafe sleep arrangements were identified as a presenting factor. The launch was attended by over 300 professionals working across Hampshire. The event was opened by Derek Benson, Independent Chair, with members of the working group presenting on the importance of the programme, sharing the key messages and detailing how it will be embedded within their service.

The programme highlights the key message that the safest place for a baby to sleep is in a cot or moses basket in the same room as their parents/carers for the first six months. It identifies known risk factors including sleeping on the sofa with a baby and co-sleeping when a parent/carer has consumed drugs or alcohol, to ensure that parents/carers are informed when making sleeping arrangements for their baby.

HSCP developed materials which have supported the campaign including posters and stickers. HSCP wanted information for parents/carers to be available in one place and have developed a leaflet detailing the benefits and risks to different sleep scenarios. An Every Sleep Counts Toolkit has been developed to support professionals to understand the importance of every sleep being a safe sleep and share the message with parents through resources.

West Hampshire CCG have supported the implementation of Every Sleep Counts across Primary Care and have included Every Sleep Counts into Level 3 Training and Development, and the Ardens Child Safeguarding and Postnatal Check templates contain links. Leaflets are now also available in neonatal, paediatric and emergency departments across Hampshire hospitals.The programme is being delivered by multi-agency professionals at key points during pregnancy and post birth, including midwifery, health visiting, GP, Children's Services, police, early years settings and housing services to ensure clear, key and consistent messages are being given to parents and carers. Train the Trainer sessions have been scheduled to spread the messages more broadly across the workforce. Further rollouts will take place during 2020/21.

Since launching the programme the feedback received has been very positive from professionals across multi-agency partners and parents and carers.

' I liked the poster and especially the not smoking bit. I do not smoke but my partner does and so I got him to read the leaflet. He now goes out to the shed to smoke and wears a 'smoking jacket'

' I had a friend whose baby died of SIDS so was really worried about keeping my baby safe. The leaflet was easy to understand and did not take long to read but the messages were really important. I felt more knowledgeable after reading it about what I could do to prevent this happening to us'

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1c - Launch the 'Safe Sleep' campaign with the other LSCBs and Child Death Overview Panels (CDOPs) in the Pan-Hampshire and Isle of Wight area by Summer 2019. Conduct a first phase evaluation by the end of the reporting period continued...

The Every Sleep Counts campaign has been promoted throughout the HSCP partnership and relevant agencies including Services for Young Children to pre-school and early years settings and via Public Health's universal Healthy Child Programme. Hampshire Constabulary have incorporated Every Sleep Counts into the training strategy being developed by the Public Protection Department and Learning and Development Team and has been woven into the safeguarding training delivered to new recruits.

Case Scenario - evidence of positive impact

As a Family Nurse I have been working with a young client throughout her pregnancy. She has a diagnosis of Complex PTSD and autism. Her child had been subject to a plan with Children's Services. I learned through the pregnancy that she was unable to retain a lot of information verbally, so we explored the Every Sleep Counts campaign in many sessions prior to birth and I gave the leaflet to review after our session. After the birth of her baby I visited the family weekly as per the Family Nurse Partnership programme and addressed safe sleeping practices at every session to ensure the information was understood.

When baby was four weeks old, I was just about to leave our session when the mother stated:

'I think you are going to be cross with me!'

I sat back down to explore this further. She had found that her baby was settling better for naps in the day snuggled under the duvet with mum and that at night she slept better on a pillow in the Moses basket on her tummy with her teddy to cuddle – she cut out the light from the TV by placing a blanket over the hood of the Moses basket which draped down over the baby. With a calm exterior I sat and explored why she had taken this action and re-visited the information about the Every Sleep counts campaign. She pulled the familiar leaflet out of her folder and we explored the information along with information on the Lullaby Trust website. There was also a discussion about safeguarding her child and not exposing her to practices that might cause significant harm

The client had already struggled to remember feeding times etc, so she had placed a pin board/ white board on the wall above her bed with reminders stuck on it and charts for nappy changes. Together we pinned up the Every Sleep counts poster and again re-visited all the information on it step by step, using a marker pen to highlight the most important messages. I also demonstrated how the baby should be positioned to sleep using my doll and got her to repeat the activity with her own baby as she would do if I was not there.

The next morning when I turned on my work phone there was a photograph sent to me by the client of her baby positioned appropriately in her Moses basket which was positioned under the poster on the wall and a caption reading: "Sleeping safe and sound!". Having access to all the information on one leaflet which enabled a visual reminder was invaluable to this client and her baby.

Further development and evaluation of the programme and additional training will be undertaken during 2020/21 to ensure that the Every Sleep Counts messages are being shared with parent/carers at every opportunity and its impact is assessed.

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1d - Review the joint HSCB/IOWSCB Neglect Toolkit and consider additional information to include. Conduct an evaluation of the understanding, use of the Strategy and Toolkit by frontline professionals, and assess impact on children and families.

The Local Safeguarding Children Partnerships (LSCPs) in both Hampshire and the Isle of Wight first published their multi-agency Neglect Strategy in October 2016, followed by the supporting online professional toolkit in October 2017. The Strategy outlines the collective partnership response to understanding, identifying and responding to neglect in children of all ages and circumstances. In addition to the areas commonly associated with neglect, the Strategy is underpinned by promoting awareness and an informed response to the four different types of neglect originally described by Howe (2005):

- Depressed/Passive Neglect
- Disorganised Neglect
- Emotional Neglect
- Severe Deprivation

Both LSCPs undertook an evaluation of the implementation of the Neglect Strategy and Toolkit in 2019, which included a staff survey across both Partnership areas, staff focus group discussions with a range of partner agencies, a review of IOWSCP and HSCP neglect themed multi-agency data and information, and a review of the usage of the online toolkit. The evaluation highlighted that:

- Over three quarters of staff who responded to the staff survey were aware of the Strategy and supporting Toolkit.
- Over half had accessed the resources available in the Toolkit. Practitioners valued the range of tools available to support their practice with particular reference to the ‘Day in a Life’ tools, neglect prompts and conversation starters, and the neglect thresholds and indicator charts.
- Staff tended to use the Toolkit resources to inform ongoing assessments, referrals to the Multi-Agency Safeguarding Hub (MASH) and in-house training materials, and as part of 1:1 direct work with children and their families. Professionals were able to give examples of how specific resources had been successfully used in direct work and to inform assessments [see quotes below for incorporation using clever formatting].
- Practitioners requested that further information be added to reflect learning from local partnership working on neglect and to highlight specific themes of neglect. To support this, professionals also asked for additional information and tools be added to the Toolkit to support targeted work with children and families.
- More work is needed to re-promote the neglect materials and information to the broader multi-agency workforce, particularly to capture new staff who have joined agencies since the original launch and promotion of the Strategy and supporting tools.

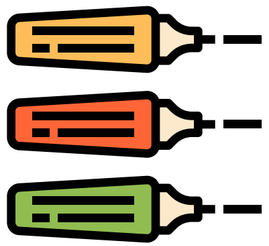
‘I used the Day in a Life of a Teenager’ tool when doing some direct 1:1 work with a teenager. It was really helpful in engaging the young person in the work and using it as a discussion opener. The prompts helped us both work through the various aspects of the child’s life and identify what is working well and where there were concerns. The younger sibling then asked me to go through a tool with them as ‘they wanted to do one too’!’

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 1: Further embed and evaluate HSCP initiatives

1d - Review the joint HSCB/IOWSCB Neglect Toolkit and consider additional information to include. Conduct an evaluation of the understanding, use of the Strategy and Toolkit by frontline professionals, and assess impact on children and families continued...

A review of multi-agency neglect themed data highlighted that:



- Numbers of referrals received by MASH due to concerns regarding neglect increased in the six month period following the launch of the Strategy, and increased again after the launch of the Toolkit. This increase was sustained for a year at which point the numbers reduced incrementally, but still remain above the pre-strategy launch rate. This trend was anticipated with the increases in referrals aligned to increased professional awareness and understanding of neglect. The reduction in referrals was also anticipated and likely to be due to stronger and more proactive multi-agency working at earlier stages of intervention
- Neglect is the most common reason that children across both Hampshire and the Isle of Wight are placed on Child Protection Plans (CPP). In Hampshire numbers of children on a CPP were at their highest in the two quarters during and after the launch of the online Toolkit.
- The numbers of neglect crimes have risen since the launch of the Strategy and Toolkit with a marked increase in the quarter immediately following the launch of the Strategy. Whilst the numbers have fluctuated differently across the remaining period, the increase in numbers has been sustained particularly during 2019 following the force-wide roll out of bespoke training on recognising neglect in children.

It is not appropriate to draw any direct comparisons between the patterns in figures, nor is it possible to fully establish the reasons for the fluctuations. However, it would be reasonable to assume that following a targeted promotion campaign of the Strategy and Toolkit across Hampshire, understanding and identification of neglect across the workforce increased over this period. The following recommendations were agreed arising from the findings of the evaluation:

- HSCP to review the neglect threshold chart against the updated main Threshold chart, and to include references to obesity etc. This action has now been completed as part of the broader work to extend the information available on the Neglect Toolkit.
- HSCP to review the language/content of the Toolkit to ensure alignment with strengths-based working. This action has now been completed as part of the broader work to extend the information available on the Neglect Toolkit
- Children's Services to consider placing a more explicit link to the Strategy and Toolkit on the Interagency Referral Form (IARF). This action has been completed on the updated IARF that is now in use.
- HSCP, in partnership with IOWSCP, to review and update the Neglect Strategy to include recent local learning. This action is ongoing and forms part of a wider review and extensions of both LSCP's joint work on neglect. The updated draft Strategy is expected to be published by the end of 2020.

1e - Seek assurance that taxi drivers operating across the Hampshire local authority area receive safeguarding training (including child exploitation) prior to issuing of a licence.

There has been a coordinated approach to ensure Hampshire taxi/hackney drivers participate in safeguarding awareness training which is a requirement of the licensing application process in all districts. All Districts have introduced Taxi Driver Safeguarding Awareness Training. The New Forest District E-Learning package, which is approved by HSCP and the Hampshire Safeguarding Adults Board (HSAB), has been adopted by four districts with the remaining districts using alternative packages, for example, Blue Lamp Trust classroom-based learning.

II. PROGRESS ON BUSINESS PLAN PRIORITIES

Priority 2: Strengthening our Assurance Programmes

a) Respond to the outcomes of the Keeping Children Safe (Section 11) audit to better promote staff understanding and awareness of key policies and procedures.

b) Review learning from Serious Case Reviews to test impact on frontline practice.

The Partnership has continued to strengthen its approach to scrutiny and assurance, reviewing our approach with the education sector and revisiting the action plan submitted as part of the Section 11 process. More detailed information is covered in the learning and development chapter within case review Section 11 and education safeguarding audits commentary.

The Clinical Commissioning Groups have established a Safeguarding Governance Meeting to ensure that the CCGs can oversee and monitor safeguarding children issues/risks and good practice. This is chaired by West Hampshire CCGs executive safeguarding lead and HSCP partnership's health representative. This meeting ensures oversight of key risks, challenges and progress against the CCGs objectives – both within the CCGs and also within the commissioned services. This includes oversight of the Section 11 action plan and learning from partnership reviews.

Priority 3: Leadership and Transformation

a) Publish new safeguarding partnership arrangements by 29 June 2019, and full implementation by 29 September 2019 in line with Working Together 2018 statutory guidance.

The new Safeguarding Children Partnership, will lead the safeguarding agenda, challenge the work of partner organisations, and commit to an approach that learns lessons, embeds good practice and is continually influenced by children, young people and their families. More information on the new HSCP can be found in our 'new arrangements' document.

b) Publish new Child Death Overview Panel (CDOP) arrangements by 29 June 2019, and full implementation by 29 September 2019 in line with Working Together 2018 statutory guidance.

The CDOPs were historically managed under the four LCSPs across Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS). Following the changes in national guidance, the Child Death Review Partners, representing all Local Authorities and the Clinical Commissioning Groups, came together to agree a combined HIPS Child Death Overview Panel established on the 1 October 2019 covering all children resident in Hampshire. This is an equal partnership for the mutual benefit of all Hampshire children and provides an oversight and assurance of the whole Child Death Review (CDR) processes in accordance with the National Child Death Review Statutory and Operational Guidance 2018 and local Child Death Review policies.

c) With colleagues across the other LSCBs in Pan-Hampshire and Isle of Wight, develop and implement new Pan-Hampshire and Isle of Wight work streams, including Exploitation and Health groups.

In conjunction with colleagues from the other Local Safeguarding Children Partnership in Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) work streams have continued to be developed. This has included development of Terms of Reference and implementation of Child Exploitation and Health groups.

III. SAFEGUARDING PERFORMANCE

Many groups of children in Hampshire are vulnerable and are at increased risk of being abused and/or neglected. These groups are not exhaustive and many factors, such as going missing from home, living in households where there is domestic abuse, substance misuse and/or parents with mental ill health can place children at increased risk of harm. The needs of these children, and other vulnerable groups, are outlined below to provide an understanding of local context.

This section of the report sets out how the Safeguarding Partners and Relevant Agencies worked to improve outcomes for specific cohorts of children and their families between 1 April 2019 and 31 March 2020. This includes key projects and programmes of work that have been undertaken including the evidence the positive impact these have had for children and their families. This section also highlights key areas of focus that will deliver continued progress against the above priorities throughout 2020/21 and beyond.

Children with Disabilities

Hampshire Approach - The Hampshire Approach has been well embedded in Disabled Children's Teams, with a clear focus on building on the strengths of families and enabling families rather than 'doing for'. Annual re-assessment enables a clearer focus on the changing needs of the child and a right-sizing of support packages.

Technology- There has been a positive impact of utilising new technology. The increased use of technology enabled care has not only replaced costly alternatives, but families prefer this as it is less intrusive than traditional options and interventions.

Evidence of Positive Impact

- Hampshire Children's Services case file auditing during 2019/2020 has evidenced significant improvements in care plans being SMART and outcome-focussed, with the child's participation increasingly informing planning.
- Closer working relationships have been established between Children's Services, Adult Social Care, Health and the Special Educational Needs Teams to support more effective and earlier transition for identified cohorts of children.

Priorities for the next 12 months

- Continued focus on effective, earlier transition of children and young people via partnership working.
- Exploration of the potential to significantly increase the pool of specialist respite carers and reduce reliance on residential provision in the private and voluntary sector.

Adult referrals to the Local Authority Designated Officer (LADO)

The LADO role is statutory, sits within the local authority and plays a key part in ensuring the children's workforce is a 'safe' workforce. LADOs are charged with the oversight of all relevant allegations against adults working with children in a voluntary or paid role, providing advice and guidance to ensure individual cases are resolved as quickly as possible. LADO work in Hampshire is measured over the academic year, as a significant proportion of the work relates to referrals involving staff in academic settings. The last full year's data for referrals therefore runs to 31 August 2019. In this period in Hampshire, 610 referrals were received, 43% of which related to school or college settings. This is a lower number of referrals to the previous year (748). This was reflected across all sectors rather than one specific. Hampshire LADOs also discharge a broader safeguarding advisory role which is much appreciated by those contacting the service and attending DSL Conferences into which the LADOs contribute.

III. SAFEGUARDING PERFORMANCE

Children who access community health systems

Public Health Nursing:

- Hampshire Healthy Families was launched in August 2019, with the providers being Southern Health Foundation Trust in partnership with Barnardos. There is now a greater focus on digital delivery and supporting those in greater need. As part of the digital offer a new website has been launched.
- ChatHealth, an anonymous texting services is now available for parents of 0-19 year olds and children and younger people aged 11-19. The service is also contributing content to the Wessex Healthier Together website that provides local advice for parents.
- The Family Nurse Partnership, which provides intensive support to the most vulnerable young families, is available across Hampshire to improve outcomes. The partnership supports families up to the child's second birthday, and through the Adapt programme some families are able to graduate earlier.
- Hampshire Health in Education website has been launched. This is a public health programme for all early years and school settings in Hampshire to support a whole setting approach to health and wellbeing supporting children, young people, and their families. It provides information and advice, teaching resources and training on a range of health issues. The programme includes a new health and wellbeing award programme for settings.

Children and families who have experienced trauma

Strategic Action Plan - Key Stakeholders including Public Health, Clinical Commissioning Groups, Hampshire Constabulary and Children's Services and others are supporting the development of a Trauma Informed Public Services Strategic Action Plan taking a life course and a public health approach. Part of this plan includes the development of a Trauma Informed Workforce Development Group to develop a workforce development plan to embed trauma-informed and restorative practices across public services in Hampshire, Isle of Wight, Portsmouth and Southampton. Additional workstreams are expected to focus on data sharing, interventions, communications and branding and community engagement. Strong links have been developed with local Violence Reduction Units and serious violence problem profiles, response strategies and programmes.

Trusted Adults Workers - The Youth Offending Team received funding to deliver a Trusted Adult Worker Service (TAWS) to 49 children in Hampshire. This funding was provided by the Early Intervention Youth Fund (EIYF) through a bid submitted by the Office of Police Crime Commissioner (OPCC). Four workers were employed to work with children who had an Adverse Childhood Experience (ACE). The intention is that by intervening at an early stage, children are less likely to commit crime in the future and experience negative health implications.

Evidence of Positive Impact

- ACEs/trauma informed workstream - Significant work included development of a Hampshire-wide Concordat and benchmarking of organisations against a set off trauma informed models.
- The New Forest Family Support Service has concluded its first year of delivering the ACEs Adult Recovery Toolkit. A total of 37 families completed the programme, including eight grandparents who have Special Guardianship Orders for their grandchildren and one foster carer. In total these 37 adults support 79 children in their care. 95% of families reported an increase in being able to support their/their child's resilience and wellbeing.

Priorities for the next 12 months

- Further development of the strategic action plan and associated workstreams aimed at emending trauma informed practices across public services.

III. SAFEGUARDING PERFORMANCE

Children affected by and/or at risk of neglect

During Children's Assessment Safeguarding Team (CAST) team meetings, work has been undertaken to highlight the Neglect Strategy and Toolkit across Hampshire, with the aim of improving social work analysis and identification of neglect and subsequent plans of support. Work has been undertaken to ensure ready availability for social workers on Children's Services internal toolkit to improve practitioner awareness. The introduction of Multi-Disciplinary Workers within Hampshire in the last 12 months has allowed for additional support for children experiencing neglect through parental mental health and substance misuse.

Evidence of Positive Impact

- There has been a reduction in the percentage of cases referred over the last 12 months for neglect (7.64%) and percentage of children categorised as neglect on child protection planning (-28.03%). This could be as a result of improved identification and work with agencies to identify the neglect indicators and thresholds. Where neglect has been identified in children in need or child protection plans there has been increased evidence of SMART planning and intervention.

Priorities for the next 12 months

- A partnership review of the Neglect Strategy Toolkit and practitioner guidance to improve all agencies understanding of the thresholds, identification of the impact of neglect on the child and appropriate responses to avoid immediate or long-term significant impairment.
- Ongoing review of Strategy and Toolkit with practitioners and managers across the partnerships.
- Implementation of recommendations around increased focus within graduate trainee year and that all new children and family support workers and social workers joining Hampshire Children's Services review this Toolkit and Strategy as part of their induction.

Children's mental health and wellbeing

HSCP with support from multi-agency partners has produced a Managing Self-Harm Resource Sheet for non-health professionals (e.g. education staff, parents/carers and others) to support children who self-harm. This resource forms part of the Self Harm Toolkit, which aims to provide practical tools and resources to aid practitioners to feel more confident in supporting all children and young people.

Hampshire Community Adolescent Mental Health Service (CAMHS):

- The CAMHS website has been continually reviewed, updated and refreshed with new materials for children/their families and carers and for professionals. The website has received national recognition for its creativity and usefulness. This is in addition to an active social media presence.
- CAMHS have introduced a referral portal which has, based on feedback, made referral criteria clearer and supports families to self-refer.
- Recognising the importance of early intervention and building resilience for children, CAMHS now have mental health support teams working with schools to support children and young people with anxiety and lower level symptoms of mental illness.

Hampshire Hospitals Foundation Trust (HHFT) - have developed 'Guidelines for the Care of Young People Admitted as a Result of Self-Harm' which promote a multi-disciplinary approach to children who present with suicidal ideation and deliberate self-harm. The pathway is currently under review and aims to ensure multi-agency input to the safety and welfare of children accessing care through HHFT.

III. SAFEGUARDING PERFORMANCE

Children in care

The Corporate Parenting Board - The Corporate Parenting Board was a subgroup of the Children and Families Advisory Panel which had been established for two years. An annual report on the progress of the Corporate Parenting Board was presented to HSCP in February 2020. In order to make progress for the Corporate Parenting Board to hold partners to account and scrutinise its work, it has been agreed by Cabinet in December 2019 that, as opposed to sitting as a subgroup, the Corporate Parenting Board needs to be a Board (Committee) in its own right. This provides decision-making authority and directly reporting to the Elected Lead Member for Children's Services emphasising the importance of children in care and care leavers in Hampshire.

Ofsted (April 2019)

'The Corporate Parenting Board effectively seeks to build a well-informed understanding of the experiences, concerns and achievements of children in care. The Board is energetic in taking steps to ensure that all children receive good services. The Board's ongoing engagement with children is essential, primary focus of its work and is gained through a wide variety of sources, including the involvement of an expanding number of children in care, engaged as care ambassadors. The Board has not extended its membership to include partner agencies due to concerns about the impact this might have on the engagement of children in care and care leavers. While the Board effectively scrutinises all the important areas of services for children in care, it does not have a systematic way of ensuring consistent collaboration with key partners, such as health services, district councils or foster carers. This dilutes its ability to ensure a joined-up response to areas for development, such as ensuring timely health assessments and delivering a more consistent approach to council tax exemption for care leavers.'

The Corporate Parenting Board ensures that all of the services to children in care and care leavers are of a high standard, and that children in care and care leavers are being well supported in all aspects of their life, including:

- support and encouragement to achieve in school;
- support to maintain good mental health and wellbeing;
- having opportunities for positive social integration; and
- enabling the most vulnerable children and young people in society to flourish into the successful adults they can become.

To achieve this, there will be greater emphasis on multi-agency engagement, holding partner agencies to account through the Board members direct engagement with children in care and care leavers and the accountability of partner agencies around service delivery and improved outcomes. The Corporate Parenting Board holds agencies to account and reports directly to the Executive Lead Member for Children's Services regarding the review and monitoring of outcomes for children in care and care leavers.

The Corporate Parenting Board have continued to engage with children and young people throughout lockdown and examples have included them providing Podcasts for children in care and continued engagement with the Care Ambassadors who they were jointly involved with in the inspection of post 16 accommodation to contribute to the quality of services contracted by Hampshire Children's Services.

III. SAFEGUARDING PERFORMANCE

Children in Care continued...

Reunification- There has been a shift in focus on the understanding that children should be in care for only as long as needed. This is a significant shift in social work practice which previously saw children's plans for long-term care being made and this remaining the plan until they reached the age of 18.

The Children Services department are proactively supporting the view that children should only be in care for as long as is necessary and significant work has been progressed under the guidelines of the National Society for the Prevention of Cruelty to Children (NSPCC) Reunification Tool to successfully support children returning to parental care. This is supported knowing that parents can and do make changes, children's needs change over time and the family relationships remain of significant importance. Children generally have better outcomes when placed with their family. Over the last year, the Children in Care Teams (this excludes the reunification plans for children who have been in care for less than 12 months which is a significantly higher rate) have seen 60 children reunified home. Children and young people are actively involved in their plans to ensure it is meeting their needs and their views are expressed through their My Life My Future Care Plans and Child Looked After Reviews.

Hear Me - was a year long campaign for 2019 which focused on children in care lead by CAMHS. It aims were:

1. To provide opportunities and platforms for young people to share their experiences of living in care and of receiving support from professional services.
2. To provide young people across Hampshire with the chance to contribute and feedback to wider conversations about pertinent issues relating to young people's health and wellbeing.
3. To increase professional and public understanding and empathy around the experiences of living in care.
4. To train, support and advise the systemic network supporting young people in care, in order to enhance their work with young people in their care and ensure its effectiveness.

A full campaign report which includes details on initiatives is available for review.

The Big Activity Week - was led by Hampshire Outdoor Education and saw 76 children in care between the ages of 10 – 13 years complete a week's residential holiday in one of Hampshire's four outdoor activity centres. The week was a huge success and saw each young person achieve something new and grow in confidence. They were supported by other young people in care and made to feel part of a group and valued. The week was supported by partner agencies such as the police and CAMHS all contributing to educating our young people in a positive and fun way. The week ended by a Celebration Event which was attended by the Police Superintendent, Councillors and Senior Managers.

Evidence of Positive Impact

- Improved stability of placements; 82.4% of children who have been in care more than 12 months have seen stability within their care arrangements having experienced less than three placement moves (2019- 2020). This includes the positive moves those children who have returned home.
- Reunification has seen 60 children (approximately 4% of those in care) return home to their parents.

Priorities for the next 12 months

- Health assessments of children in care. This has taken a dip with a county year-end figure of 59.4% children having had an annual health assessment. There is a focus on reviewing the process and challenging existing processes in order to identify a system that works and has value. A joint health and social care Rapid Review was scheduled for May 2020 but postponed until September 2020 due to Covid-19.
- Embedding the multi-agency accountability within the Corporate Parenting Board to continue to improve the services we provide to our children in care.

III. SAFEGUARDING PERFORMANCE

Care leavers

Homelessness Prevention Personal Advisor (HPPA) - As a direct result of a government initiative and funding (Ministry of Housing, Communities and Local Government) Hampshire County Council (HCC) has created four new specialist posts focused on promoting accommodation stability for young people – Homelessness Prevention Personal Advisors (HPPA). These posts will run from September 2019 to March 2021 inclusive. The HPPAs since being in post have worked to develop processes and procedures for joint working with partners especially accommodation providers, as well as processes to enable early intervention with care leavers and those identified at risk of homelessness. The HPPAs have also developed tools to assess young people's skills to inform appropriate and successful move on and enhance placement stability overall and prevent homelessness through targeted tenancy sustainment work.

HCC plans are to continue to embed these processes and develop best practice. It was recognised there was a lack of knowledge around the specific needs of care-experienced young people who have partners and a need to address this to ensure better outcomes. This will require our continued focus on partnership working and engagement with partners at all levels through local meetings and the Strategic Housing Group (SHOG) meetings. This includes the importance of utilising the Private Rental Market (PRM) to its full potential for those care leavers who are ready. This will enable a better through flow for internal accommodation options.

Groupwork Programme initiative - HCC have developed and piloted a group work programme for care leavers focused on developing their resilience. The expectation is that this groupwork programme will become part of the core offer to care leavers. They seek buy-in from key partner agencies and organisations (both internal and external) to develop their participation within the groupwork programme. Engagement from health is particularly important in light of the need to promote the emotional wellbeing of care leavers who are at risk of social isolation, anxiety and depression. Mental health is evidenced within the data to be a factor in Not in Employment, Education or Training (NEET) and unsuitable accommodation and risk of homelessness.

Primary Care Training - West Hampshire Clinical Commissioning Group (CCG), on behalf of the five Hampshire CCGs, have developed level 2 training for primary care staff regarding what a care leaver is, in response to feedback from care leavers at the 2018 Primary Care Conference. This is going to be integrated with information on Looked After Children (CiC) and will be rolled out in 2021 as a training package for Primary Care practices.

Evidence of Positive Impact

- HPPAs support to a care leaver has prevented homelessness on multiple occasions, for example, working with a young person who had been issued warnings regarding anti-social behaviour whereby notice was positively withdrawn.
- As part of the councils' corporate parenting responsibilities, local councils have established links and supported council tax reductions for any care leaver aged under 25 who is the sole occupier of a property and liable to council tax.

Priorities for the next 12 months

- 71% of care leavers were in suitable accommodation at quarter two 2019-20 compared to a South East average of 82% for the same period (quarter two 2018-19 78%). HPPA's will support and encourage local housing authorities to have Care Leaver Leads which will be invited to care leaver team meetings to enable the progression of joint working and developing understanding of needs of care leavers within local authorities housing. This will support the progression of the overall operative of improving numbers of care leavers in suitable accommodation.
- Emotional wellbeing and mental health is a key factor for care leavers. A further work stream for care leaver mental health has been identified which is being taken forward by the HCC Partnerships Manager.

III. SAFEGUARDING PERFORMANCE

Children and families in need of Early Help

Family Support Service (FSS)

Hampshire children and families have continued to benefit from effective multi-disciplinary early help services coordinated by the Family Support Services (FSS). Emotional/mental health, domestic abuse and parenting support have continued to be the top three reasons for support requests and the service has responded to this with targeted interventions.

This year has seen the introduction of the Police Community Support Officers (PCSO) pilot into the Family Support Service to reduce repeat incidents of domestic abuse and missing children. HCC in partnership with Hampshire Constabulary initiated the 12-month project which aims to appropriately reduce repeat calls to service through a problem solving and early intervention approach with PCSOs based in district FSS teams.

Transition planning also commenced this year in preparation for the Supporting Families Programme moving under the management of the Family Support Service from 1 April 2020. Each district FSS Team Manager now takes the lead for the programme to provide a more direct line of accountability and to, in turn, improve the payment by results performance. All children's cases coming via the Multi-disciplinary Hubs are now automatically attached to the programme and the managers have been allocated the Supporting Families budgets to allocate resources to families whose needs meet the programme criteria.

Evidence of Positive Impact

- FSS evidence based programmes has seen a positive increase in recorded progress, with up to 88% of those attending courses completing programmes and making progress.
- This year saw the greater alignment between the Young Carers Service and the Family Support Service. Positive outcomes for children engaged with Hampshire's Young Carers projects shows a healthy start, with more than 40% of children reporting their situation had improved using the Shooting Star assessment tool. To support closer working between the two services, quarterly contract monitoring meetings are now taking place and FSS Young Carers Champions have been identified in each district to buddy with their Young Carers projects.

Priorities for the next 12 months

- Continued close working with the police, offering week-long attachments and awareness days within districts to encourage interest in the PSCO roles, with a combined aim to achieve a PCSO in each district's Family Support Service.
- Supporting partnership professionals with the relevant expertise and knowledge to take on the role of Early Help Coordinator for families.

Children who offend or are at risk of offending

Hampshire Fire and Rescue Service - Firewise is a programme for children who show an unhealthy interest in fire. During 2019-20 Hampshire Fire and Rescue Service continued to work with children to support prevention of fire setting related harm. Referrals from any source are welcomed and staff have experience with children with special education needs. Shock tactics are not used; instead a therapeutic approach which is proven to be more effective at changing behaviour is utilised. This is achieved by showing film clips, photographs and getting the child to participate in games, songs and craft activities appropriate to their age. This complements additional programmes targeting children which include Prince's Trust Team Program, Prince's Trust 'Get Started' Programme and Fire Cadets Programme. The overarching aim for each of the above programmes includes promoting wellbeing, increasing confidence and the employability of young people.

III. SAFEGUARDING PERFORMANCE

Children who offend or are at risk of offending

Hampshire Youth Offending Team (HYOT) - HYOT continue to deliver a service to children in the youth justice system, those who are subject to court orders and out of court disposals. This includes a small number of children who receive a custodial sentence. In addition, the HYOT deliver a preventative service to children who are at risk of coming into the youth justice system. During the year, HYOT carried out a review of its Youth Crime Prevention Service. This has enabled workers to have more contact with children and in a more focused way and released capacity to target more difficult to reach children. HYOT has further developed its Quality Assurance Framework to make it better aligned to the criteria used by HMI Probation and the National Standards for Youth Justice. This framework is underpinned by the principle of achieving, consistency, objectivity, and continuous improvement.

Joint Decision Making Panels (JDMP) - The Hampshire JDMP is a multi-agency forum which take into account all available information, and take particular care when a case involves a child with additional vulnerabilities, for example, they are a Looked After Child, have Adverse Childhood Experiences (ACE's) or exploitation risk factors. Since April, the Hampshire JDMP has invited an independent observer to provide a view on the cases under consideration, with the intention to embed this “critical friend” approach on a consistent basis. The JDMP maintains a comprehensive database to track and collate the number and type of sanction given to children to ensure consistent decision making.

Caution Clinics - Weekly caution clinics, where out of court sanctions are administered, are attended by the child and their parent/guardian. These are now being utilised as a 'reachable moment', not just as a clerical necessity. HYOT police officers will take the opportunity to talk to the child and guardian and explore any current concerns in the child’s life, their views on the criminal justice system and any issues that have not yet been disclosed.

Violence Reduction Unit (VRU) - In August 2019, the Government announced that Hampshire was one of a number of areas chosen to receive funding to develop a VRU targeting those between the ages of 14 and 25. Led by Public Health, VRUs has a multi-agency approach, with key stakeholders including being HYOT, Hampshire Constabulary and Children's Services.

Evidence of Positive Impact

- HYOT has further developed its performance framework and associated activities to improve performance against key priorities. Currently HYOT’s reoffending rate is around 35% which is an improvement on previous years. During the last year, HYOT team managers have been able to interrogate their own data and tailor their approach accordingly.
- The reoffending data showed that most children reoffend within the early days of an intervention. Accordingly, HYOT has targeted the improvement of the numbers of assessments and plans which are completed within 20 days. The quarter four figures indicate that this stands at around 80% against a target of 85%.
- HYOT's National Standards for Youth Justice strategic and operational self-assessment, included an audit of 130 cases. HYOT assessed itself as good and outstanding in all but two areas.

Priorities for the next 12 months

- To identify all areas where children experience a transition and develop HYOTs approach to supporting children with these changes.
- To develop a strategy which encourages children, their parents/carers and victims to participate in the work of the HYOT.
- To ensure that children from diverse backgrounds are not discriminated against at the point where outcomes are decided.
- Police to continue advocating for the completion of Public Protection Notices for every child who is arrested, interviewed under caution or issued with a formal outcome on first contact. This will ensure risks and concerns associated with the whole event are shared and mitigated.

III. SAFEGUARDING PERFORMANCE

Children not attending school

Vulnerable Children - A robust data system enables monitoring and intervention at both a pupil and strategic level which includes greater levels of probing and challenge to schools regarding those children who are most vulnerable. This data is now used to inform training needs re-managing challenging behaviour in schools and meeting Social, Emotional and Mental Health (SEMH) needs.

Mental Health Support Teams (MHST) have been introduced in some schools. Two areas were successful in bidding (Havant and Gosport) and are now part of the MHST project, training is underway for the teams and schools awaiting placements. This will support schools in building internal capacity to promote good mental health and wellbeing, establish an associated whole school culture and undertake early intervention work at an individual pupil/family level. Mental health leads have been identified in all schools. Expressions of interest for MHSTs in other districts were submitted during the year but unfortunately were not successful; further expressions will be made in subsequent rounds.

The Director of Children's Services has led discussions/workshops with groups of representative headteachers to explore ways in which educational attainment and outcomes for those open to social care might be improved and to consider ways of working across agencies to support that improvement.

Links have been strengthened with Public Health colleagues regarding mental health and wellbeing, Personal Development Learning (PDL) and Relationships, Health and Sex Education in schools. The latter has included preparation and briefings/training for schools on new statutory requirements in place from September 2020. The Primary Behaviour Service has produced resources to support curriculum content for good mental health and wellbeing in primary schools. Trauma Informed practice developments have continued, particularly through the Virtual School for Looked After Children, the Education Psychology Service and the Primary Behaviour Service.

Interventions - There has been significant work and development in partnership working across departments to improve communication and streamline the work of the Legal Intervention Team. The overall aim is to ensure an efficient referral service for schools; to ensure schools follow Hampshire's Code of Conduct in the issuing of Penalty Notices to parents; provide parents with up-to-date and quality information in respect of school attendance by both schools and the Legal Intervention Team; ensure a swift and effective service from the Legal Intervention Team when children are not attending school.

A focus this year has been to use parenting contracts to improve school attendance. The law gives schools and local authorities powers to offer parenting contracts which are voluntary but formal written agreements between parents and the local authority or the governing body of a school. Parenting contracts are an excellent tool that can be used to identify support and strategies that are needed to fully engage children in education and ensure they attend school regularly and punctually. A focus of the contract is parental responsibility and how parents are going to communicate more effectively with schools, which is crucial in safeguarding children and young people.

Elective Home Education - The department are responding to the change of Department for Education guidance (April 2019), namely increased oversight of Elective Home Education (EHE) by the local authority and judgement of how suitable the education being provided are major workstreams. The Inclusion Support Service have worked closely with the Attendance Manager for Vulnerable Children to put in place new processes for referrals to Attendance Legal Panels when a parent has not provided the EHE team with evidence of 'suitable education'. The new process aims to return children to school without the need for a prosecution. Engagement with families is a major target – this continues to be a safeguarding concern.

III. SAFEGUARDING PERFORMANCE

Children not attending school continued...

Children Excluded from School - The Inclusion Support Service (ISS) has a strong presence within the local authority to challenge schools regarding children who are excluded from school and those in receipt of reduced hours provision. ISS presence is complemented by established protocols and procedures which are adapted annually to better reflect changing needs. Parent guides are available for both exclusion and reduced hours and ISS enables easy phone contact with parents who want to voice concerns.

Partial timetabling and reduced hours - The local authority's ability to gather, report and share useful data with partner agencies around partial timetabling and reduced hours provision continues to improve. There is a well-established monitoring system for reduced hours provision (RHP) with escalation routes to Hampshire Inspection Advisory Service (HIAS), Education Inclusion Branch Management Team (EIBMT) and HSCP for pupils who have extended reduced hours.

Evidence of Positive Impact

- Vulnerable Children Presentations have enabled staff to better understand that there are a range of parental responsibility measures to ensure vulnerable children are able to fully engage with education to improve their outcomes and life chances without the necessity to prosecute. Staff feedback has been positive and evidences learning gained.
- There was a significant increase in the use of Parenting Contracts in 2019/20 with 50% of parents agreeing to contracts compared to only 7% in 2018/2019.
- Unauthorised absence data was collected at the point of referral to the Legal Intervention Team. In 2019/2020 there was a significant improvement in school attendance with children attending 2019 more school sessions by the time their involvement with the Legal Intervention Team had ended and equates to a 56% improvement in attendance against a target set for the year of 30%.
- Improvement in communication with professionals and families has improved the timeliness and understanding of referral routes, understanding of legal responsibilities and wider consequences of poor school attendance.

Priorities for the next 12 months

- Roll out the successful pilot of the Single Justice Procedure, where parents can plead guilty by post when they have taken an unauthorised school holiday. This will result in more time for Legal Intervention Court Officers and the Legal Team to concentrate on the most vulnerable children.
- Continued roll out of Vulnerable Children Presentations across all districts.
- The newly appointed (April 20) County Attendance Officer is liaising with schools around attendance matters with a focus on medical referrals to ensure children receive their entitlement. During the reporting period (1 April 2019 and 31 March 2020) this was identified as a weakness.
- Due to Covid-19 it is expected many children, especially those who already have poor attendance, will not return to school in September 2020. Legal Intervention Court Officers will be re-focussed on engaging with children and their parents to identify barriers to education and encourage, support and engage children to return to education and learning at the earliest opportunity.
- Review of parent guides in the summer recess to both ensure that it is parent accessible and to include a Parent Evaluation regarding excluded children to enable further improvements.
- Building capacity – skills, knowledge, training, expertise – to support Children with SEMH needs in their education settings.
- Improved inclusivity in schools – reduction in exclusion, reduced hours provision and persistent absenteeism.
- Increase monitoring of Elective Home Education (EHE) and raise the profile across agencies of potential risk factors via reviewing lessons learnt.

III. SAFEGUARDING PERFORMANCE

Children living in secure accommodation

Health Requirements- The Designated Nurse for Looked After Children contributed to the national review of health care standards for children and young people in secure settings – which is supported by the Royal College of Paediatrics and Child Health. This review underpins the health requirements of secure accommodation settings, including secure children's homes nationally.

Swanwick Lodge- Swanwick Lodge is a Secure Children's Home registered with Ofsted to provide care, education and support for up to 16 young people aged 10 to 17 years who are deemed to be at such a significant risk of harm to themselves or others that they need to be temporarily placed in secure accommodation. This provision is usually made under Section 25 of the Children Act (1989).

The home provides placements for children nationally. Swanwick Lodge has continued to work closely with health and education partners to continue developing the service in line with the national SECURE STAIRS framework, moving towards a developmentally and trauma informed service model. Swanwick Lodge adheres to a 'positive management of behaviour' policy and procedure which emphasises the minimisation of physical intervention and incorporates the use of 'Team Teach' in common with Hampshire's educational settings to support young people with their behaviour. The Team Teach approach promotes a continuum of gradual and graded techniques, with an emphasis and preference for the use of verbal and non-verbal strategies being fully exhausted before positive handling strategies are utilised. Restraint is also minimised via individual risk assessments which aim to identify triggers to challenging behaviour and controls to minimise incidents. In addition, all young people have an individual behaviour support plan developed in consultation with the young person, embedded healthcare providers and Team Teach instructors.

- During 2019/20 there were 105 recorded incidents related to aggressive behaviours by young people towards others (44%), self-harm (34%), significant damage (6.5%), the security of young people or staff (6.5%), or other high risk behaviours (9%).
- 77 (73%) of these incidents resulted in the use of restraint. This represents a reduction in both incidents (105 compared with 595 during 2018/19) and the proportion of incidents leading to physical intervention (73% compared with 94% in 2018/19) - which is unrelated to occupancy levels. In addition to the care and support afforded to young people to contain and help them regulate their behaviour, this reflects planned placement endings and effective placement matching.
- The least restrictive holds ('guiding away' and 'single elbow') continued to be used in most interventions (60%) and most restraints lasted no more than five minutes (84%).

Evidence of Positive Impact

- An interim Ofsted inspection (October 2019) gave positive feedback in particular about the value and advantages of the new integrated paperwork, including capturing a range of professional's views and emphasis on collaborative working.
- There was a significant reduction in the use of restraint at Swanwick Lodge during 2019/20. Physical interventions continue to be used as a last resort and, when applied, the least restrictive methods are used in most cases and interventions tend to be brief.

Priorities for the next 12 months

- Further development of the staff induction programme, with input from commissioned health services at Swanwick to ensure all new starters have an opportunity to develop their understanding of attachment processes and the impact of early adverse childhood experiences – and how this may impact upon their presentation. Developing this knowledge from the start of someone's career with us will influence their interactions with young people – supporting the idea of every interaction matters.
- Development of a robust strategy enabling staff to access, at least monthly, reflective sessions facilitated by Clinical Psychologists from the Health and Wellbeing Team at Swanwick. These sessions will provide a safe space for staff to reflect upon their own personal experiences, their experience of working as a team and experience of supporting young people.

III. SAFEGUARDING PERFORMANCE

Children living in secure accommodation continued...

Bluebird House - Bluebird House is an adolescent forensic medium secure unit and part of the national network of adolescent medium secure services. It is a national unit, commissioned by NHS England, and admits young people from all over the country. Young people are aged between 12 and 18 years, and admission criteria includes that they suffer from a mental disorder, are detained under the Mental Health Act (MHA) 1983, and pose a high risk of harm to other people. There is currently 14 commissioned beds with one ward closed during this reporting period.

Austen House - Austen House is a 14 bed adolescent low secure unit, based at Tatchbury Mount site in Calmore, Southampton. This unit was commissioned by NHS England from Southern Health to meet the needs of young people requiring low secure care closer to home. This is the only NHS low secure unit in the south and acts as gate keeping for all young people in the south requiring assessment. Young people referred to the service are aged between 12 and 18 years, and admission criteria includes that they suffer from a mental disorder, are detained under the MHA 1983, and pose a high risk of harm to themselves or others and cannot be supported in a setting with lesser security.

Young people admitted to Bluebird House and Austen House pose many high risks of harm to others, and as such, present with a range of severely challenging behaviours. This sometimes requires the use of restrictive interventions such as restraint in order to manage the immediate risk, in order to keep not only that young person, but the other young people as well as staff members, safe. All restraint is carried out in accordance with the legal framework as prescribed in the MHA Code of Practice, and trust policies and procedures. All incidents, including episodes of restraint are reported on the trust incident reporting system. This information is available to clinical teams in Bluebird and Austen House to identify emerging trends, and to track the progress of individual young people.

Over the last two years Bluebird House has been involved in the national Reducing Restrictive Practices Quality Improvement Project and this has led to continual review of internal processes including staff inductions. This project has involved the frontline staff and young people working together to reduce seclusion, restraint and rapid tranquilisation on the wards. The use of all positions of restraint have reduced significantly over the last year. Austen House is about to embark on the same project due to its success.

- For Bluebird House, during 2019/20 there were 817 episodes of restraint. This is a reduction of 2,260 incidents on the previous year. This reflects a downward trend of incidents over the last two years. Of the 817, 513 were required to manage the risk of harm to others, 260 interventions were to manage risk of harm to self, and 43 interventions to stop young people from inflicting serious damage to property.
- For Austen House, during 2019/20 there were 949 episodes of restraint. Of the 949, 871 interventions were to manage risk of harm to self, 71 were required to manage the risk of harm to others and seven were required to prevent serious damage to property.

Priorities for the next 12 months

- Restraint continuing to be necessary as an intervention of last resort, when other measures such as de-escalation have failed.
- Continued application of initiatives to reduce the use of restrictive practices which is reviewed regularly through the Local Governance Forum, Learning from Incidents Forum and the CAMHS Quality and Safety meeting.
- Quality improvement lead to continue auditing the use of seclusion, rapid tranquilisation to ensure learning from each event is captured and shared.
- Extension of the reducing restrictive practices project to Austen House.

III. SAFEGUARDING PERFORMANCE

Children affected by and/or at risk of domestic abuse

There is a diverse range of activity in Hampshire in relation to domestic abuse and services on offer. Stop Domestic Abuse is the Hampshire Commissioned Domestic Abuse Service which came into effect on 1 April 2019. Stop Domestic Abuse (formerly SDAS) delivers all the commissioned victim and children/young people support services across the county, while the Hampton Trust continues to deliver perpetrator support services across Hampshire and Southampton.

Early Help Hub support for children and young people are identified within the remit of the commissioned service, Stop Domestic Abuse. Stop Domestic Abuse staff have been linked with the Early Help Hubs as consultants, attending the weekly hub meetings to advise and signpost professionals in order to improve outcomes for children and young people.

Hampshire Domestic Abuse Strategic Board - The Board is chaired by the Director of Public Health, HCC, and this meeting updates agencies on current initiatives and to set the strategic direction and ensure that domestic abuse services are meeting need. All agencies are represented at this meeting to ensure that emerging themes are managed to ensure the ongoing protection of children and young people.

Break 4 Change - The HYOT have delivered the Break4Change groupwork programme. This programme addresses adolescent to parent violence, working in tandem with both children and their parents.

High-Risk Domestic Abuse meeting (HRDA) - Partners have implemented the HRDA since January 2019. The purpose of this was to provide a faster response to high risk-domestic incidents and provide a coordinated response from agencies and with consistent thresholds being applied. The cases for HRDA are provided by the police under the following agreed criteria; honour-based abuse, GBH, arson, threats to kill, asphyxiation, evidence of coercive control, stalking and ABH. A formal evaluation of the service was to be undertaken by an academic from the University of Southampton, with an anticipated end date of April 2020. This has been delayed by the Covid-19 pandemic but the application for ethical approval is underway.

Parental Conflict Training - Parental conflict training has been launched for all professionals to access across HCC, as an E-Learning program. The Reducing Parental Conflict Training Programme is part of the Government's commitment to reducing conflict between parents - whether they are together or separated. The Training Subgroup of the Domestic Abuse Strategic Board meets bimonthly and has recently supported the roll out.

Priorities for the next 12 months

- Delivery of a Hampshire Children's Services project to identify the services that are available to social care staff working with families, and the accessibility/availability and effectiveness of those services. This will ensure that children and young people in Hampshire will continue to have access to good quality services when required and that staff within the county will know where they can access this support.

III. SAFEGUARDING PERFORMANCE

Children and adults at risk of homelessness/temporary accommodation

Homelessness Prevention Personal Advisor (HPPA) and Group Work Programme Initiative - See Care Leavers.

Joint Housing Protocol - Children's Services worked directly with the local housing authorities to ensure a holistic response and action plan for each young person who presents as at risk of homelessness or in temporary accommodation. This is underpinned by a Joint Housing Protocol which is reviewed at the Strategic Housing Group (SHOG).

Supported Accommodation Contracts - The Hampshire Children's Services department has a number of contracts to offer supported accommodation to young people (aged 16-21) in line with their support needs. HCC also sits on the Southampton Collaborative Framework for supported accommodation allowing for placements outside of Hampshire. As part of these contracts, the department has commissioned six emergency beds for when a young person presents as homeless and requires a placement to enable an assessment of their needs to identify appropriate move on. The contracts are monitored quarterly to ensure outcomes are being met as identified within the young person's assessment and that young people are being supported to access appropriate move on accommodation.

District Housing Teams - across the county have undertaken extensive measures to safeguard and accommodate many families. Ensuring early intervention is most important and improving access to necessary support when required is key to sustainable and independent living. When working with families with a disability in the family, the whole family approach is used and assessments completed with appropriate multi-agency support.

Evidence of Positive Impact

- Hampshire's inclusion in quarterly monitoring reviews of the Collaborative Framework for supported accommodation that is led by the Senior Commissioning and Procurement Officer. This helps ensure focus on the utilisation of the placements made, move on placements security and that outcomes achieved link with young people's assessments.

Priorities for the next 12 months

- Ongoing review of contracts to provide supported accommodation to ensure appropriate provision is available in required locations with inbuilt flexibility to deliver support needed for changing trends.

Adults supervised by Probation Services

The National Probation Service (NPS) has a responsibility to ensure that the voice of the child is heard. NPS's Victim Liaison Service have contact with victims through their Victim Liaison Officer (VLO) network. Within this context, VLOs will have a broader level of contact with victims, their families, children, and carers etc, including the families of offenders.

Risk Management Plans (RMPs) include a variety of measures tailored to the particular risks in each case, designed to protect children at risk of serious harm. These include licence conditions prohibiting the service user from having contact with the child and their parent, and exclusion zones of the area where they live and/or study. The completion of these plans is subject to quality assurance practices, with all RMPs countersigned by a Senior Probation Officer when they include all necessary measures to protect those at risk.

Where appropriate, the voice of the child is also included within Pre-Sentence Reports prepared for the court to assist sentencing. This is through inclusion of the perspective of, and impact on, victims and witnesses of the offence, and the impact on a child should their parent be taken into custody. During 2019-20 NSP rolled out a video looking at the impact on children whose parents go to prison and this has been shared across the service.

III. SAFEGUARDING PERFORMANCE

Children affected by and/or at risk of exploitation, including children who go missing or unaccompanied and separated children

Willow Team - The Willow Team is a children's social care led specialist multi-agency child exploitation team launched in September 2015 and has continued to operate over 2019/20. The team comprises a team manager, three social workers, two specialist CAMHS Mental Health Practitioners, one child and family support worker (CFSW) and administrative support. The Willow Team works collaboratively with Hampshire Constabulary's Missing, Exploited, Trafficked (MET) team, Hampshire's Youth Offending Service, Barnardo's and various other professional teams, as needed. The team operates across Hampshire and works directly with children identified at high risk of child exploitation. The team receives referrals for assessments from Hampshire MASH relating to children who are not currently open to Children's Services. In addition, the Willow Team supports missing children and those at risk of or being trafficked, which often goes together with child exploitation. The team takes case nominations from the other teams within social care for children already open and offers support in a range of ways.

Frankie Service - Hampshire Children's Services have continued to support and manage the FRANKIE Service; a counselling service for children and young people who have been subject to child sexual abuse or child sexual exploitation.

Missing, Exploited and Trafficked (MET) Operational Meetings - Since the end of 2019, there has been a change to how the Hampshire OP MET meetings are facilitated with each District in Hampshire holding their own meeting rather than one central one. This has ensured that the meeting has the right level of local knowledge and ownership with partners and police attending. This has allowed for the MET Team to allocate specific officers to each district allowing for continuity and direct management of risk and vulnerability. An early review of this new model will take place in 2020/21.

Violence Reduction Unit (VRU) - Hampshire Children Services' Willow Team have worked alongside the Youth Crime Prevention Team to implement a project aimed at ensuring there is a dedicated worker linked to Pupil Referral Units (PRUs) in order to work directly with those children at risk of county lines. Every PRU in Hampshire has undertaken two direct work sessions with youth workers specialising in gang related issues from St Giles Trust.

Missing Exploited and Trafficked (MET) Team - The strategic direction of Hampshire Constabulary has set protecting children at risk of criminal and sexual exploitation as a force priority and is embedded within the Force Control Strategy and the Public Protection Department Development Plan 2020. The MET team provide a force-wide coordination capability to protect children and adults who are at risk of going missing and children who are being sexually and criminally exploited. In partnership, they will develop opportunities to identify persons at risk of harm and perpetrators exploiting their vulnerability, in order to prevent, reduce, and manage that risk.

Children who go Missing - Hampshire Constabulary's Serious Case Review Team (SCRT) were commissioned in July 2019 to conduct an audit of force compliance with regard to conducting self and well checks on children following missing episodes. This follows a serious case review in Southampton which identified possible gaps in service delivery between 2015 and 2017. Recommendations will continue to be embedded via a new online training resource (Policy Optimisation Drops or PODS), MET team Terms of Reference, and a new pilot whereby certain children who are at High Risk of Criminal or Sexual Exploitation are Designated High Risk Missing. This seeks to ensure the desired response from specialists, such as MET officers influence the tone of the investigation through the lifetime of the search and the trauma informed review of why that child was missing and the risks presented to them.

A Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) multi-agency task and finish group has been established to share good practice, consider the particular needs of Out of Local Authority children, continued update of missing policy, training and guidance on return 'conversations'.

III. SAFEGUARDING PERFORMANCE

Children affected by and/or at risk of exploitation, including children who go missing or unaccompanied and separated children continued...

Unaccompanied and Separated Children - HCC have close links with south east migration scheme and also were involved in the development of the care planning tool 'Outcome Star'.

The police MET Team are responsible for first response to unaccompanied children entering the United Kingdom through ports and borders or been discovered, having already entered. In the summer of 2019, a review of this process was undertaken and a set of standards were created along with further guidance around the journey the child would have taken both physically and emotionally and the value added to their support by police attendance. This approach has been welcomed by partners and has been followed up by Unaccompanied Asylum-Seeking Children Strategy meetings. This continues to support a joined up approach with regards to children having been trafficked and exploited through our borders.

West Hampshire CCG, on behalf of the five CCGs, have undertaken an audit in relation to tuberculosis and blood borne virus screening for unaccompanied asylum seeking children, to ensure that their health needs are met. Following the audit, awareness raising across primary care has commenced to ensure that the children are referred into local programmes for blood screening.

Evidence of Positive Impact

- Hampshire Constabulary's performance data, the Child At Risk Matrix, maps current trends around exploitation of children and associated missing episodes. Overall, this indicated that children are going missing less frequently and although more children have been identified as being at risk of exploitation, the view is that this is associated to improved relationships with partners and cross strands within the Police. This has led to improved confidence in identifying and raising such risks.
- A Missing Scrutiny Panel has been set up and chaired by the MET Detective Inspector. This considers all aspects of a missing report and the authorities response to it, taking into account whether the management of it is trauma informed and considers the voice of the child.

Priorities for the next 12 months

- Publishing the HIPS Exploitation Strategy and coordinate implementation of associated plans.
- Launch of the revised Child Exploitation Risk Assessment Framework (CERAF) tool.
- Completion of a video resource for all schools to cover county lines, gangs and grooming.
- Facilitation of training/awareness raising to parents in respect of county lines, gangs and grooming.
- To secure a non-office based venue where Unaccompanied Asylum Seeking Children can be taken to complete trafficking assessments and that they have somewhere comfortable to wait while placements are identified.
- Through the Safe and Well Audit commissioned by the MET Team and the increased awareness around the need for police to take a trauma informed approach, a review of Hampshire Constabularies Missing Person Policy is planned.
- Hampshire Constabulary delivery of PODS focusing on child missing episodes related to harmful practices and those children which are unaccompanied and may have been the victim of harmful practices.
- Education and Inclusion highlighted an emerging need to raise awareness of signs and risk factors associated to exploitation and secure greater multi-agency working.

IV. LEARNING & IMPROVEMENT

Multi-agency training

HSCP commissions and delivers multi-agency learning to complement single agency training. HSCP offers fully-funded multi-agency events that bring professionals together to develop knowledge and skills, emphasising the benefits of working together to deliver positive outcomes for children and families. HSCP have produced a Training Brochure that includes the learning outcomes for each multi-agency course. During 2019-20 the HSCP Partnership Team transitioned into commissioning training independently which included the implementation of a new learning management system. Below is a selection of the feedback delegates have shared on how they plan to use the learning to impact practice.

'After attending the Train the Trainer session, our staff have felt passionately about communicating the ICON message to families and expectant parents. We have used the resources provided by ICON in one-to-one sessions and group workshops to raise awareness of infant crying, and to help parents plan for how to manage and cope when it gets tricky.'

'I will be applying the principles of authoritative to my own practice as well as confidently guiding other midwives in the concept when we undertake safeguarding supervision. I was unaware of the NSPCC information service and will be making use of this. It has also given me a lot to reflect on and think about the information I gather, request and analyse' (Working with Hostile Families and Disguised Compliance)

'The course has helped me to consider how past events will have impacted and changed the child's behaviour and how they manage their emotions' (*Listening and Responding to Children: The Impact of Abuse and Attachment Problems*)

'I will be more aware of / reflect on risks and indicators, when receiving safeguarding referrals from church youth workers. Asking the right questions, gaining information, remaining professionally curious' *(Missing Exploited and Trafficked)*

'Learning about all the apps that are available will apply to all the children I look after and we always try to make it safe online for them and learning about the dangers will help me have a better understanding' *(Safeguarding Children in the Context of Social Media and Technology)*

'I have already emailed the head of the College to meet to review provision and supervision practice. I have recommended all DSLs attend the course' *(Managing Safeguarding Supervision)*

'I learnt a lot and will be taking lots of the knowledge back to my work place to discuss with colleagues' *(Safeguarding Disabled Children Including Those with Complex Needs)*

Delegate Feedback
Impacts on Practice

'Use the HSCP website toolkits to offer my staff training and support. Use the bruising protocol leaflet for parents on our safeguarding information board. Find more information for dads involvement and responsibilities and add to our parent information board. Make staff aware of Emotionally Unstable Personality Disorder. Think about introducing home visits to our new families to help us get a better insight in to home life for the child.' (Safeguarding Children Briefing: Learning & Themes)

'I will be able to use the Neglect Toolkit to support my work with children in school. I will also be able to share it with other professionals that I work with'. *(Child Neglect)*

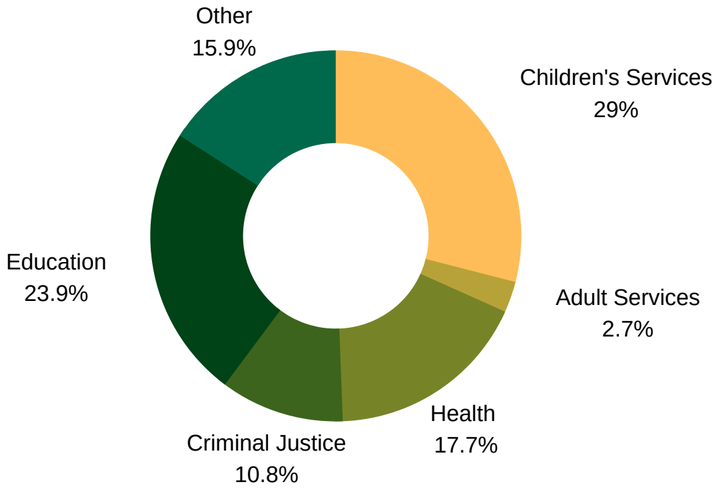
'This is by far the most engaging training I have been to. The setting/facilities were great and the overall feel of the training was very informal. The structure of the training and the trainer herself was really good, kept me interested and engaged and I learned a lot. The roleplay of a pretend CPC was the best way to learn - seeing it in action.' *(Working Together & Preparing for Child Protection Conferences)*

'By thinking more about the family footprint and who might be in it and any concerns about safeguarding. About being more professionally curious. Recognising that someone might choose me; I don't choose them. Useful refresher on Care Act 2014 responsibilities. By disseminating this information/ learning within the team and in supervision session.' *(Adopting a Family Approach*)

IV. LEARNING & IMPROVEMENT

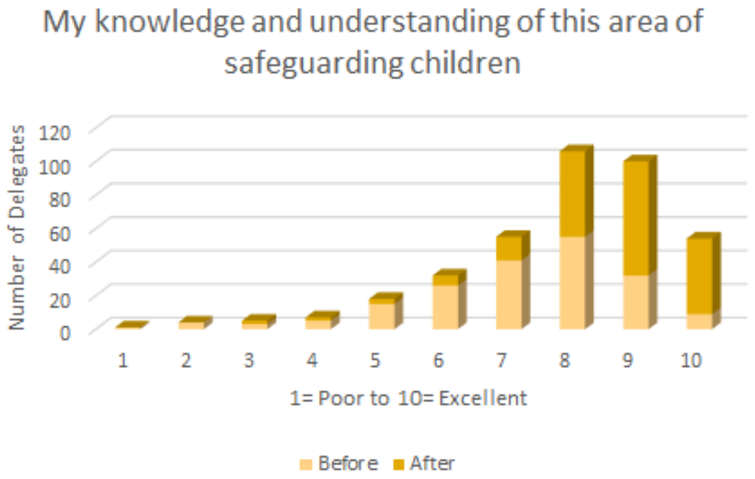
Multi-agency training continued...

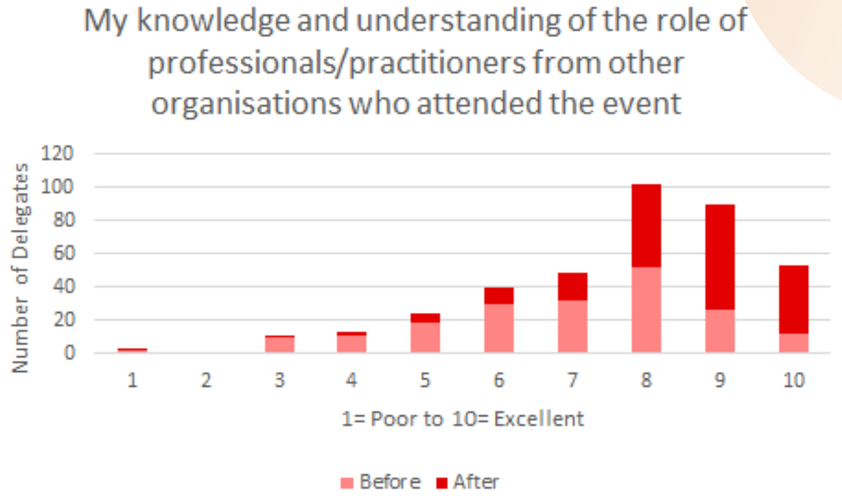
Delegates from across the workforce attended. All training events were free at point of delivery.

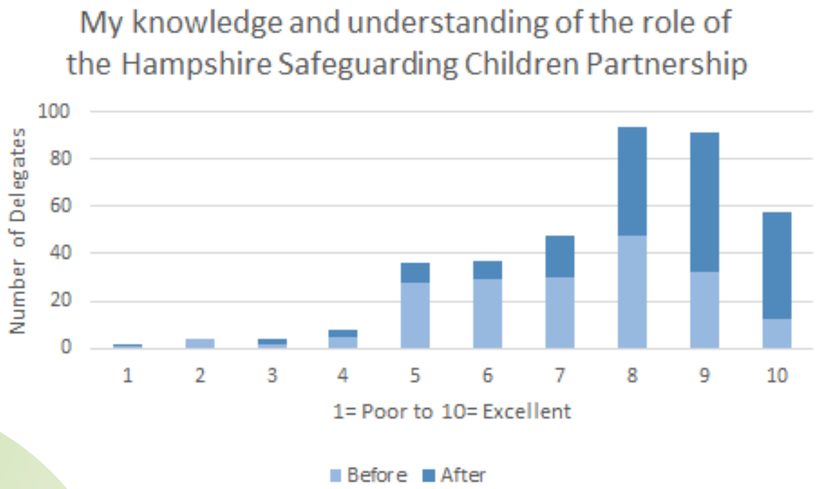


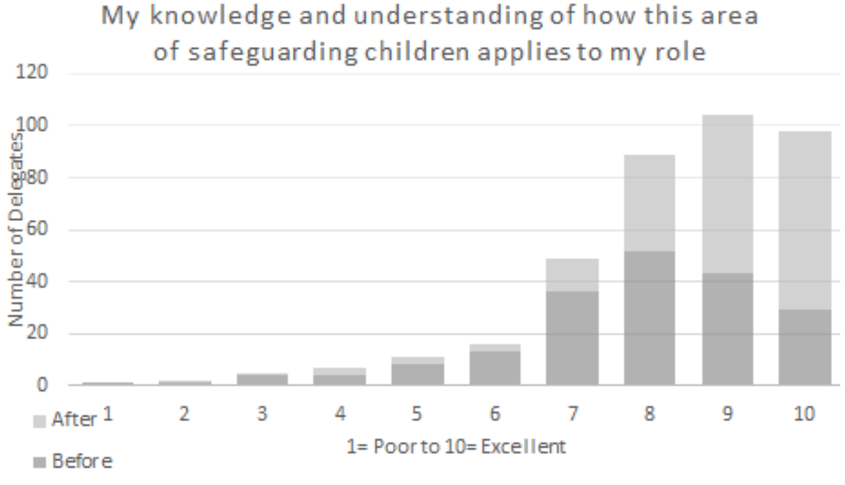
The new Learning Management System (LMS) due to be fully rolled out in April 2020 will enable the Partnership Support Team to manage training courses from start to finish in-house. Set up work was carried out during quarter three and quarter four of 2019/20 to include pre and post evaluation forms. Realtime reports will enable monitoring of capacity for courses as well as enable feedback to be provided to individual trainers.

A sample of distance travelled evaluations:









IV. LEARNING AND IMPROVEMENT

Local Child Safeguarding Practice Reviews (LCSPRs)

Serious child safeguarding cases are those in which:
• abuse or neglect of a child is known or suspected; and
• the child has died or been seriously harmed.

Meeting the criteria does not mean that safeguarding partners must automatically carry out a LCSPR. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families. Where a case meets the criteria for a Local Authority Serious Incident Notification as set out in Working Together to Safeguard Children 2018, LSCPs are required to undertake a Rapid Review. This requires Key Partners to review information from all available agencies to identify learning and establish whether a further review (LCSPR) is required.

During 2019/20, the Learning and Inquiry Group (LIG) received 14 referrals, this is an increase from 2018/19 when 9 referrals were received.

3 met the criteria for a Rapid Review

9 did not meet the requirement for further review.

5 resulted in a LSCPR being undertaken

During 2019/20, HSCP published five Serious case Reveiws, which had been commissioned in previous years:

Baby Hattie

Child G & H

Child A

Family B

Child N

The reports and HSCP responses are published on the HSCP website where you can see a full list of recommendations..

IV. LEARNING AND IMPROVEMENT

Local Child Safeguarding Practice Reviews (LCSPRs) continued...

Dissemination

- Learning from reviews have been built into current HSCP workstreams and training opportunities for frontline professions.
- During 2019/20 learning lessons from reviews were included in the HSCP Briefing Learning and Themes sessions, held three times a year in different venues across the county. These sessions focussed on learning from cases being undertaken throughout the year and those published in 2019/20. The sessions were interactive including the use of case studies and focussed on themes arising from reviews.
- Learning and development related to case reviews is key for social workers in their early years post qualification and is included in the Graduate Entry Training Scheme (GETS) for newly qualified Social Workers and second year of practice training.
- Learning reviews topic recommendations are referenced and embedded into HSCP toolkits and procedures, which are disseminated across partnerships, for example, The Management Of Actual Or Suspected Bruising In Infants Who Are Not Independently Mobile Protocol.
- Learning from reviews has been shared at Head Teacher meetings, DSL training and branch management teams.
- Baby Hattie - NHS England have developed a Safeguarding Alert Briefing and disseminated this to support understanding.

Implementation

- Promotion of the NSPCC campaign ‘Let children know you are listening’ is now embedded into a new toolkit.
- ICON and Every Sleep Counts programmes have been rolled out across the Partnership.
- All links to all areas are updated frequently for dissemination to schools and early years providers during our training.
- Processes are in place to regularly update safeguarding facilitators on new content.
- The police force have a specific Case Review team with dedicated trained reviewers that link across the range of products and mechanism, both locally and nationally. This team then maintain records of relevant reviews, learning and areas for action, holding the relevant strand of policing to account for implementing the necessary change in order to manage the safeguarding risk identified.
- Learning from reviews was including in the 2019/20 Briefings, Learning and Themes sessions.
- Case studies were developed, incorporating learning from a number of reviews and have been used for HSCP toolkits, Briefing, Learning and Themes sessions and for use in team meetings.
- Workshops were held in a number of locations across the county to further promote the Family Approach Strategy and Toolkit .
- Children G and H - West Hampshire CCG, on behalf of the five Hampshire CCGs, supported the HSCP to develop the ‘Unidentified Adults Toolkit’. This includes a ‘GP Registration Form’ for children, which incorporates other adults living in the home. The registration form has been approved and endorsed by the Local Medical Committee.
- Family B - Guidance on Vulnerable Family (Safeguarding) Meetings has been developed in collaboration with GP safeguarding leads, the Health Visiting Service and Midwifery. Methods for communicating outcomes to GPs who are unable to attend the Vulnerable Child Meeting have been developed and the use of a risk assessment framework to guide discussions around individual cases is being promoted.

IV. LEARNING AND IMPROVEMENT

Local Child Safeguarding Practice Reviews (LCSPRs)

Implementation continued:

- Family B - HSCP, with colleagues from West Hampshire CCG, on behalf of the five Hampshire CCGs, and in partnership with the other 4LSCB Board's, has updated the 4LSCB guidance on child protection investigations to make it clear when a medical assessment is required. This guidance also includes the need to ensure that the outcomes of medical examinations are recorded in writing and shared with relevant partner agency staff at the time of the examination, to inform the timely assessment of a case.
- Family B - The Designated Doctor from West Hampshire CCGs, on behalf of the five Hampshire CCGs, worked with health professionals from across the 4LSCP area and have developed, launched and evaluated the use of the Preliminary Paediatric Opinion Form (PPOF) which supports clearly articulated outcomes from a child protection medical examination.
- Child D - The 4LSCP Bruising Protocol was updated during 2019/20 and a workshop held in early 2020 to promote awareness and share learning from this case.
- Baby Hattie - HSCP developed and published a 'Spotlight on Disguised Compliance' to promote the issue amongst the workforce. Learning on this case will be included in future HSCP training.
- As a result of the SCR on Child K published during 2018/19, HSCP launched the Every Sleep Counts programme aimed at reducing the number of Sudden Unexplained Death in Infancy cases in January 2020.

Impact

- Feedback from delegates indicates that learning from reviews does change practice, for example, reference Threshold Charts feedback actions which will be taken e.g. 'Use the threshold charts to explore the evidence and knowledge around the child and family, and what they are experiencing.'
- Reflective discussions with Newly Qualified Social Workers about the baby bruising training take place with Practice Educators and they are asked how to think about how having the knowledge has then helped when working with non-mobile babies.
- In working with perpetrators of violence, case reviews are used to explore specific scenarios. For example, where the family has moved area, the focus is on identifying which authority is responsible. Learning has been on making sure the child is seen and safeguarded whilst any handovers are taking place.

Future *Opportunities*

- Continued evaluation of feedback mechanisms and follow up with delegates to assess long-term learning and 'so what' factors.
- Ensure continued review of learning content of safeguarding training is reviewed to ensure key messages and learning are up-to-date.
- Implementation of supervision themes for newly qualified social workers, for example, supervision at month three will be specifically about baby bruising which will then be revisited in following supervisions to explore good practice as a result
- Introduction of Lunch and Learn sessions – to support Children's Services Team Managers to cascade messages to all staff.
- Improve gathering evidence of impact via continual focus in relevant subgroups.

IV. LEARNING AND IMPROVEMENT

Multi-agency audits

HSCP undertakes regular auditing of multi-agency safeguarding arrangements in Hampshire. This work is commissioned by the HSCP Scrutiny Group and learning is disseminated to frontline practitioners through a programme of events, briefings, and conferences. Over the last year, the Partnership undertook four multi-agency audits to establish how well agencies work together to identify and respond to key safeguarding issues. In accordance with HSCP's learning and improvement policy, the Safeguarding Children Partnership Team will incorporate the learning from this audit within its commissioned and in-house training programme for multi-agency professionals.

Unborn Baby Protocol

The Unborn/Newborn Baby Safeguarding Protocol was originally ratified in July 2011 and was reviewed and revised in 2013 and 2016. In 2019/20, HSCP sought assurance from partner agencies that their staff are both aware of and are using the protocol. However, despite reassurance being provided by partner agencies, there have been several learning reviews which have highlighted requirements for additional assurance. As a result, three audits of frontline practice were carried out to gain the required assurance alongside a staff survey to establish the level of professional awareness of the protocol.

Midwifery Audit - An audit was undertaken to scrutinise application of the protocol in midwifery services across the 4LSCP areas through a deep dive of 47 cases. A key strength was identified regarding the positive response from the midwifery services in discussing strengths, risks, and needs. Opportunities for learning were identified regarding:

- Professionals evidencing that tools were used to support risk assessment.
- The provision of feedback on the outcome of referrals to Children's Services.
- The sharing of the Child Protection Plan and 'birth plan' with midwifery services.
- Professional awareness, and application of, the HIPS multi-agency escalation procedure.

Health Visitor Audit - An audit was undertaken to scrutinise application of the protocol in health visiting services across the Hampshire, Isle of Wight, Portsmouth, and Southampton areas through a deep dive of 46 cases. A key strength was identified regarding the Health Visitors making antenatal contact with mothers. Opportunities for learning were identified regarding:

- Health Visitors being made aware of the reasons for late bookings.
- The provision of feedback on the outcome of referrals to Children's Services.
- The sharing of the Child Protection Plan and 'birth plan' with Health Visitors.
- Participation of Health Visitors at Initial Child Protection Conferences (ICPCs).

Children Services Audit - A deep dive audit was carried out into 10 children's files who were all open to social care in the weeks and months leading up to their birth. The following key strengths were identified: detailed pre-birth planning that covered all relevant areas including engagement with families, robust and tenacious work with families where circumstances and risk assessments changed and the ability of agencies to identify high risk pregnancies. Opportunities for learning were identified regarding:

- Timeliness of planning in line with the protocol.
- Evidencing liaison with midwifery services.
- Gathering key information about the child and the mother's wellbeing from health professionals.

The key recommendation arising from these three audits was for the LSCPs across the Hampshire, Isle of Wight, Portsmouth and Southampton areas to commission a task and finish group to ensure that the learning from this audit informs a review and refresh of the Unborn/Newborn Baby Safeguarding Protocol. This work is due to complete by end of 2020.

IV. LEARNING AND IMPROVEMENT

Multi-agency audits

MASH Audit (Unborn Babies and Baby Bruising)

On 17 June 2019, a multi-agency group comprising Quality Assurance Group members from HSCP, along with staff and partners who work as part of MASH, reviewed 12 cases referred to MASH. The audit focused on referral, assessment and decision-making processes for cases referred under the following 4LSCP protocols:

1. 4LSCP Unborn/Newborn Baby Safeguarding Protocol - The aim of this protocol is to enable practitioners to work together with families to safeguard unborn/newborn babies where risk is identified. The protocol provides an agreed process between health agencies, social care and other agencies working with the mother and her family on the planning, assessment and actions required to safeguard the unborn/newborn baby.
2. 4LSCP Protocol for the management of actual or suspected bruising in infants who are not independently mobile - This protocol must be followed in all situations where an actual or suspected bruise is noted in an infant who is not independently mobile.

In all the cases audited:

- Information regarding parents/carers, and other adults linked to the family, was sought, shared, and used to inform decision-making.
- Information-sharing between agencies was effective and timely.
- There was evidence of multi-agency involvement in the risk assessment process.
- Decisions taken involved relevant partner agencies.
- The case and referral outcomes were reached, evidenced and recorded within agreed timescales.
- The outcome of MASH involvement was followed through appropriately and within agreed timescales.
- The subsequent actions taken were appropriate and timely including the child being seen within five working days.
- There was an appropriate level of management oversight from point of referral to case outcome.

Opportunities for learning were identified regarding:

- The extent to which police information is used in the analyses of risk.
- Obtaining the views of paediatricians in written form.
- The provision of referrer feedback following allocation to social work teams.

The recommendations taken forward included:

- Referring all unborn baby cases to police MASH for checks.
- West Hampshire CCG, on behalf of the five Hampshire CCGs, using the findings from the audit to support implementation of the Preliminary Paediatric Opinion Form (PPOF), which is designed to give a clear paediatric opinion about the likelihood of abuse in writing, at the time of initial discussion between examining paediatrician and social worker.
- Children’s Services providing assurance to HSCP that feedback is sent to referrers, in line with the agreed criteria, following allocation from MASH to the Children’s Assessment and Safeguarding Teams (CAST).

IV. LEARNING AND IMPROVEMENT

Multi-agency audits

Joint Targeted Area Inspection Dry Run (Children's Mental Health)

On 19 November 2019, a multi-agency group comprising Joint Targeted Area Inspections (JTAI) leads from HSCP reviewed six cases in receipt of intervention/support due to mental ill health. The audit followed the journey of each child from the point of referral to the actions taken and outcomes reached by the multi-agency partnership.

The following key strengths were identified:

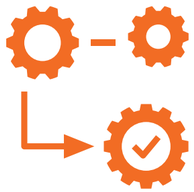
- Involvement of children and their families at all stages of the multi-agency response and consideration of their needs.
- The strength of multi-agency working to protect the child and make sure that they received the services they needed to improve outcomes.
- Robust monitoring of progress against agreed actions in a multi-agency setting.
- Management oversight, challenge, and support.
- The actions taken by agencies to ensure the child was safe.
- There were many examples presented regarding the positive contribution of education professionals in supporting the children to improve their mental health and ultimately attendance (e.g. pastoral support, counselling provision).
- Implementation of the Was Not Brought guidance for health professionals, which ensured that children continued to be offered support.

Opportunities for learning were identified regarding:

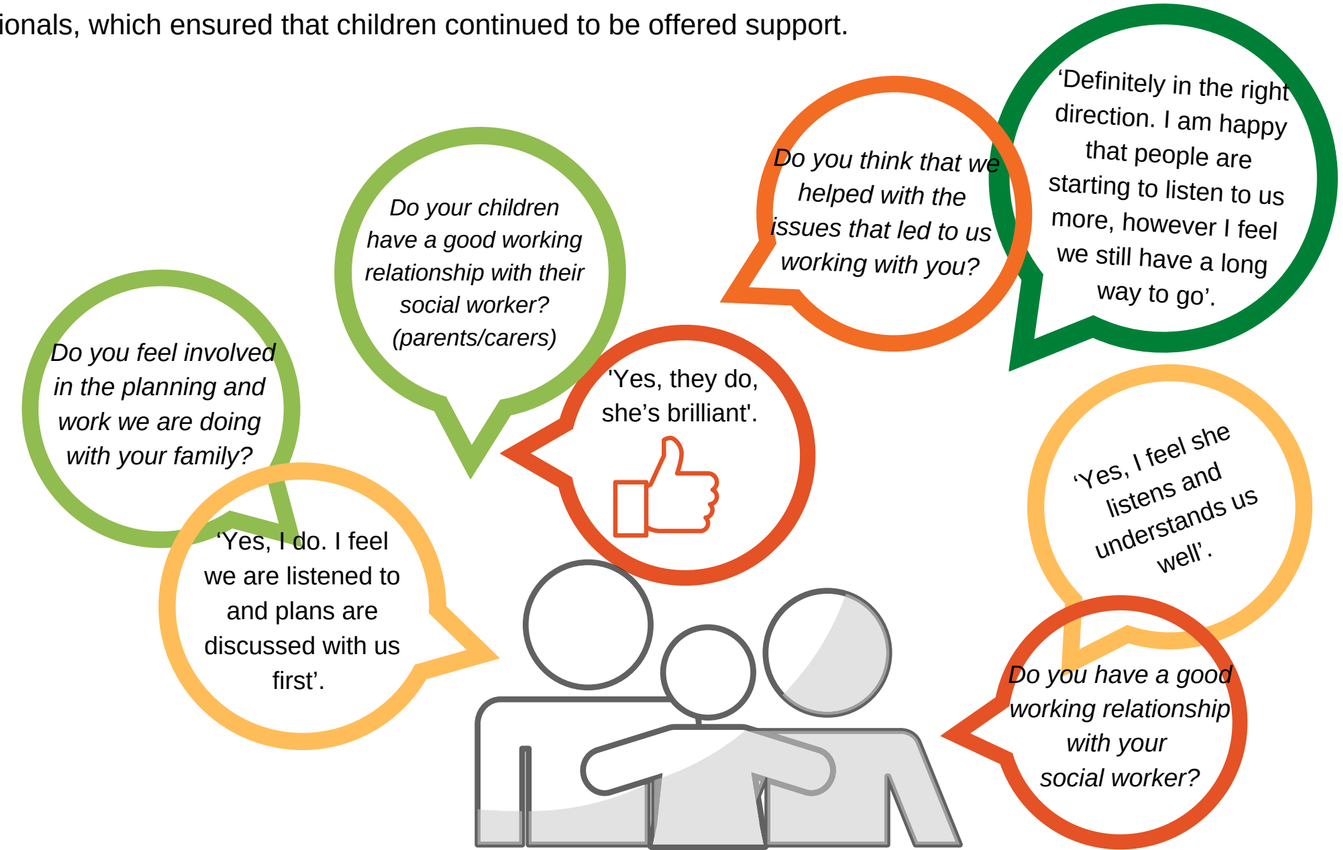
- Evidencing multi-agency challenge in decision-making.

For this audit it was agreed that the views of children and families would be sought directly where deemed appropriate by the social work team. See pictorial examples.

Implementation and Impact:



- Children's services, via HSCP, has provided briefings on the legislative parameters of information sharing at the various levels of involvement, with a focus of how refusal of consent by parents, carers/and/or children (for 16-17 year olds) can impact on the single and multi-agency response.
- It was clear from this audit that some agencies had different interpretations about the legal parameters that children's social care work within. A series of briefings to agencies to clarify and promote awareness has led to a greater understanding of roles. Feedback from agencies has been that this knowledge would assist them in future joint working.



IV. LEARNING AND IMPROVEMENT

Scrutiny Visits

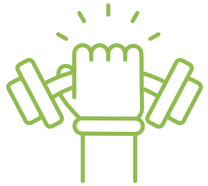
Scrutiny visits are led by the HSCP Team with support from a group of scrutineers from agencies across the Partnership. Their purpose is to establish whether safeguarding governance and processes in partner agencies enable frontline professionals to recognise and respond to abuse, including the application of agreed safeguarding procedures.

The visits offer Board members and quality assurance leads the opportunity to visit settings other than their own, and to engage directly with safeguarding leads and frontline staff on a range of issues including:

- Leadership (governance, strategic line of sight, safeguarding supervision, appraisal processes, safeguarding culture)
- Dissemination of HSCP and internal safeguarding policies, procedures, and resources.
- Safeguarding training and professional development.
- Engagement with multi-agency forums (e.g. Early Help hubs, Child Protection Conferences).
- Knowledge and use of referral thresholds including agreed escalation processes.
- Safeguarding in the context of commissioned services.

A visit to CAMHS took place in March 2020.

The following key strengths were identified:



- Supportive and enabling leaders with a clear commitment to improving the lives of children with mental health needs.
- All staff were aware of, and placed high value on, the Named Nurse role in providing guidance and support around child protection and broader safeguarding.
- Compliance with mandatory safeguarding training.
- Awareness of HSCP's online toolkits (e.g. Neglect, Unidentified Adults, Family Approach) and learning from reviews has been shared with frontline practitioners.
- Professional awareness of the guidelines for practitioners who have a direct working relationship with a child who discloses abuse.

Opportunities for learning were identified regarding:

- Accessing multi-agency training to further enhance professional development.
- Application of the Joint Working Protocol for the Professional Challenge and Resolution of Professional Disagreement beyond the initial level.
- Difficulties in obtaining progress updates on cases with multi-agency involvement.

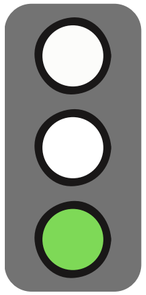
IV. LEARNING AND IMPROVEMENT

Section 11 Safeguarding Self-Assessment & Survey

The purpose of this self-assessment and survey, which is aligned with the safeguarding standards outlined in Section 11 of the Children Act 2004, is to:

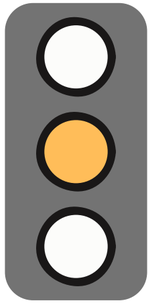
- Enable agencies to scrutinise and reflect on their safeguarding governance, processes, and practice, and to identify how arrangements could be strengthened.
- Enable agencies to showcase areas of good practice where positive outcomes for children can be evidenced.
- Provide a feedback mechanism to the safeguarding children partnerships on progress against areas for improvement, including any barriers to partnership working.

The process endorsed by the four partnerships reflects a two-year cycle of self-assessment (year 1) followed by monitoring and tracking of action plans (year 2). Last year's audit involved completion of the full Section 11 self-assessment and an online staff survey (year 1); therefore, the focus for 2019/20 was to assess impact (year 2). 35 organisations submitted a return. While optional for 2019/20, 814 frontline professionals completed the accompanying Section 11 survey. The staff survey will be repeated in 2020/21 to establish a broader range of views from the frontline, which will inform improvement initiatives in the future.



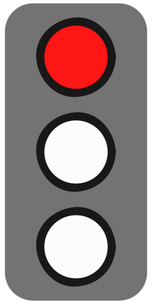
>=90% of Professionals Agree

1) I am clear about the responsibilities of my organisation in identifying children with unmet needs or in need of protection from abuse (physical, emotional, sexual, neglect, exploitation).
2) I am clear about my responsibilities in identifying children with unmet needs or in need of protection from abuse.
c) If you were recruited to your organisation within the last 12 months, did your induction include information on how to identify children with unmet needs or in need of protection from abuse?
3) I know who to speak to in my organisation if I have a concern regarding the safety or welfare of a child.
4) I can access timely advice and support from my organisation when I have a concern regarding the safety or welfare of a child.
5) I have been made aware (in the last six months) of information, guidance or resources that support identification of children with unmet needs or in need of protection from abuse.
6) I am clear about the types of information regarding children, parents and carers that can be shared with other organisations to keep children safe.
7) I know when, and how, to report concerns regarding the safety or welfare of a child to Children's Services/the Multi-Agency Safeguarding Hub.
8) I know how to escalate concerns when I believe that actions to protect a child have not been taken by a member of staff in my own or another organisation.
9) I know who to speak to if I have concerns that another member of staff (including a volunteer) has behaved in a way that has harmed, or may have harmed, a child.
10) My organisation promotes opportunities to attend in-house training/events on how to identify and respond to children with unmet needs or in need of protection from abuse.



75% - 89% Professionals Agree

11) My organisation promotes opportunities to attend external training/events on how to identify and respond to children with unmet needs or in need of protection from abuse.
12) I am aware of the guidance on assessing levels of need, which supports a contact/referral to Children's Services/the Multi-Agency Safeguarding Hub in my organisation's local authority area.
16) My annual appraisal includes a review of competencies and knowledge around my practice in keeping children safe.



<75% Professionals Agree

13) I have used the guidance on assessing levels of need to support a contact/referral to Children's Services/the Multi-Agency Safeguarding Hub.
14) I am supported in attending or contributing to multi-agency meetings that consider individual children (e.g. Child Protection Conferences, Child in Need meetings).
15) I have the support and resources to work effectively with disabled children and their families.

IV. LEARNING AND IMPROVEMENT

Education Safeguarding Children Audits

There is a requirement for all schools and colleges, including local authority maintained schools, academies, and the independent sector, to complete an annual safeguarding children audit. This audit is conducted in line with the statutory obligations placed on the Governing Bodies (or equivalents) by Keeping Children Safe in Education 2016 (with reference to section 175 of the Education Act 2002, section 7 of the Education (Independent School Standards) Regulations 2014 and Section 3 of the Non-Maintained Special Schools (England) Regulations 2015.

In the autumn term 2019, HSCP and the Assistant Director (Education and Inclusion) of Hampshire Children's Services commissioned a quality assurance exercise in relation to the annual school audit process. This focused on the quality of returns especially in relation to the action planning. Eight settings were selected for quality assurance visits. These were a mix of two secondary schools, two special schools, one of which is an independent school, three primary schools and a tertiary college. These included four maintained schools and three academies.

The quality assurance visits took place in December 2019 and January 2020. The visits were led by an advisor from Hampshire Inspection and Advisory Service (HIAS). Two schools (the special independent school and the maintained secondary school) were visited alongside a representative from the HSCP. As part of each visit a discussion took place with:

- The Headteacher.
- The Designated Safeguarding Lead (DSL).
- The Chair of Governors (or equivalent).

Areas of Strength:

- Where the audit tool is used to inform reflection of progress within each of the areas of the audit, the action planning provides an opportunity to engage in an honest appraisal of areas of safeguarding that require further development. Some of these areas may have been fully compliant in previous years but needed a refresh after a review of the evidence available. Schools described the audit tool as being most effective in promoting reflection, evidence-based evaluation and prompting change to practice, as well as proving an opportunity to celebrate.
- Where the 'guidance document' is used to review and evaluate, the development plan generated as a result is generally more comprehensive and inclined to change practice in the school/college.
- The self-reflective questions as well as the annual changes to the Keeping Children Safe in Education (KCSiE) document, that were provided by the HSCP, were found by schools and colleges to be very useful.
- Where action planning is informed by the outcomes of the audit tool/process, the plan becomes a part of the whole school/college development plan which assists in ensuring an ongoing review of progress. One school is planning to include headings from the audit tool within the school improvement plan, so that the areas of development can be cross-referenced easily.

IV. LEARNING AND IMPROVEMENT

Education Safeguarding Children Audits

Areas of Strength continued ...

- Development of safeguarding is most effective where there is a comprehensive review cycle embedded into regular meetings on a cyclical basis. Exemplification of meetings included with the welfare team, the senior leadership team, and governors on a weekly or monthly basis. Where safeguarding is a standing item in governor meetings, this supports the governors in challenging the actions, in some cases providing the opportunity to RAG (Red-Amber-Green) rate the progression and impact of identified areas of development. Safeguarding review is most effective when it is included as part of both operational and strategic discussions/meetings.
- In a number of schools, safeguarding is being developed as a distinct curriculum area with a vision statement, intentions and a provision map as well as a review cycle.
- Electronic methods of record-keeping such as CPOMs and MyConcern are providing a consistent and comprehensive approach to collecting information on pupils. The analysis and reporting of that over-arching information at a strategic level is less consistent.
- Where the action plan identifies key areas of development, it is supporting improved culture and professional knowledge/provision of training, for example, relating to knife crime, internet safety and the self-harm pathway.
- In a number of schools, staff with different responsibilities in the school/college were involved in identifying areas of development within the action plan. Examples included administrative staff, site manager, pastoral staff as well as the safeguarding governor, DSL and Designated Teacher for Looked After Children. This exemplifies a strong safeguarding culture where there is collective responsibility and ownership.
- Using pupil voice and staff questionnaires to evaluate the effectiveness of the safeguarding frameworks as well as using ‘case studies’ to identify key learning points is a strength in a number of schools/colleges.

Areas for Consideration:

- A good starting point for completing the annual return is to reflect on the outcomes of monitoring and evaluation for the year to which the return relates. There has been good progress by a number of schools/colleges over this year in developing monitoring systems and processes to better inform the audit return. This area needs further work/embedding within all school/college cycles of planning, monitoring and evaluating.
- Schools and colleges would all benefit from a reminder to use an evaluation tool and the ‘guidance document’ to inform their audit return (which is just a summative document) as well as inform future planning.
- It was suggested that the planning tool might benefit from having an ‘action points’ and ‘impact’ column in addition to RAG rating the progress of the development points.
- It was identified that HSCP should clarify that a negative response within an audit return does not indicate failure of a school’s/ college’s safeguarding duty, rather an area that needs further development and may benefit from external advice/support.
- Special schools identified that they gained a great deal from sharing good practice within establishments. They may wish to consider working collaboratively to enhance the self-evaluation audit tool with specific areas applicable to specialist provision.

This report was shared with the HSCP, initially through the Education subgroup. It was also shared with all schools and colleges, along with the notification of audit requirements for 2020.

V. COMMUNICATION

Newsletter

The HSCP Newsletter 'Keeping Our Children Safe' continues to be published quarterly. Over 617 professionals have signed up so far!

Subscribe to our newsletter

HSCP Website

The HSCP website is full of information and is where you will find toolkits, governance arrangements and training links. It is continually updated and should be a key reference point for all professionals working with children in Hampshire.

hscp@hants.gov.uk

019862 876355

@HAMPSHIRESCP

www.hscp.org.uk

www.hipsprocedures.org.uk

HIPS Procedures

During 2019-20 Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Safeguarding Children Partnerships worked together in partnership to produce a local Procedures Manual.

Register for updates

Twitter

The HSCP twitter account @HAMPSHIRESCP has over 800 followers. Follow us to keep up to date with our latest publications and events.

VI. 2020/21 BUSINESS PLAN PRIORITIES
Strategic Objectives and Activities 2020-2023.

To support its new arrangements, HSCP has published a three year Business Plan including longer term strategic objectives and shorter term activities. The structure of the Business Plan will allow the Board to focus on key strategic areas of partnership activity but also remain flexible to respond to emerging needs and refine existing programmes of activity in line with feedback received from children, their families and professionals. To support the delivery of the Business Plan more detailed work plans, aligned to the Board's priorities, will be developed for each sub and working group.

Part A Strategic Objectives 2020-2023:

To be undertaken in partnership with the IOWSCP.

Safeguarding Adolescents - A task and finish group will be established to review the range of risks relating to safeguarding adolescents and consider:

- The current level of multi-agency understanding and response to these risks.
- Examples of good practice and establish how this can be shared across agencies.
- Whether there are gaps in service provision and our collective response to protecting young people at risk, and what action can be taken by HSCP to respond to these.
- Whether frontline professionals need any further tools, training or support to strengthen their practice.
- To hear from the experience of young people who have received services from HSCP partner agencies.

Responding to Neglect - Re-establish the joint HSCP and IOWSCP Neglect Task and Finish Group to:

- Respond to the outcomes of the 2019 HSCP evaluation of neglect.
- Update the joint HSCP/IOWSCP Neglect Strategy.
- Review the joint online Neglect Toolkit to include additional information on neglect and consider other tools and practical information to support frontline practice.
- Review current HSCP training offer on neglect.
- Provide material to support single agency training in HSCP Safeguarding Partners and Relevant Agencies.
- Consider gaps and other opportunities to promote best practice in multi-agency working to understand and respond to neglect.

Part B Strategic Activities 2020-2021:

- Evaluate the impact of HSCP initiatives and programmes including: Family Approach, Every Sleep Counts and Launch of Lurking Trolls.
- Improved and effective dissemination and communication channels cross HSCP safeguarding partners and Relevant Agencies including: Review Learning and Improvement Framework. Produce communications strategy, communications plans for core initiatives and key information dissemination.
- Understanding the safeguarding risks for children who are excluded from education and/or receiving reduced hours provision (not in full-time education).
- Participate in HIPS-wide Dare to Share project.
- Effective safeguarding of unborn and newborn babies.

GLOSSARY OF TERMS

ACEs—Adverse Childhood Experiences
ADHD—Attention Deficit Hyperactivity Disorder
APWA—Absent from Placement Without Authority
ASB—Anti Social Behaviour
ASD—Autism Spectrum Disorders

CAF—Child And Family Assessments
CAFCASS – Child and Family Court Advisory and Support Service
CAIT—Child Abuse Investigation Team
CAMHS—Child and Adolescent Mental Health Service
CAPs—Community Alcohol Partnerships
CAST—Children's Assessment Safeguarding Team
CAWN—Child Abduction Warning Notice
CCE—Child Criminal Exploitation
CCG—Clinical Commissioning Group
CDOP—Child Death Overview Panel
CERAF – Child Exploitation Risk Assessment Framework
CIN—Children In Need
CLA – Children Looked After
CP—Child Protection
CPC—Child Protection Conference
CPI – Community Partnership Information Form
CRC—Community Rehabilitation Company
CRT—Children's Reception Team
CSD—Children Services Department
CRT - Children's Reception Team
CSE—Child Sexual Exploitation
CSP—Community Safety Partnership

DA – Domestic Abuse
DVA – Domestic Violence and Abuse
DAF—Domestic Abuse Forum
DBS—Disclosure and Barring Service
DfE—Department for Education
DHR—Domestic Homicide Reviews
DSL—Designated Safeguarding Lead

E&I—Education and Inclusion
EET—Education, Employment and Training
EHA—Early Help Assessments
EHCP—Education, Health and Care Plan
EHE—Electively Home Educated

FGM—Female Genital Mutilation
FII – Fabricated or Induced Illness
FIT—Family Intervention Team
FTE—First Time Entrants

HSCP – Hampshire Safeguarding Children Partnership
HIAS – Hampshire Inspection and Advisory Service
HHFT - Hampshire Hospital Foundation Trust
HSAB – Hampshire Safeguarding Adults Board
HIOW—Hampshire and Isle of Wight

IRAF – Inter Agency Referral Form
ICPC – Initial Child Protection Conference
IRO – Independent Reviewing Officer

JTAI – Joint Targeted Area Inspections

KCSIE – Keeping Children Safe in Education

LA – Local Authority
LADO – Local Authority Designated Officer
LIG—Learning and Inquiry Group

MASH – Multi Agency Safeguarding Hub
MET—Missing, Exploited and Trafficked
NEET—Not in Education, Employment or Training

NPS—National Probation Service
NRM—National Referral Mechanism

OPCC— Office of the Police & Crime Commissioner

PSHE—Personal, Social, Health and Economic Education
PPN – Public Protection Notice

RJ—Restorative Justice

SCR—Serious Case Review
SCAS – South Central Ambulance Service
SHFT – Southern Health Foundation Trust
SEND—Special Educational Needs and Disabilities
SEN—Special Educational Needs
SIRI - Serious Incident Requiring Investigating

UASC—Unaccompanied Asylum Seeking Child
YCP—Youth Crime Prevention
YOT—Youth Offending Team

APPENDIX 1

Safeguarding Partners

Hampshire Children's Services
Hampshire Constabulary
West Hampshire Clinical Commissioning Group (CCG) on behalf of Hampshire 5 CCG's

Relevant Agencies

Ministry of Defence
District/Borough/City Councils
Child and Family Court Advisory Service (CAFCASS)
Education establishments (primary, secondary, independent, post-16 years and special schools, Pupil Referral units and Early Years Settings)
Hampshire County Council, Adults' Health and Care
Hampshire County Council, Education and Inclusion
Hampshire County Council, Public Health
Hampshire Fire & Rescue Service
National Probation Service in the Hampshire Local Authority Area
Hampshire & Isle of Wight Community Rehabilitation Company
Hampshire Youth Offending Team
NHS England, Local Area Team
Health providers: − Southern Health NHS Foundation Trust − Hampshire Hospitals NHS Foundation Trust − Frimley Park NHS Foundation Trust − University of Southampton NHS Foundation Trust − Portsmouth Hospitals NHS Foundation Trust − South Central Ambulance Service − North Hampshire Urgent Care − Solent NHS Trust − Sussex Partnership NHS Foundation Trust − All Primary Care providers commissioned by the five Hampshire CCGs. − Partnering Health Limited (PHL) − Independent Providers − Commissioned Providers of Substance Misuse Services
The Office of the Police and Crime Commissioner
Commissioned Providers of Domestic Abuse Services
Voluntary Sector
Winchester Diocese
Portsmouth Diocese
Sporting organisations via the Hampshire and Isle of Wight County Sports Partnership
Language Schools

APPENDIX 2

Board Membership

Derek Benson: Independent Chair
Claire Cox: Lay Member
Camilla Pearse: Lay Member
Steve Crocker OBE: Children's Services, Hampshire County Council
Stuart Ashley: Children's Services, Hampshire County Council
Darren Rawlings: Hampshire Constabulary
Ellen McNicholas West Hampshire CCG on behalf of Hampshire 5CCGs
Cynthia Condliffe: West Hampshire CCG on behalf of Hampshire 5CCGs
Kim Jones West Hampshire CCG on behalf of Hampshire 5CCGs
Dr Simon Jones West Hampshire CCG on behalf of Hampshire 5CCGs
Trish LeFlufy: Hampshire Hospitals NHS Foundation Trust
Caz Maclean: Southern Health NHS Foundation Trust
Trish Dennison:NHS England (Specialised Commissioning)
Ruth Hillman: Sussex Partnership NHS Foundation Trust
Nicky Priest: NHS England
Simon Bryant: Public Health, Hampshire County Council
Karen Nye Education and Inclusion, Hampshire County Council
Dr Steve Bailey: Independent Schools
Lesley Spicer: Primary Schools
Gwennan Harrison-Jones: Secondary Schools
Ali Foss: Post-16 Colleges
Tim Jackson: Post 16 Colleges
Catherine Le Roux:Special Schools
Jennifer Parsons: National Probation Service
Siobhan Cavanagh: Hampshire and Isle of Wight Community Rehabilitation Company
Nikki Shave: Youth Offending Team, Hampshire County Council
Kailea Hurcombe: Voluntary Sector
Bob Jackson: District / Borough / City Councils
Jo Lappin: Adult Services, Hampshire County Council
Sue Lee: Hampshire Safeguarding Adults Partnership
Andrew Robinson Diocese of Winchester
Nathan Ditton: Ministry of Defence
Councillor Patricia Stallard: Hampshire County Council
Tim Houghton: Community First
Glenn Bowyer: Hampshire Fire and Rescue Service