Hampshire Safeguarding Children Board

Annual Report 2014/15

Contents

Forward by the Independent Chair

I am pleased to introduce the Annual Report for Hampshire Safeguarding Children Board 2014/15. I have now completed my second year in this role and would like to thank all organisations represented on the HSCB for their commitment, grip and engagement in making sure improvements continue to be made in protecting all children from harm across Hampshire. The standard set remains high.

The findings from audits, data, serious case reviews and reporting schedules provided to the HSCB during 2014/15 have given me a clear view of how well child protection work is being managed.

The information collated gives me a clear picture of the pressure points across children's social care services, across the many different NHS bodies, and from the criminal justice sector, particularly from policing, in relation to public protection and child abuse investigation work. Moreover, during this reporting year the HSCB has engaged with the diverse education sector across Hampshire, including secondary and primary schools, the large number of independent and privately run schools and special schools.

The HSCB has examined carefully the work that is being done to improve services and ensure that those working on the front line, as social workers, police officers, health visitors, teachers and any part of the children's workforce are involved in key learning and development. This has included actively listening to the voices of children, families, and the welfare of disabled children, and to the most vulnerable children.

In particular, there has been a focus on older children in the child protection system and systems and practice has been strengthened to ensure that this group of children are being supported appropriately and not disadvantaged in the transition into adulthood. Children who go missing from their care, school or home are much better responded to so as to better mitigate their vulnerability. All these issues remain priorities within next year's Business Plan.

Furthermore, during 2014/15 the HSCB has identified that it must extend its reach into the wider community through engagement with faith groups, community groups and the voluntary sector to raise awareness of child protection matters. HSCB has been fortunate to have strong and supportive lay members but their current tenure has come to an end and we will be recruiting new lay members.

There have been many and varied examples of working, innovative approaches to service delivery and commitment in Hampshire that I have seen. I have reported very recently on the progress made within education and there has also been a more united response from the health sector across Hampshire through a new health safeguarding group. Everyone knows the part they have to play in keeping children safe.

As Hampshire continues to make progress and build upon the undoubted improvements in relation to work with older children, the need for consistent strategic grip of services and partnerships remains of paramount importance now and in future.

Our priorities for 2015/16 are set out in the report and include a focus on how best to respond to austerity measures hitting all child protection agencies at a time of increased complexity and workload in the system. The numbers of child abuse cases reported to Hampshire Constabulary and referrals into the new MASH in Hampshire have continued to rise and I have been impressed with the rigour in which professionals have continued to deal with this increased pressure.

It is vital that the HSCB continues to keep a tight grip across the partnership on what is working well and where challenges are emerging. I believe we are in a sound position as a Board to provide this scrutiny and give assurance that safeguarding children in Hampshire is at the forefront of all organisations.

Maggie Blyth
Independent Chair HSCB

Local Demographics

Hampshire County Council is the third largest county in the country (based on population) with 1.32 million people Office for National Statistics (ONS) Census 2011. Figures from the 2011 Census show that there were 280,150 children and young people aged 0-19.

Hampshire has a predominantly white ethnic population with 92.5% of children aged 0-17 of white ethnicity and 97.8% of children aged 3-14 first language is English. (Office for National Statistics, 2011 Census).

The county is a mix of urban and rural populations, with areas of affluence and areas of significant deprivation. 5 areas in Hampshire are among the most deprived in the country (Index of Multiple Deprivation 2010).

HSCB's underlying philosophy has been to focus attention on those children who are most vulnerable and at risk of suffering harm.

Vulnerable groups

It is impossible to offer a complete picture of the children whose safety is at risk in Hampshire because some abuse or neglect may be hidden, despite the best efforts of local services to identify, step in and support children who are being harmed or are at risk of being harmed. However, HSCB expects partner agencies to understand the local context and escalate all new concerns about the range of children at risk to the Board as they emerge.

Many groups of children in Hampshire are vulnerable and are at increased risk of being abused and/or neglected. This annual report starts by looking at the categories of children and young people in Hampshire who have been identified by partner agencies as in need of protection as they are more vulnerable.

These categories 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 are mentally ill can place children at increased risk of harm from abuse and/or neglect.

Children who go missing from home or from school are placed in greater danger of harm. The needs of these children and other vulnerable groups, are outlined on pages 3-9 to provide an understanding of local context. The impact of the work done to support these children is outlined extensively later in the report.

Children with a Child Protection Plan

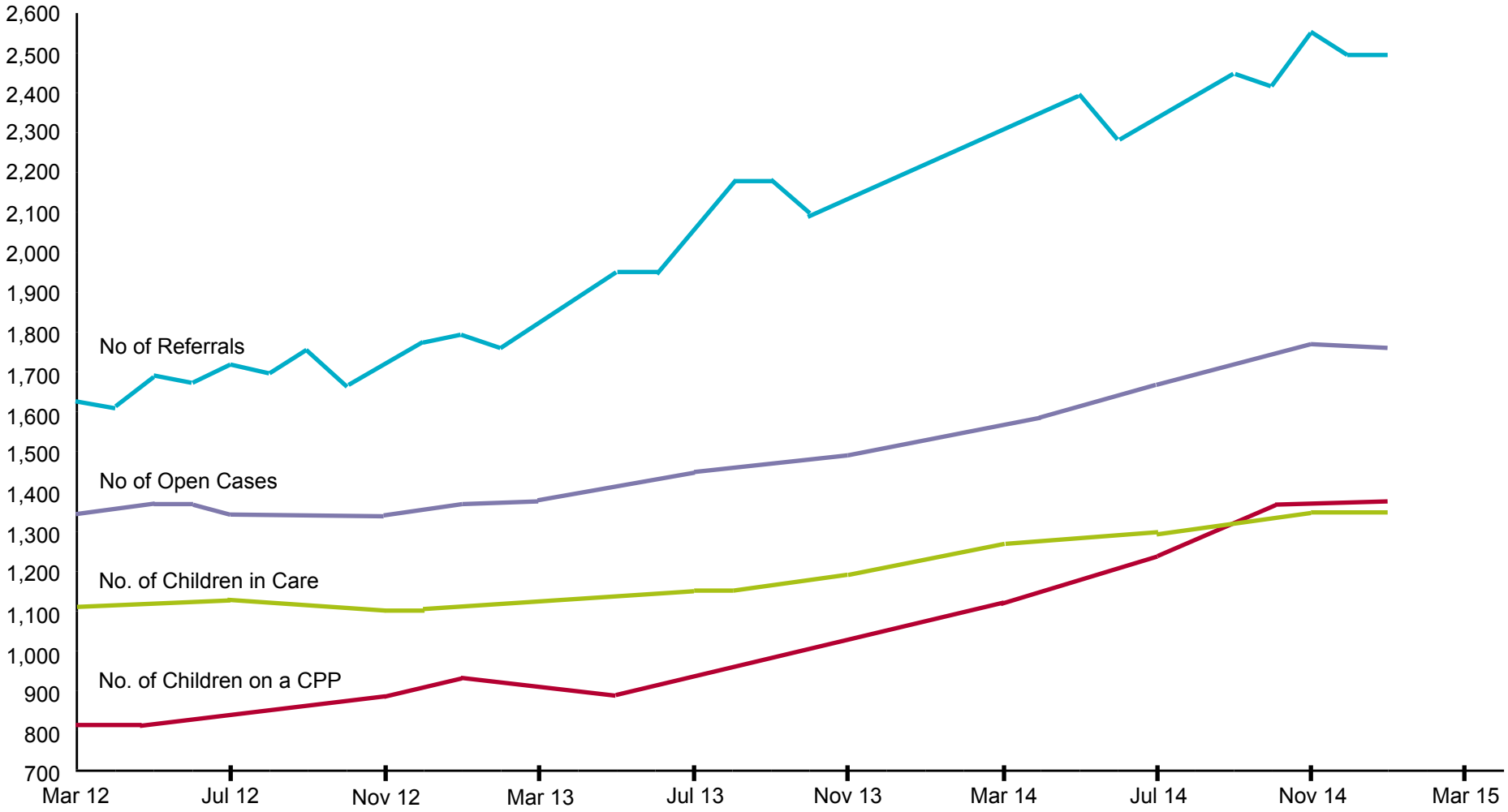
Children who have a child protection plan (CPP) are considered to be in need of protection from either neglect, physical, sexual or emotional abuse, or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made.

During 2014/15 the numbers of children subject to a CPP have continued to steadily increase. At the end of March 2014 the numbers stood at 1,113 and at the end of March 2015 the numbers stood at 1,352. The trend in Hampshire follows that from the previous reporting period, and is similar to the national trend.

The national and local trends reflect greater pressures on families caused by the recession and poverty. Importantly, the increase also reflects better recognition of abuse and neglect amongst professionals which lead to increased referrals. Historically the use of CPPs in Hampshire was lower than statistical neighbours however the more pronounced increase reflects a greater consistency in the application of thresholds, particularly since the introduction of the agreed HSCB Thresholds Chart, and the factors highlighted above.

The chart below shows how the numbers of children on a child protection plan broadly reflects the numbers of referrals based on the agreed HSCB Thresholds Chart. The Hampshire use of CPPs is in line with statistical neighbours.

Activiy volumes from March 2012 to March 2015



Whilst it is encouraging that there is greater awareness of risk indicators, and therefore appropriate protection and support to those children in greatest need, the increase in CPPs creates pressures within the system for all partners to attend the multi-agency planning meetings, and for children's social care, in particular, to maintain close oversight and visiting arrangements.

The HSCB routinely scrutinises child protection activity at a county level and where required looks at what is happening at a local level to understand any specific trends or issues impacting on safeguarding activity.

Children in Care

Children in care are those looked after by the local authority. Only after exploring every possibility of protecting a child at home will the local authority seek a parent's consent or a court decision to move a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

There were 1,343 children in care at the end of March 2015, compared with 1,266 at the end of March 2014. All children in care are subject to regular independent reviews of their care to ensure that their circumstances are reviewed and their needs are met. The local authority and other agencies work together to ensure that children in their care are offered the best possible care and this work is co-ordinated and overseen by the Hampshire 'Care Matters' board.

The increase in the children in care population has been broadly spread across the child population with a slightly higher increase in 5-9 year olds coming in to care. The vast majority of these children are placed in foster care (76%).

Less than 10% of children were in some form of residential care with around half of those being children with disabilities and complex needs which require specialist placements. The ethnic profile of children in care in Hampshire is similar to the general population and the overall profile of children in care in Hampshire is similar to that of England as a whole.

Children who are privately fostered

Parents may make their own arrangements for their children to live away from home. These are privately fostered children. The local authority must be notified of these arrangements.

At the end of March 2015 the local authority were aware of 13 privately fostered children. This figure has remained fairly static to previous years and may be comparable with rates recognised in some other local authorities, but is still suspected to be an inaccurate reflection of actual private fostering arrangements in the County.

The HSCB recognises that an emphasis on awareness raising with front line staff is important to ensure that new referrals and checks are made to ensure children living in all circumstances are kept safe.

The number of notifications of new private fostering arrangements in 2013/14 was slightly higher than the previous year, increasing from 6 to 8, with four of these translating into recognised and assessed new private fostering arrangements. The relatively low numbers merit monitoring, which will happen automatically as private fostering data is submitted annually to the Department of Education (DfE).

Disabled children

There has been a decrease in the number of disabled children with a child protection plan. At the end of March 2015 there were 18 disabled children with a CPP compared to 47 at the end of March 2014.

Since the creation of the Children with Disabilities Service in 2011, significant work has been undertaken to refocus the perspective of the Disabled Children's Teams to consider the child first, rather than the disability or the parents. This significantly increased the numbers of disabled children and young people being appropriately managed within the child protection process.

Many of these cases were existing open cases to the teams where a more robust approach has been taken than was previously applied to them. However, the numbers of new referrals coming into the teams has not seen a corresponding increase and this may account for the numbers reducing over the previous twelve months.

It is also true that the service has experienced an increase in staff turnover, including management and the previous staff development work is being refreshed to ensure the focus of the teams is maintained. The Safeguarding Disabled Children's Subgroup is also focussing on raising awareness across the children's workforce to ensure that appropriate identification of disabled children and young people at risk is taking place outside of the social care system.

Safeguarding disabled children was identified as a priority for the HSCB again in 2014/15 and the achievements made in safeguarding this vulnerable group are outlined later in this report.

Young people with mental health issues

During 2014 – 2015, 6,534 children and young people were referred to the specialist Child and Adolescent Mental Health Service (CAMHS). This is a slight reduction on the previous year. At the end of March 2015 there were 6,120 open cases of young people receiving an on-going service. Waiting times for young people to be seen within 4 weeks has fluctuated over the year ranging from 34% in June 2014 to 58% in September, with the average percentage of young people waiting 0-4 weeks to be seen was 45%. HSCB has requested an update from CAMHS on progress to reduce this which will be included in next year's annual report.

The service has seen a significant increase in the number of urgent and crisis presentations requiring immediate assessment. These are both those who present in Accident and Emergency departments, often with high levels of deliberate self-harm, as well as those who are referred directly into the service with complex and high risk behaviours.

In order to respond to this increase in urgent referrals, CAMHS have extended their i2i service, which is an intensive home treatment service. The i2i service assesses all those young people who present in Accident and Emergency with deliberate self-harm as well as young people who require urgent assessment within a clinic following referral, and those needing intensive treatment at home.

The total number of young people receiving inpatient care was 101 throughout 2014 – 2015. This shows a steady increase when comparing against 90 in 2013/14, and 72 in 2012/13. Of those 101, only 36 could be placed locally at Leigh House. The remaining 65 were placed in provision, either facilities run by the NHS, or some in private facilities outside of Hampshire. The high demand, and therefore relative and shortage of local provision, makes care planning and transition arrangements more challenging for the local teams.

These figures reflect similar positions in local authorities across the country, and the overall picture is one of national debate at present. CAHMS services across Hampshire are working hard with partners across the system to reduce waiting times and ensure that those children and young people most at need are seen as quickly as possible. HSCB will continue to monitor services and waiting times throughout the coming year.

Children who offend or are at risk of offending

The children who are involved with Hampshire Youth Offending Team (HYOT) often present with complex needs requiring significant support both in and out of custody. HYOT has continued to see the number of children they work with decrease from previous years.

At the end of March 2015 they worked with 813 young people through pre-court disposals and community orders compared to 1,104 at the end of March 2014.

The number of children (under the age of 18) in custody on remand or sentence has decreased slightly from 51 in 2014 to 46 in 2015. The overall decline is consistent with a national reduction in the number of children formally entering the criminal justice system.

HSCB continues to scrutinise the safeguarding practices within local secure settings, particularly in relation to the use of restraint and further information on this can be found later in this report.

Children Missing from Home

There were a total of 1,397 missing episodes for under 18 year olds during 2014/15. Processes in place for monitoring children going missing have been strengthened and include a rigorous follow up action, a welfare check by the police, as well as return interviews to ascertain why the child went missing, where they have been, what they were doing and what support should be put in place to prevent this happening in the future.

Deadlines are set to ensure this takes place and the HSCB will challenge agencies that are not routinely fulfilling their responsibilities. While the numbers of children going missing has increased, this has provided some initial assurance that childrens' whereabouts are monitored and the safe return home pursued.

During 2015 Children's Services will be expanding their recording categories to include:

- Missing
- Away from placement without authorisation
- Absent

These additional categories will provide greater understand of children who go missing, and will help to differentiate those who are actually missing against those who have missed curfew deadlines but are not missing.

Children who are at risk of sexual exploitation

Multi-agency work to identify children and young people who may be at risk of child sexual exploitation (CSE) in Hampshire has been a focus for 2014/15. This multi-agency work is coordinated by the Hampshire Missing, Exploited and Trafficked Subgroup (MET). At the end of March 2015 95 children and young people were identified as being at risk of CSE.

The HSCB previously approved the use of a specific Barnardo's assessment tool (SERAF) which has been the subject of a multi-agency audit later on in this report. During the reporting period these agencies represented at the Hampshire Operational MET Group have reviewed 566 SERAFs covering children at being at risk of exploitation as defined by the SERAF scoring. As of 31 March 2015 there were 26 SERAFs still open for multi-agency review and intervention. All of these children have multi-agency safeguarding plans to reduce the risks.

Child sexual exploitation was identified as a priority for the HSCB again in 2014/15 and the achievements made in tackling child sexual exploitation locally are outlined later in this report.

The use of a screening tool to identify CSE is important as it enables children's' needs to be identified, the risk managed and allows the HSCB to get a better picture of how many children are in danger of sexual exploitation. We know from data collected that most children at high risk of CSE are exploited by white males and more likely to be groomed via social media than pulled into exploitation through street grooming. The predominant age profile for girls starting to be exploited is 10 to 17 and for boys is slightly older. Figures for boys are also more complex as they may be both victims and perpetrators.

Female Genital mutilation (FGM)

Female Genital Mutilation (FGM) is medically unnecessary, extremely painful and has serious health consequences for women who undergo it both at the time when the mutilation is carried out and in later life. There is a programme of work, led by the Department of Health, to improve the NHS response to FGM, and subsequent management of women and safeguarding for girls at risk.

Professionals from across Hampshire have attended a pan-Hampshire FGM working group and contributed to the development of a toolkit to aid professionals to better understand what to do when engaging with women and girls that have either had FGM performed on them or are at risk of it happening in the future.

This work will be taken forward by a Hampshire-specific task and finish group during the next financial year and will be reported on in the next annual report.

What is the HSCB?

HSCB is a partnership of local agencies, and the key statutory mechanism for agreeing how the relevant organisations in Hampshire will co-operate and work together to safeguard and promote the welfare of children and for ensuring that this work is effective. The Board works at a strategic level to positively impact on frontline service offered across all partner agencies.
HSCB was established in compliance with The Children Act 2004 (Section 13) and The Local Safeguarding Children Boards Regulations 2006.

The work of HSCB during 2014/15 was governed by the statutory guidance in Working Together to Safeguard Children 2013 (now 2015), which sets out how organisations and individuals should work together to safeguard and promote the welfare of children, and the Local Safeguarding Children Board Regulations 2006 which sets out the functions of Local Safeguarding Children Boards.

Our Objective:

To co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Hampshire. The HSCB influences how children's services are planned in Hampshire and is a strong advocate for ensuring that children are prioritised by all agencies.

We aim to do this in three ways

To co-ordinate local work by:

- Developing robust policies and procedures.
- Participating in the planning of services for children in Hampshire.
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

To ensure the effectiveness of that work by:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children.
- Undertaking Serious Case Reviews and other multi-agency case reviews sharing learning opportunities.
- Collecting and analysing information about child deaths
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Hampshire.

And most importantly:

- To measure the impact of what we have put in place in how professionals work on the front line to protect children.

"The success of the HSCB is in the extent to which there is a partnership diagnosis of pressure points in the system"

Organisation of HSCB

The Board meets four times during the year and has a membership made up of representatives from all statutory partners and other voluntary services, schools, education providers and agencies concerned with safeguarding children. We have been fortunate to have two lay members for the last three years but one of these lay members resigned at the end of the reporting period.

Board Membership:

- Independent Chair
- Representation from the Armed Forces
- CAFCASS (Children and Family Courts Advisory and Support Service)
- 5 Clinical Commissioning Groups
- 11 District Councils
- Hampshire Constabulary
- Hampshire County Council including Adult Services, Children's Services and Public Health
- Hampshire Hospitals NHS Foundation Trust
- Hampshire Probation Trust (now National Probation Service and the Community Rehabilitation Company Purple Futures)
- Hampshire Youth Offending Team
- 2 lay members (1 vacancy part way through 14/15)
- NHS England (Wessex Area)
- South Central Ambulance Service Trust
- Southern Health NHS Foundation Trust
- Sussex Partnership NHS Trust
- Representation from the voluntary sector (The Children's Society)

The Board is also supported by designated health professionals as well as legal and financial services. The Board and its subgroups experience good attendance with representation across Board partners, particularly from core members. Further work is needed to strengthen the involvement of the voluntary sector and this will be a priority for the coming year.

A list of board members is provided at the back of this report.

11 District Councils

Hampshire County Council

2 Lay Members

NHS

5 Clinical Commissioning Groups

Hampshire Constabulary

yot Hampshire Youth Offending Team

Army · Royal Navy · Royal Air Force

Cafcass — Children and Family Court Advisory and Support Service

National Probation Service

Hampshire & Isle of Wight Community Rehabilitation Company — Probation

The Children's Society

Southern Health NHS Foundation Trust

NHS England

South Central Ambulance Service NHS Foundation Trust

Sussex Partnership NHS Foundation Trust

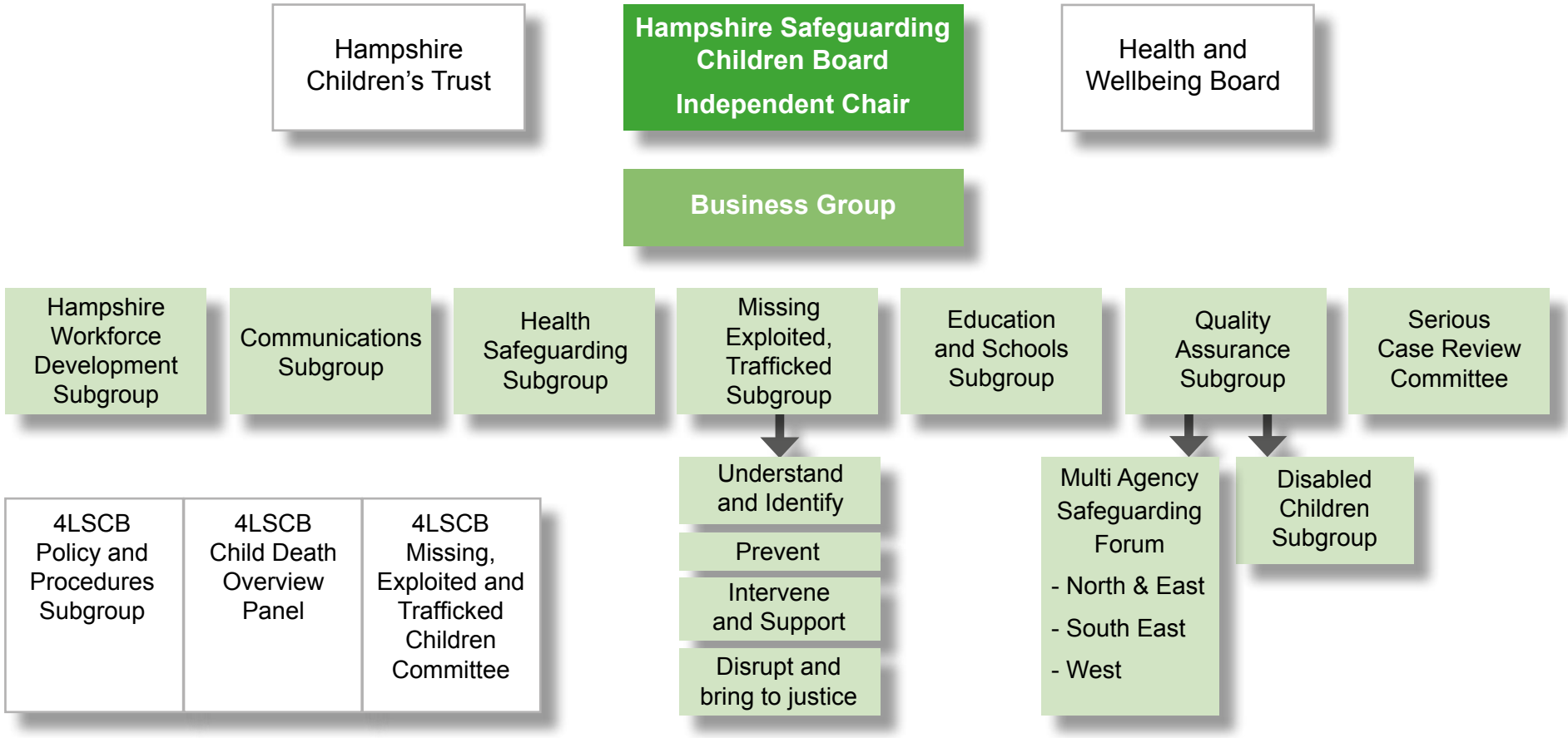
Hampshire Hospitals NHS Foundation Trust

The Board, led by the Independent Chair, will during 2015/16 lead a comprehensive programme of evaluation and review of both board membership and structure. All agencies across the public and voluntary sector are experiencing increased demand for their services at a time when budgets are tight and staffing numbers stretched. The Board has a pivotal role in coordinating activity and holding partners to account, and has not reviewed arrangements since 2013.

It is timely that we review board membership and consider how we develop effective strategic relationships with both the voluntary sector and faith groups across Hampshire, as well as the Community Safety Partnerships.

HSCB Structure

The main Board is supported by a range of subgroups that enable its functioning. The structure of the board is illustrated below. Towards the end of 2014/15 the Board agreed to form a new Communications Subgroup. In addition, the existing Missing, Exploited and Trafficked Subgroup has formed four separate work streams to support in delivering across the work of the group.



4LSCB Arrangement

Hampshire, Isle of Wight, Portsmouth and Southampton each has its own LSCB, but come together under the 4LSCB umbrella in order to share procedures and policies, skills, knowledge, resources and learning.

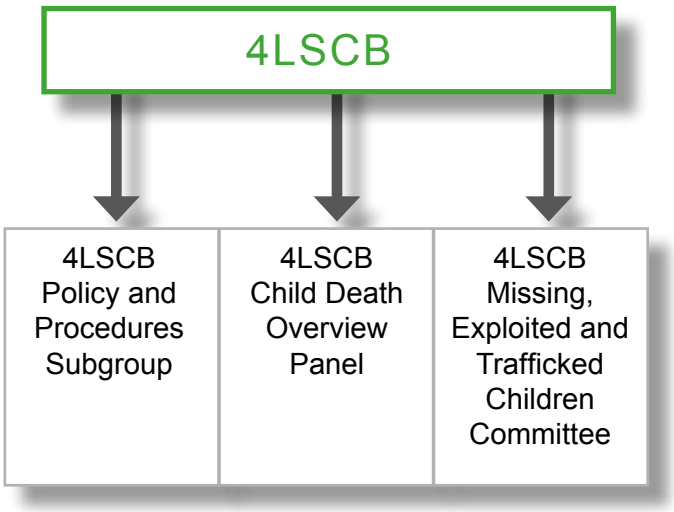
Hampshire Safeguarding Children Board

Isle of Wight Safeguarding Children Board

Southampton Local Safeguarding Children Board

PSCB Portsmouth Safeguarding Children Board

The 4LSCB has a number of subgroups:



Key roles

Independent Chair

The Board is led by an Independent Chair, Maggie Blyth, ensuring a continued independent voice for the Board.

The Independent Chair is directly accountable to the Chief Executive of Hampshire County Council and responsible with partner agencies for the effective working and delivery of agreed objectives for the HSCB. The Independent Chair will also work closely with the Director of Children's Services to discuss safeguarding challenges.

Local Authority

Hampshire County Council is responsible for establishing an LSCB in their area and ensuring that it is run effectively. The ultimate responsibility for the effectiveness of the HSCB rests with the Leader of the Hampshire County Council. The Chief Executive of the Council is accountable to the Leader.

The Lead Member for Children's Services is the Councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. The Lead Member contributes to HSCB as a participating observer and is not part of the decision-making process.

Partner agencies

All partner agencies in Hampshire are committed to ensuring the effective operation of HSCB. This is supported by a constitution setting out governance and accountability arrangements .

Member agencies retain their own lines of accountability for safeguarding practice. Members of the Board hold a strategic role within an organisation and are able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

Designated professionals

Health commissioners must have a Designated Doctor and Nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguard children across the local area. As clinical experts and strategic leaders, designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB.

The Designated Doctor position in Hampshire had been vacant for some time but was successfully filled during the course of 2014/15. There are also two Designated Nurses covering the full area, a Designated Nurse for Children in Care and a Designated Doctor for Unexpected Child Death.

Key relationships

Hampshire Children's Trust

HSCB has a strong relationship with the Hampshire Children's Trust, which is responsible for developing and promoting integrated front line delivery of services which serve to safeguard children.

The Chair of HSCB is a member of the Children's Trust and the Chair of the Children Trust sits on HSCB. The Children's Trust has produced a Children and Young People's Plan (CYPP) which sets out the Trusts priorities, including a focus on early help, and how these will be achieved.

The HSCB will be formally consulted as part of any commissioning proposals regarding safeguarding children made by Children's Trust.

HSCB presents its annual report to the Children's Trust outlining key safeguarding challenges and any action required from the Children's Trust.

The Health and Wellbeing Board

The Health and Wellbeing Board (HWB) was set up in Hampshire during 2012/13. It brings together leaders from the County Council, NHS and District and Borough Councils to develop a shared understanding of local needs, priorities and service developments.

The HSCB and the Health and Wellbeing Board (HWB) have an established protocol outlining the working arrangements between the two boards. HSCB will be formally consulted as part of any commissioning proposals regarding safeguarding children made by the HWB.

HSCB reports annually to the HWB and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Hampshire.

Clinical Commissioning Groups

There are 5 Clinical Commissioning Groups (CCGs) across Hampshire and they have been important contributors to the HSCB during 2014/15.

HSCB, NHS England, the CCGs and health providers have worked together to establish the accountability framework for safeguarding across the health sector in Hampshire.

The Health subgroup was established in September 2014 and has continued to develop over the course of the year and provides an important forum to engage the number of heath commissioners and providers in the work of the board, and for health professionals to feed back to the Board.

Hampshire Constabulary

Hampshire Constabulary is a key stakeholder in the partnership response to safeguarding the most vulnerable in our community throughout Hampshire. Over the last 12 months, despite financial restraints, the Constabulary has continued to prioritise safeguarding.

The Constabulary structure has had to change to enable it to meet the challenges of a reducing budget and still deliver a quality of service. The two most relevant changes to safeguarding are the Child Abuse Investigation Team (CAIT) moving to the Investigation strand and the Safeguarding Teams and Offender Management Teams (OMT) being incorporated in the Neighbourhoods and Prevention strand. Moving CAIT into the Investigation strand gives resource resilience at times of high demand and allows the specialist officers to work closely with investigators to raise their skills base.

Incorporating Safeguarding and the OMT into the Neighbourhood and Prevent strand has combined the experience of these teams with the Neighbourhood Policing Teams (NPT - aka Beat Officers and PCSOs) to ensure a truly community focused service. This has encouraged better communication between the teams, which is crucial, having regard to the recognised links between domestic abuse, child abuse and abuse of vulnerable adults. NPT has taken ownership for medium risk domestic abuse victims by engaging and signposting victims to support networks, thus reducing the risk to both adults and their children.

Police and Crime Commissioner

The Police and Crime Commissioner (PCC) is an elected official charged with securing efficient and effective policing services in the area.

The PCC has met with representatives from the HSCB to ensure an understanding of the need to protect the most vulnerable children in Hampshire, particularly those at risk of child sexual exploitation. More information on this specific element is included later in this report. HSCB presents its annual report to the PCC outlining key safeguarding challenges and any action required of policing in the area.

It is recognised that further work is needed to develop stronger and clearer links with the Safeguarding Adults Board and various Community Safety Partnerships across Hampshire. This will be a focus area for the coming year.

District Councils

HSCB recognises that although Hampshire County Council has the overall responsibility for children's social care and education services, through the Director of Children's Services, the 11 District Councils also have an important role in keeping children safe, particularly in relation to housing and community safety. During 2015/16 district authorities will be expected to report to the HSCB on their role in keeping children safe from exploitation and an audit will be undertaken of their S.11 responses, and role as licensing authorities, particularly in relation to taxi licensing.

Schools

HSCB has a very active education subgroup which has representation from different aspects of education including schools, early years, further education and the independent sector. There are headteacher representatives on this group and during 2014 very strong links were made with the independent sector.

Financial arrangements

Board partners continue to contribute to the HSCB's budget in addition to providing a variety of resources 'in kind'. Contributions from partners for 2013/14 were £234,200 with Hampshire County Council contributing £52,200 towards the costs of running the 4LSCB Child Death Overview Panel (CDOP).

The Board inherited an underspend from the previous year, mainly attributed to additional funds received from the Social Work Improvement Fund. These funds were carried forward to support the workforce development strategy on early help.

The costs associated with serious case reviews rose compared to the previous year and is expected to place continuing pressure on the budget in the coming year. The staffing budget was underspent against the forecast amount due to the vacancy of a Board Manager for 6 months, which was then replaced with a part-time position, and also a vacant Administrative Officer.

The numbers of serious case reviews and other reviews that the board carries out has steadily increased over the last 12 months. This is not expected to decrease going forward and as such, the Board has agreed additional partner contributions to support this work over the coming year.

It is also recognised that the structure and staffing levels in the HSCB Business Unit are insufficient to support the growing programme of work. An interim Board Manager was appointed at the beginning of 2015 to undertake a review of the current structure and make recommendations for its future structure and function.

2014/15 Budget summary as at 31 March 2015

	2014/15 agreed budget	2014/15 actuals
Income		
Total contribution from partners	234,200	234,200
Hampshire County Council CDOP allocation	52,200	52,200
Training income	7,000	4,900
Brought forward from previous years surplus	70,300	70,300
Total budget available	**363,700**	**361,600**
Expenditure		
Training and conference budget	116,400	106,353
Admin and Communication	11,400	12,103
Serious Case Reviews	54,900	56,315
Staffing - including on-costs and travel	105,000	83,644
Independent Chair	21,800	24,785
Finance Support Service	2,000	2,000
CDOP HSCB contribution	52,200	52,200
Total Expenditure	**363,700**	**337,40**
Net Expenditure (Income)	**0**	**24,200**

Key Priorities

During 2014/15 HSCB has focused its attention on the following key priorities:

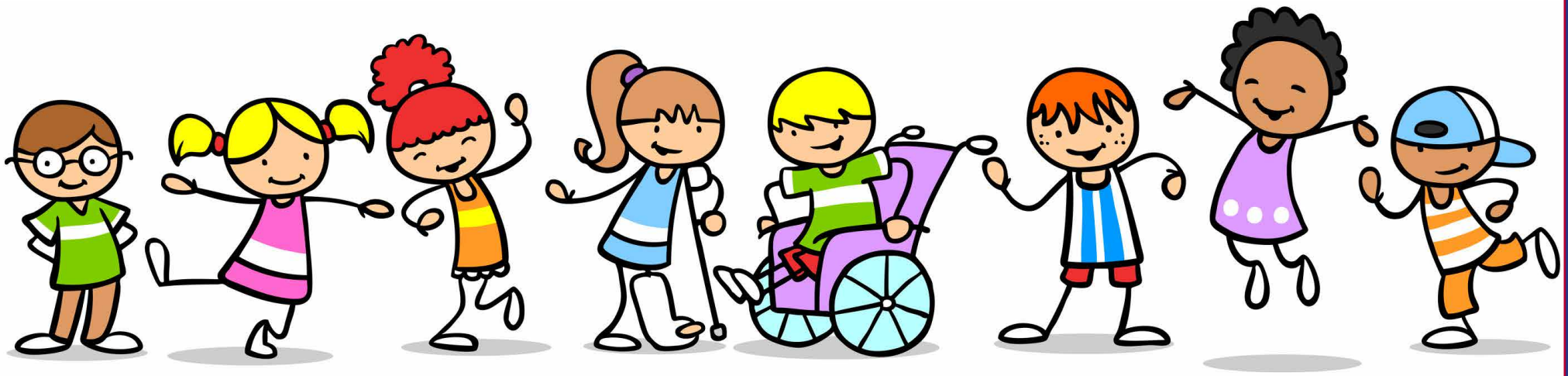
Priority 1: Evaluating the effectiveness of Early Help

Priority 2: Tackling Child Sexual Exploitation

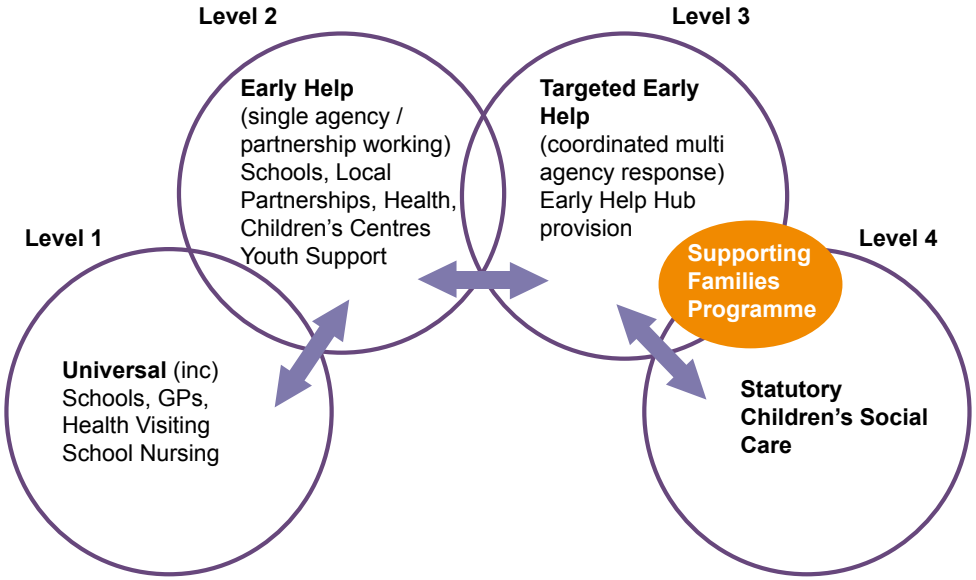
Priority 3: Safeguarding disabled children

Priority 4: Maintaining a quality assurance framework

Priority 5: Maintaining a learning and improvement framework



Priority 1:
Evaluating the effectiveness of early help



The Hampshire Early Help model

Early Help focusses on providing the right help at the right time to safeguard children and promote best outcomes for children, young people and their families.

The central premise to this revised way of working is to ensure partners work together to provide universal, targeted and specialist services for children, young people and families, including children's social care, children's centres, health, schools, youth provision, local and district borough councils and the voluntary sector.

During the course of 2014/15, 10 Early Help Hubs were been established across Hampshire. The revised model of early help works with children and young people from the ages of 0-19 years, and aims to ensure a seamless pathway of interventions as families move in and out of services, across the windscreen of need - shown above.

Early Help assessments are completed and families supported by regular team around the child (TAC) meetings to monitor progress. Support includes help for children where parents or carers misuse drugs or alcohol and help for those families where social care intervention has ended.

All of the 10 Early Help Hub's were established by 1 January 2015 and by the end of March 2015 there were 2,073 children from 945 families involved in cases open to the EHH's (at Level 3 of the Thresholds Chart). 55% of these cases had been 'stepped down' from Level 4 social care intervention for more appropriate support to children and their families.

Children's Trust Thresholds Chart

To support the establishment of the Early Help Hubs, the HSCB published a revised **Thresholds Chart** in April 2014 to promote a shared understanding of thresholds for early help services. This was approved by all Board partners. HSCB undertook a multi-agency staff survey to test understanding and application of the Thresholds Chart.

This survey highlighted that there was a good level of awareness and understanding of applying thresholds in decision making about child protection intervention, but a low number of practitioners who had actually used it to access and progress a case. The findings showed that the Thresholds Chart was impacting positively on how and when referrals were being made to the appropriate service at the right time.

Feedback from the survey did highlight that practitioners would benefit from guidance to support the application of the Thresholds Chart. HSCB asked the Early Help Team to develop guidance which will be published later in 2015. HSCB will monitor and evaluate its use and effectiveness in a subsequent follow up audit.

The Thresholds Chart may be refined further by the Hampshire Neglect Working Group as part of their work to develop a multi-agency practitioner toolkit to assist staff in identifying and responding to neglect.

MASH

The Hampshire Multi-Agency Safeguarding Hub (MASH) became operational in January 2014. The MASH team of co-located partners includes Children's Services, Adult Services, Police and Health professionals. There are established links with a number of virtual partners such as Probation and Housing.

The MASH triage all incoming referrals to Children's Services and share information to ensure children and families receive a responsive, proportionate service that enhances the safeguarding of children in Hampshire.

During 2014/15 there were 62,888 contacts made to MASH relating to Hampshire children. 27,276 contacts arose from police Child and Young Person at Risk reports the remaining 35,612 arose from telephone and email contact.

MASH were able to resolve on average 63% of these contacts through advice and information and by signposting to other agencies.

23,153 contacts were progressed to referrals for further assessment and investigation. This resulted in 2,309 section 47 child protection investigations and 10,420 Child and Family Assessments being completed by the local Referral and Assessment teams.

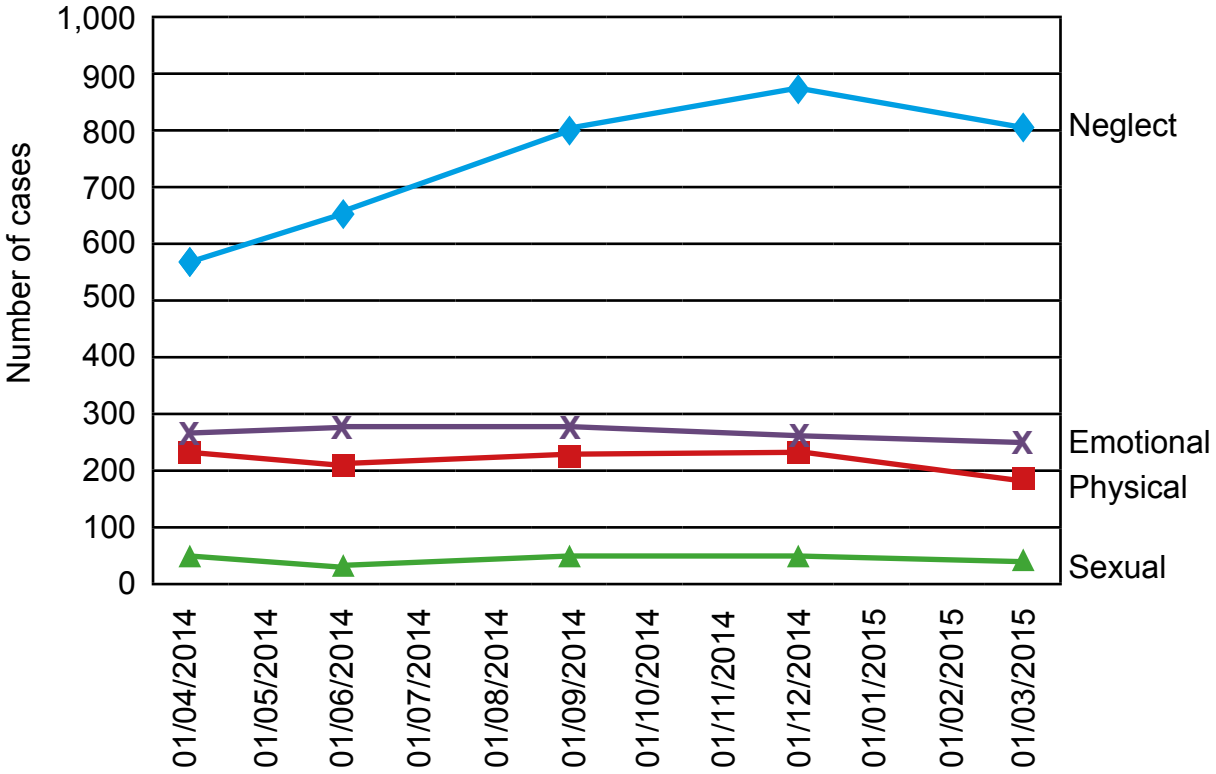
The HSCB partners have influenced the planning and implementation of this new service and its development has been reported to the Board. The Independent Chair has requested a full report from the MASH Project Board evaluating its effectiveness after the first year of delivery which will be reported in 2015/16.

Addressing issues of neglect

HSCB can report that neglect remains the main feature of cases on child protection plans across Hampshire. At 31 March 2015 neglect was the main feature on 62% of all child protection plans in Hampshire. Neglect can often be linked to emotional abuse, which was the main factor in a further 20% of child protection plans.

The number of children under 5 years of age (including unborns) subject to a Child Protection Plan on 31 March 2015 was 480. This is an increase of 21 compared with the previous reporting period. However, as the total number of Child Protection Plans has risen, including a more significant increase amongst older children, the overall percentage of plans relating to those under 5 years fell from 41% to 37%.

Children's social care has developed its evidence base during 2014/15 to ensure that neglect is understood widely across partner agencies. Results of the new toolkit will be reported in 2015/16.



Priority 2:
Tackling child sexual exploitation (CSE)

HSCB has overall responsibility for ensuring there is a co-ordinated, multi agency response to the issues of CSE and Missing, Exploited and Trafficked children (MET), in Hampshire. HSCB has established a 'Hampshire MET Subgroup' chaired by a senior manager from Children's Services and supported closely by Hampshire Constabulary with excellent engagement from Health, Education, the voluntary sector (Barnardo's) and a range of other key agencies.

The Hampshire MET Subgroup is set up to tackle the issues of MET in Hampshire. This includes:

- Developing, sharing and promoting best practice across Hampshire including information sharing across agencies about children who are vulnerable to CSE.
- Ensuring all practitioners and managers who work with or come into contact with children, are trained to identify and support children at risk of exploitation.
- Raising awareness of the issue of children at risk of exploitation amongst members of the public, encouraging them to report their concerns.
- Developing and implementing processes for the sharing of information about children at risk of exploitation, across local authority/agency borders.

Significant momentum to develop the MET programme has been gained through 2014/15, so much so that the Hampshire MET Subgroup have formed an additional work stream to support its work – called the Operational MET Group.

The Operational MET group is a multi agency, operational group that reviews cases of children and young people who are deemed at risk of being missing, exploited, and/or trafficked. The group is chaired by Hampshire Constabulary and includes representatives from Hampshire Children's Services, residential care, education , adult services, YOT and voluntary organisations i.e. Barnardo's, No Limits.

The group works together to:

- Build an accurate and clear picture of local trends and networks with a focus on victim, offender and location (to include internet safety as well as places).
- Confidentially share information within the group about local children and young people at risk of and experiencing these issues to enable support and prevention work to be put in place and build coordinated responses.

During 2014/15 HSCB has undertaken a benchmarking exercise to evaluate its progress in tackling CSE following publication of the Jay Report (August 2014) and the Casey response to Rotherham (September 2014 and February 2015). It has also closely followed developments in neighbouring Oxfordshire to make sure that it is well positioned to learn lessons in tackling CSE.

MET across the Pan-Hants Arena

In addition to these groups, HSCB is also a member of, and contributes to the work of, the overarching 4 LSCB MET Group.

The 4LSCB MET Group has been established to ensure that there is a coordinated, multi-agency response to the issues of Missing, Exploited and Trafficked children (MET), across Hampshire, the Isle of Wight, Portsmouth, and Southampton. The group seeks to make the best use of its shared skills, knowledge and resources in safeguarding and promoting the welfare of children and young people.

The group has produced an agreed 4LSCB MET Protocol which offers guidance to all practitioners regarding identification and response to children and young people deemed to be at risk. A 4LSCB MET Action Plan has also been agreed which seeks to ensure that all LSCBs in Hampshire are proactive and accountable for their involvement within the MET agenda.

A new addition to police resources in 2015 is a dedicated Child Sexual Exploitation Team (CSE). The Hampshire-wide team comprises of a Detective Sergeant, 4 officers, 4 police staff investigators and an analyst working closely with the MASHs to develop intelligence around CSE, with an aim to prosecute and/or disrupt offenders. This is a 1 year pilot.

In the second half of 2014/15, and coinciding with the force structure change, Hampshire Constabulary has instigated a wide-reaching safeguarding training programme for staff throughout the Force.

This input is provided for staff managing first contact, through to the outcome stage and gives them a better understanding of risk indicators as well as options that put victims at the heart of the police response. This is an on-going training programme.

MET – What is next in Hampshire?

The work to develop this key area of safeguarding will continue during 2015. As a result of a successful Innovation Bid to the Department for Education, Hampshire Children's Services are establishing a multi-agency team specifically aimed to assess and safeguard the needs of children who repeatedly go missing or are exploited/trafficked into and within Hampshire.

This team will include professionals from Social Care, Police, Health and Barnardos and will be known as 'The Willow Project'. The aims of the Willow Project are:

- **Understand and Identify** - strengthen the identification and assessment of children at risk of MET
- **Prevent** - raise awareness of MET issues across agencies, children/young people and their families and the wider Hampshire community
- **Intervene and support** - Improve safeguarding of vulnerable children deemed to be at risk of exploitation and trafficking. Reduce incidents of children going missing. Provide direct therapeutic support and access to specialist services
- **Disrupt and bring to justice** - lead in disrupting perpetrator behaviour and bringing those offenders to justice by building an accurate and clear picture of local trends and networks

The team will undertake work with children and young people already identified as at risk of MET, alongside undertaking assessment and support to newly identified children and young people that are referred in via the Multi-Agency Safeguarding Hub (MASH).

HSCB will monitor the work of this team and will be part of the early review of its effectiveness. This will be reported on in more detail in next year's annual report.

The Review of Historic Cases of Child Sexual Abuse in Hampshire

Shortly after the publication of the Jay report (August 2014), a decision was taken by the Hampshire and Isle of Wight Police and Crime Commissioner that a historical child sexual exploitation (CSE) scoping review, covering the same time period, should be undertaken by Hampshire Constabulary.

The focus of the review was to identify any cases that had not been appropriately investigated and any cases where children may have been left at risk. The review would also ascertain whether there was evidence of any organised exploitation of children. This included a review of any looked after children placed in Hampshire's children's homes. HSCB agreed to promote partnership involvement in this review.

Hampshire Children's Services have worked alongside the Police, undertaking a full and open review of any cases as identified by the police. Whilst HSCB are awaiting the final report from this review, updates have been regularly reported to the HSCB.

Hampshire Children's Services can confirm that to date, there has been no evidence found of adult organised street grooming of the children and young people in Hampshire, or of the type of sexual exploitation reported in Rochdale, Oxfordshire and Derbyshire. Furthermore, there has been no evidence found of any systemic organisational failure to address the issue of child sexual exploitation, such as those found in Rotherham.

To further support this review, the HSCB Health Subgroup was asked to undertake an audit and review of the health response to CSE, in particular, to consider historic cases of CSE, known to lead agencies, as well as to benchmark health professionals' current knowledge and understanding of the issues and risks common to CSE.

The work was commissioned by the HSCB Health Subgroup with support from the NHS England Local Team and designated leads from the West Hampshire Clinical Commissioning Group. Providers from primary, secondary and community services across the county contributed to the findings. The audit and review comprised three strands of activity:

1. A review of health commissioner and providers' internal safeguarding policies, protocols and guidance;
2. An audit of health professionals' knowledge and understanding of CSE based on similar work carried out by Oxford Brookes University (Appleton et al., 2014);
3. A retrospective audit of the health contacts of the 'Hampshire Group' of children and young people known to have been victims of CSE.

Recommendations from the review were reported in March 2015 and included:

- Commissioning organisations will work with healthcare providers to support the development of CSE policies which fully meet the expectations of national (HM Government, 2009) and local (4LSCB) guidance and policy. This will form the basis of policies for the prevention, recognition and response to CSE across the HSCB area.
- Commissioners and providers will ensure that available training meets the expressed need of practitioners for opportunities to develop their knowledge and understanding of child sexual exploitation. This should be clearly linked to the HSCB training provision, as well as 'in-house' learning events and MET plans.

HSCB, via the Health Subgroup and Quality Assurance Subgroup, will monitor the implementation of these recommendations during 2015/16 and consider whether a follow-up audit will be needed.

Multi-Agency CSE Risk Assessment Tool Audit

In March 2015 HSCB conducted a multi-agency audit and staff survey into awareness, use and understanding of the Sexual Exploitation Risk Assessment Framework (SERAF) risk assessment tool.

The purpose of the audit was to test awareness of and review the practice of the SERAF since its implementation in Hampshire in 2013. The SERAF has been rolled out across multi-agency partners to identify and support children and young people at risk of CSE. The audit considered whether the tool was being used effectively both to identify CSE at the earliest opportunity, and to enable appropriate planning and intervention to protect children and young people at risk of CSE.

The audit comprised of two elements:

1. A 'deep dive' audit of cases where a SERAF was completed. This included a mix of high risk and medium risk (categories of risk as defined by the Operational MET Group), and cases involving 'looked after children'. This element of the audit focussed on the effectiveness of the SERAF tool in its implementation and review.
2. An electronic staff survey to examine the use of the SERAF across partners, and test understanding of its function and completion as well as ascertain views from front line staff on its effectiveness of preventing CSE.

The audit identified a generally good level of awareness of the SERAF, particularly within children's services, but also across partner agencies. For example, the Central Referral Team routinely undertake an adapted version of a SERAF for all incoming referrals for children aged 10 years and over.

There was however, outside of children's services, a much lower rate of initiating and completion of the SERAF within and across other partner agencies. The HSCB MET Subgroup is working with its members, and professionals within the Health Subgroup to further promote the use of the tool. They are also trialling the completion of the SERAF within core group meetings to ensure that each assessment is informed and agreed within a multi-agency setting, and that any subsequent interventions involve colleagues from relevant agencies.

I learned that the SERAF should be reviewed every three months and with my first case it really highlighted what happens when the tool isn't completed.

The audit made it clear how important it is to share the SERAF with other agencies so that everyone has up to date information and can add information from their own systems on an on -going basis.

Going forward, I will ask for the SERAF straight away and if it has not been updated within three months then I will ask for that to be completed too in the future.

Feedback from frontline professional, Voluntary Sector, having taken part in the audit

There was a lower level of understanding of CSE indicators amongst staff in Adult Services, but a proactive request to understand more. HSCB will work with colleagues in Hampshire Safeguarding Adults Board to raise awareness of these factors and make relevant multi-agency training available to staff.

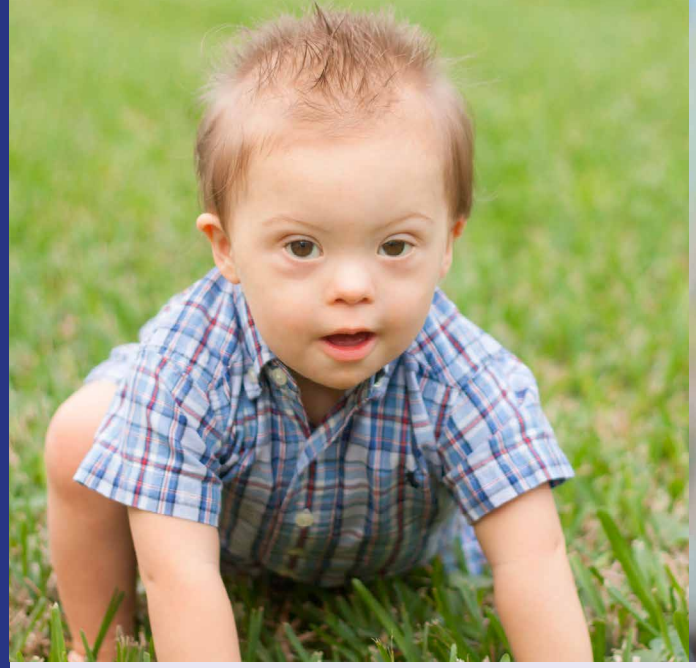
The audit also highlighted lower levels of awareness of the SERAF, and how to access and use it, from staff in schools and education settings. The HSCB Education Subgroup, in partnership with the MET Group, is further promoting use of the SERAF across schools during 2015.

The audit made a number of observations about the low availability of specialist and therapeutic support available to children who have been identified at risk of CSE. There is a particular concern about this provision in 2015/16 given that a number of programmes currently run by voluntary sector organisations have seen their funding come to an end, and there is no clear solution to the continuing of their service. HSCB will monitor this area during the course of the coming year.

Discussions are on-going with colleagues in other LSCBs and agencies across the pan-Hampshire area to standardise the SERAF tool. These will continue in 2015/16 and the SERAF tool will be updated to respond to practitioner feedback across the area.

Problem profile

Hampshire Constabulary developed a detailed problem profile which provides a comprehensive, intelligence based, picture of the nature and scale of CSE related activity across Hampshire. This is used by the multi-agency partners within the MET group to monitor the prevalence of CSE in each area and inform multi-agency initiatives.



Priority 3:
Disabled Children

HSCB commissioned the establishment of a multi-agency subgroup to review the effectiveness of the arrangements to safeguard disabled children in Hampshire. The group comprised representatives from a wide range of agencies, including parent/carer representatives from the Hampshire Parent/Carer Network, children's social care, health and police. In addition, HSCB updated the section 11 Audit tool to include a specific and standalone element relating to disabled children. The group met throughout 2014/15 and have identified the following continuing priorities:

- **Data collection and analysis** - further work is required to improve the data set available in order to enhance the scrutiny of safeguarding disabled children. This is a long term challenge that will require gradual improvement due to the different collection methods, systems and definitions used in partner agencies.
- **Awareness and understanding of agency responsibilities** - the section 11 Audit revealed a mixed understanding across agencies and organisations of both the needs and vulnerabilities of disabled children and how these should shape the response to families who include a disabled child. The children's subgroup produced some guidance to support agencies in considering their work in relation to disabled children and their families as a result of this first audit and a further section 11 audit is being undertaken during 2015 to check on progress.
- **Awareness raising activities directed towards families, carers and the wider community** - the progress in achieving greater awareness due to the HSCB identifying safeguarding disabled children as a key priority theme has been of immense value. However, this is an area of work that requires maintaining and the Disabled Children's subgroup will continue promoting its work across the county.



- **The culture of professional practice** - there is further work required to continue the shift in focus of professionals working with disabled children and their families away from the parents and carers and onto the child. This includes understanding that disabled children are children first and should not be defined by their disability. These considerations continue to contribute to the Board's training and development offer.
- **Participation and engagement of disabled children and young people** - the participation and engagement of disabled children and young people in service planning and development requires strengthening and is not fully embedded in current infrastructure. However, a number of significant developments have been achieved in relation to the Special Educational Needs and Disability (SEND) reforms and the provision of advocacy services which can be built on. The Disabled Children's Subgroup will continue to support this area of development.
- **Children placed in out of county placements** - there have been a number of changes to this area of work as a result of recent court judgements, OFSTED guidance and inspection outcomes of providers of placements. The Disabled Children's Subgroup will maintain an overview of this area in order to ensure Hampshire is well placed to respond to future changes in statutory duties and guidance as may emerge in the future.

Hampshire County Council has also developed a bespoke website – the 'hants local offer ' providing access to services for children with special educational needs and disability: **www.hantslocaloffer.info**

HSCB agreed that the Disabled Children's Subgroup will become a formal subgroup of the Board, reporting into the Quality Assurance Subgroup throughout the coming year.

Priority 4:
Maintaining a Quality Assurance Framework

HSCB links its quality assurance work to learning and improvement. HSCB, in accordance with its quality assurance framework, undertook a programme of multi-agency audits. These were thematic audits and have been reported on elsewhere in this report (Early Help, CSE and Disabled Children).

The purpose of these audits was to check how well agencies worked together, providing a good snapshot of how well frontline multi-agency practice is working and they gave good examples of how risk was being identified, responded to and reduced through both child protection or child in need interventions.

Learning summaries have been provided for all multi-agency audits and shared with practitioners at the Multi-Agency Safeguarding Forums (MASF) in each part of the County.

A gap in the audits has been the inclusion of feedback from children. The challenge for the HSCB is to ensure that the experiences of children become a feature of audit work.

The Quality Assurance Subgroup used the opportunity of the CSE/ SERAF audit to trial a different approach to audit of practice across the partnership. This approach involved selecting a number of cases and inviting all frontline professionals involved in each to a focussed session enabling reflective multi-agency discussion.

This approach proved very successful in allowing professionals to better understand processes and perspectives from different agencies, and highlighting mutual issues for on-going joint-working. This approach will be used for all multi-agency audits during 2015/16.

Going forward, the Quality Assurance Subgroup has considered how to best utilise audit and other information already in existence to inform partner agencies own assurance programmes. This information will be used to enhance the Boards scrutiny and challenge functions but without additional burdens placed on partners.

In addition to these audits, the Quality Assurance Subgroup has received reports from key service delivery partners throughout the course of the year, including safeguarding in schools, the Local Authority Designated Officer (LADO), private fostering, MARAC (Multi-Agency Risk Assessment Conference), MAPPA (Multi-Agency Public Protection Arrangements), MASH and children living in secure accommodation. This has provided HSCB with the opportunity to scrutinise and constructively challenge the provision of safeguarding in Hampshire.

The Quality Assurance Subgroup has continued to develop the multi-agency balanced score card to monitor and evaluate performance on safeguarding indicators across the partnership. There have been challenges in consistently collating information that can be meaningfully analysed and reported on across the partnership in order to provide a full picture of safeguarding across Hampshire. Further refinement to the data set will continue in 2015.

Section 11 Self Assessment

Section 11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children and ensure that services they contract out, or commission from others, are also provided with due regard to that need. As part of its scrutiny function HSCB undertakes monitoring of compliance with section 11 through a detailed audit. The section 11 audit is a self-evaluation audit aimed at supporting agencies in achieving compliance, learning and improvement. It enables HSCB to identify good and effective practice, as well as understand common areas for development within the geography of the HSCB.

35 agencies were asked to complete the audit and of these 34 provided completed returns. (The exception being British Transport Police). Following discussion of previous audit work relevant departments and sections within Hampshire County Council were subject of separate requests for the first time. This audit process also requested returns some agencies which are in their infancy, namely the CCGs.

29 respondents out of 34 were judged to be compliant with expectations following the section 11 audit. Of the five not judged as compliant most had already self-identified their own areas of development to achieve compliance, much of which centred around providing sufficient and robust information to clearly evidence against the requirements. Some organisations struggled with being in the middle of the change from the CAF processes to Early Help Hubs and were not able to fully respond to questions on 'Early Help' as Hubs were not yet operating in their areas.

Future audits should elicit more helpful responses in relation to the 'Early Help' agenda. It was also not always clear in returns if sub-contracted services were fully considered and expected to meet the safeguarding standards of the contracting partner. This is a particular issue for Boroughs and Districts in respect of housing associations and registered social landlords and a potential issue for Health if they contract out services. Also, some organisations needed to ensure that all relevant staff are considered within the audit (i.e. any with customer contact, not just those specifically employed to work with children).

Schools safeguarding audit

All primary and secondary schools in Hampshire are required to complete a safeguarding audit in line with the DfE statutory guidance Keeping Children Safe in Education. The HSCB welcomed the update on this guidance in March 2015 which now places an expectation on Further Education colleges to make this return for the 2014/15 academic year. We will report on the progress of this next year.

There was no requirement on schools and colleges to submit an audit return in 2014 as they had completed the audit the previous year. This gave the Safeguarding Team the opportunity to revise the audit tool and associated guidance in line with national and local changes to legislation and procedures. Schools were advised to self evaluate using the existing audit tools.

However, HSCB required those independent schools who did not submit a return during 2013 to the section 157 audit to complete their return during 2014/15.

HSCB is pleased to report that 95% of Independent Schools responded to the self assessment.

This is broken down as follows:

- 36 schools returned their audit in 2013/14. This is out of a total of 56 independent schools in Hampshire listed on the DfE website.
- 20 schools did not respond, so were required to during 2014/15.
- 19 Schools have returned their audit following this request.
- 1 school did not submitted a return within the required timescales.

The returned audits report on the full range of safeguarding requirements in schools and have shown good compliance e.g. whether the schools have had child protection training, adheres to safer recruitment guidance, implements child protection procedures.

The audits indicate good levels of compliance with the guidance and HSCB is satisfied that Independent Schools are compliant with their statutory obligations under section 157 of the Education Act 2002. The audit did highlight that some schools need to better understand how, and who, to quickly refer concerns about pupils at risk of possible abuse and/or neglect. This will be a focus for HSCBs ongoing engagment with the education sector.

In June 2014 the HSCB organised its first Independent School event for head teachers and safeguarding leads to discuss the requirement and to consider the key pressure points facing the Child Protection Partnership in Hampshire. This is now an annual event and the HSCB is pleased to be working with all schools across Hampshire.

Local Authority Designated Officer (LADO)

The LADO should be informed of all allegations against adults working with children and provides advice and guidance to ensure individual cases are resolved as quickly as possible.

Referrals have increased steadily over the last 3 academic years to 451 at the end of August 2014. Last year's annual report highlighted a slight reduction in numbers of referrals from education settings. HSCB was pleased to note that this has not been the case this year and the number of referrals has been maintained.

There has been an increase in referrals from other settings, indicating an ever greater awareness of the LADO role across the broadly defined children's workforce.

While it's hard to measure progress it is also worth noting that the new guidance for education settings has introduced a mandatory expectation that all schools now have a code of conduct for staff which will be provided to them as part of what is now called a mandatory induction period.

Children living in secure accommodation

Swanwick Lodge
During the period January–December 2014 there was a total of 146 restraints. This shows a decrease on the previous year (161 restraints), which was noted at the time to be unusually high but due to weaknesses in the staff team's capacity to intervene early to prevent incidents from occurring and escalating. HSCB were assured that during the course of the year the staff competency issues appear to have been addressed.

Bluebird House
Between 1 April 2014 and 31 March 2015, a total of 1,757 restraints were reported in Bluebird House. Of these, 695 (39.5%) involved prone (face down) restraints. The remainder were other restraints such as emergency hold, isolated supportive holds and walking holds. This is a reduction from 2013/14 where a total of 1,485 restraints were reported, of which approximately 850 (57%) were prone restraints. This should be noted against the context of Bluebird House caring for a higher average number of patients during 2014/15.

Bluebird House undertook a systematic programme of work in 2013/14, continued into 2014/15, to reduce the use of restraints. This included:

- Changes to the physical environment of the building.
- Changes to procedural security.
- Review of relational security.
- Changes to clinical practice.

It is notable that in 2014/15, while the number of young people with severely challenging presentations admitted to Bluebird House has increased by a third, compared to 2013/14, the number of prone restraints has fallen. HSCB will continue to monitor this during 2015/16.

Looking forward

Over the coming year HSCB has committed to completing the review of the multi agency data set. Alongside this further work is done to engage stakeholders, including children, and their parents and carers, in all aspects of its quality assurance work.

Priority 5:
Maintaining a learning and improvement framework

Training

HSCB continues to support agencies in meeting their responsibility to ensure staff receive safeguarding training by providing a multi-agency training programme.

The development of the 2014/15 programme was based on themes coming from the HSCB annual training needs analysis, HSCB priorities, and national and local learning. A total of 1,160 professionals came to HSCB training during 2014/15. Training received strong multi-agency representation and was received positively by those attending.

HSCB has a comprehensive range of training. As well as core safeguarding courses the HSCB runs courses for practitioners working with vulnerable groups such as carers or disabled children.
Key training provided by the HSCB

- Four conferences were offered;
  - Think the Unthinkable (89 attended),
  - Challenging Perceptions (107 attended),
  - Safeguarding disabled Children (76 attended),
  - Protecting Children at risk of Domestic Abuse (85 attended).
- Two-day Working Together training was offered on 14 occasions and was attended by 227 people in total.
- Training on working with hostile families and disguised compliance was offered on 5 occasions and attended by 109 people in total.
- Training on Child Sexual Exploitation was offered on 4 occasions and attended by 126 people in total.

Working Together 2015 requires that LSCBs monitor and evaluate the effectiveness of training, including multi agency training, for all professionals in the area. HSCB has recognised that further work is required by the Board and partner agencies to understand what difference training is making on frontline practice.

An audit of single agency induction training was carried out as part of the section 11 Audit. This was the first time that such an audit had been undertaken and there was a clear variance in the quality of the returns received which made it difficult to draw consistent and meaningful conclusions. HSCB will provide clearer guidance and examples to agencies for future audits. General findings from the audit included:

- A number of agencies have different training for different staff groups, or describe relevant or key staff being offered additional training. More information on who these groups are and what training is offered to them would be helpful to forming a complete picture.
- Very few agencies demonstrated any meaningful evaluation of the impact of training on practice although it is recognised that this is an area of development over the coming year.
- It appears that staff often undertake the induction programme as a refresher rather than accessing multi-agency training or conferences/workshops.

As a result 2 recommendations were proposed:

1. HSCB to recommend that best practice would be for all staff to have safeguarding training within the first month of starting employment
2. HCC to share their Safeguarding Training Pathway with other agencies to inform their own training programmes.

Quotes from a recent professional discussion with the Adult Services Substance Misuse Team include:

'I am more likely to challenge decisions at a CP conference' ***'I complete more referrals for parenting support and am quicker to share concerns'*** ***'I have more honest conversations about why we have made a referral to Children's Services'***

In response to the last Ofsted Inspection in 2014, HSCB has been undertaking a thorough evaluation programme of its multi agency training. Three different courses were identified for in-depth evaluation throughout the training year and a methodology agreed as:

- Pre and post training questionnaires for all learners
- 3 month follow up for all the participants and their managers
- 6 month follow up interview with managers
- 12 month follow up with learners as a recorded professional discussion in a team meeting

Each of the courses is at different stages of the evaluation process with the first course follow up almost completed.
Early findings are:

- Clear and strong evidence of a significant increase in confidence and understanding as measured against the learning outcomes for each of the courses evaluated immediately following completion of the training, with the increase being particularly marked for the Working Together Course.
- There is good evidence to support that learning has been embedded and resulted in changes in practice at the 3 month learner review for all three courses. There is also some evidence to suggest this may have contributed to improving outcomes for children and families.
- Clear evidence that key lessons from the Working with Hostile Families training had been embedded in practice within 12 months and had been shared with the wider team.

One member of staff described how they now think more about the other adults in the house who may pose a risk and not making assumptions. She gave a recent example:

'The penny dropped – why haven't I met the grandma?'
When followed up it became clear that grandma was a heavy drug user and also a dealer ... until that point she had thought it was beneficial that her client and the children had support from her family'.

Learning and Improvement

HSCB procedures

HSCB online procedures are available to all practitioners on the HSCB website. This includes access to all of the 4LSCB procedures that have been agreed across the pan-Hants area. All priority procedures have been updated and reviewed in light of new legislation and guidance. The layout has been improved to provide better clarity. The HSCB is concerned that some procedures, while recognising the need for consistency across pan-Hampshire to support front line staff, have been delayed in review, because of differences in understanding across professionals.

HSCB Communication

The HSCB ensures that learning not just from multi-agency audits and serious case reviews is distributed to the front line – but all work and safeguarding messages are well communicated.

This year we have:

- Published in full all Serious Case Reviews and the Board's response to all recommendations on our website.
- Incorporated key themes and lessons arising from reviews into 'learning lessons' workshops held for professionals across the county.
- Taken lessons from reviews and audits to inform our regional Multi-agency Safeguarding Hub conferences.
- Led awareness raising events with housing associations to promote awareness of blind cord safety and safer babies.

Child death review

The Child Death Overview Panel (CDOP) is a sub-committee of the 4 LSCBs of Hampshire, Isle of Wight, Portsmouth and Southampton, and enables the LSCBs to carry out their statutory functions relating to child deaths.

It carries out a systematic review of all child deaths to help understand why children die. By focusing on the unexpected deaths in children, it can recommend any interventions to help improve child safety and welfare to prevent future deaths. The findings are used to inform local strategic planning on how best to safeguard and promote the welfare of the children.

With a business manager in post during 2014/15 the back log of monitoring child death reviews from previous years has been addressed.

Hampshire received 56 child death notification's this year of which 25 of these were unexpected. In 18% of these deaths, the Panel identified 'modifiable factors' that could help prevent deaths in the future. These modifiable factors included; safe sleeping arrangements for babies; adolescent suicide; deaths caused by poor health and safety practices; and death from asthma and infection related causes. These factors have been reflected in key messages both locally and nationally.

When a child dies unexpectedly a process is set in motion to review the circumstances of the child's death called the rapid response process. There continues to be some inconsistency in implementing this process across the four areas, and a review of the rapid response procedure was completed in early 2015. Further information can be found in the **CDOP annual report 2014/15**.

At the time of writing, the four LSCBs are reviewing the current structure of the pan-Hampshire CDOP to ensure that it continues to meet the needs of each board, and to strengthen accountability arrangements. From October 2015 the HSCB will have oversight of its own CDOP but will ensure that learning and trends analysis continues across the pan-Hampshire area.

Hampshire Safeguarding Children Board

ISLE OF WIGHT SAFEGUARDING CHILDREN BOARD

PSCB Portsmouth Safeguarding Children Board Protecting Portsmouth's Children

LSCB Southampton Local Safeguarding Children Board

Serious case reviews

A serious case requiring review is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

LSCBs must always undertake a review of cases that meet the criteria of a SCR. The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

HSCB has also been committed to undertaking smaller scale multi agency case reviews for instances where the case does not meet the criteria for a serious case review but it is considered that there are lessons for multi-agency working to be learnt.

During the year the Serious Case Review Committee (SCRC) has seen a significant increase in referrals, many of which have either resulted in SCRs or multi-agency reviews (MARs) being commissioned. Between 1 April 2014 and 31 March 2015 the SCRC received 11 Referrals. Of these:

- 4 resulted in SCRs being commissioned
- 3 resulted in MARs being commissioned
- 2 related to YOT Extended Learning Reviews (ELRs) that the committee are supporting
- 2 did not result in any requirement for review

	2012/13	2013/14	2014/15
Referrals	36	13	11
No further action	32	9	2
Reports commissioned	4	4	9
SCRs	1	3	4
MARs/ELRs	3	1	5

These figures illustrate the increase in volume of work since the additional guidance and definition was given in Working Together 2013, and again updated in 2015.

Whilst of course it is impossible to predict how many referrals are made throughout the course of a year, or how many will lead to SCRs or other reviews, this trend is not expected to reduce during 2015/16.

Methodology

HSCB is committed to exploring and using different methodology for all types of reviews and will consider which methodology provides a proportionate response, and is the most appropriate approach to best extract any learning.

Serious Case Reviews (SCR)

During 2014/15 HSCB has published SCR's on Child V, Child X and Child I, all of which are available on the **HSCB website**.

The Story of Child V

The serious case review examined the services provided to the family of a 5 month old baby. Following her death she was found to have significant injuries. The overall conclusion was that there were no historical warning signs that could have alerted staff, and contacts with services were not exceptional.

There were one or two opportunities which might have led to a helpful pooling of information, although this is not certain and one opportunity which almost certainly would have led to intervention which would have protected the baby. All these instances need to be seen in the context of how individuals were prepared for their work.

Responding to some of the findings:

- The local guidance around responding to bruising in infants who are not independently mobile was revised
- Hampshire County Council wrote to schools, particularly those with nurseries to outline that the responsibility for staff safeguarding training lies with the governing body and provided advice on where to access training
- Relevant health providers have ensured that all staff working for them are aware of and have easy access to safeguarding guidance.

Embedding learning into practice:

As part of the HSCB response to recommendations arising from the Child V report, North and North East Hampshire CCG has worked successfully with the out of hour's provider, North Hampshire Urgent Care (NHUC), to ensure that any future cases of vulnerable children are identified and prioritised effectively.

It is recognised that children accessing out of hours services can be particularly vulnerable. NHUC have ensured that all staff have access to their safeguarding children's policy and training at the appropriate level.

In addition they have completed an early review to identify the number of children seen out of hours in order to map and recognise specific vulnerabilities. Also, as part of their response to Child V, NHUC now forwards attendance of children under 5 years to the appropriate health visitor so that any follow up action can be taken.

The Story of Child X

The review examined the services offered to a 2 year old child and their family between November 2012 – Summer 2013. Child X had been diagnosed soon after birth with a serious medical condition. At aged two, Child X died having suffered a number of serious injuries.

Responding to some of the findings of the review the HSCB has:

- Held a multi-agency learning event with front line professionals to feed back the learning quickly and effectively inform policy and practice
- Ensured that multi-agency audits of work are carried out with children with disabilities and their families, to ensure that agency involvement is planned, co-ordinated and reviewed, and appropriately alert to safeguarding issues
- Included training on Disabled Children in the annual HSCB training plan
- Commissioned specific work to develop guidance to staff about identifying, assessing and following up concerns arising from poor home conditions.

The Story of Child I

The review examined the services and support offered to the family of Child I, a 6 week old baby born in the UK to Saudi Arabian parents. Baby I died at 6 weeks of age to what was later found to be a skull fracture.

Responding to some of the findings of the review, HSCB has:

- Held a multi-agency learning event with front line professionals to feed back the learning quickly and effectively inform policy and practice
- Confirmed that all GPs will undertake safeguarding training up to Level 3
- Confirmed arrangements for medical staff to have access to, and be able to signpost patients to interpreters when English is not spoken or understood
- Requested that written information on ‘sudden infant death syndrome’ is available in other languages.

HSCB takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. As outlined earlier in this report the HSCB has set up an annual programme of practitioner workshops to share key learning from both national and local cases.

Challenges ahead

The HSCB Data set - what does it tell us?

The Board has an agreed data set that views key points across the child protection system in Hampshire. There are a number of key messages from the data which tells us the pressure points are:

- An increase in early intervention work: more assessments completed in Early Help Hubs
- An increase in levels of general activity across child protection planning, neglect being the most common reason for a child protection plan
- Children at risk of CSE continue to make up 4% of the caseload and numbers have remained steady
- Children who offend – fall in numbers of children in the youth justice system
- The implications of increased workloads suggesting the system is under more pressure and it is harder to keep children safe

National Drivers

- Tackling child sexual exploitation
- Children who go missing
- Female Genital Mutilation (FGM)
- PREVENT and the radicalisation agenda.

For the Board:

Leadership and Governance

- Reviewing the structure and membership of the Board and its sub groups to ensure arrangements remain effective, but proportionate given the resourcing challenges faced by many partners
- Complete the review of the Business Unit structure and secure sufficient staffing to support the work of the Board

Impact on Practice

- Developing stronger links with the voluntary sector, faith groups and community safety partnerships, particularly to enhance existing work on CSE/Missing, Exploited and Trafficked children
- Enhance the strands of participation, particularly of children, across the various activities of the Board

Scrutiny

- Embedding robust and rigorous quality assurance activity, particularly the multi agency scorecard

Key priority areas for 2015/16

Reviewing the challenges ahead, and using information available from data, cases, audits, reviews and other sources, the Board remains committed to responding to the following key priority areas:

- Neglect
- The impact on children of the 'toxic trio' in adults (substance misuse, parental mental health and domestic abuse)
- Missing, Exploited and Trafficked children
- PREVENT and radicalisation
- Quality Assurance and scrutiny
- Community engagement

Forward Look

Family Intervention Teams

During 2015, Hampshire will develop multi disciplinary Family Intervention Teams (FIT), based around our current Children in Need Teams based in Children's Services. These FIT teams will include domestic abuse workers, community mental health practitioners and substance misuse workers. These practitioners will work alongside social workers delivering specialist interventions as part of a whole family approach to families, where there are children either subject to CiN/Child Protection Plans, or who are subject to Public Law Outline.

There will be one specialist FIT team per district (10 districts overall). By placing these specialists within our FIT teams we can directly target those specialist interventions where they are most needed. HSCB understands that whilst ensuring our focus is on the child, we must also focus our interventions on the parents if we want to provide maximum impact of our social work interventions and provide the best possible outcome for the child.

Key messages to:

Messages to children

- Your voice is most important as you are at the heart of the child protection system. Tell us what you think, especially when we ask, and help us to improve the way that agencies help you and your family

Messages for the community including faith sector

- You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them
- Use online resources available through the NSCPCC and HSCB
- We all share responsibility for protecting children. If you are worried about a child, call Hampshire Children's Services on 0300 555 1384

Messages for local politicians

- You can be the eyes and ears of vulnerable children and families in your ward making sure their voices are heard by HSCB. Councillor Keith Mans is the lead member for children and families. The lead member provides the route for individual councillors to make sure the voices of children and young people are heard by the HSCB and for councillors to be aware of local safeguarding children priorities
- When you scrutinise any plans for Hampshire, keep the protection of children at the front of your mind. Ask questions about how any plans will affect children and young people

Messages for Clinical Commissioning Groups

- CCGs in the health service have a key role in scrutinising the governance and planning across a range of NHS organisations
- You are required to discharge your safeguarding duties effectively and ensure that services are commissioned and provided for the most vulnerable children

Messages for the Police and Crime Commissioner

- Ensure that the voices of all child victims are taken notice of within the criminal justice system, particularly in relation to listening to evidence where children disclose abuse
- Monitor what police and probation staff do to share information regarding high risk MAPPA and MARAC cases and the risks that some adult present to children
- Build on the learning and findings of the review of historical cases of CSE to shape services and challenge delivery in this complex area of safeguarding

Messages for Independent Providers (Health, Education and others)

- Ensure policies and practices are updated to reflect changes in national guidance which apply to professionals in all settings
- You are required to discharge your safeguarding duties effectively and ensure that staff are given appropriate training to share information and effectively safeguard children in their care

Messages for Chief Executives and Directors

- Ensure your workforce is able to contribute to the provision of HSCB safeguarding training and to attend training courses and learning events
- Your agency's contribution to the work of HSCB must be categorised as of the highest priority. Every agency must ensure that it takes into account the priorities within the HSCB Business Plan and the agency's own contribution to the shared delivery of the HSCB's work. This includes meeting the duties of section 11 of the Children Act 2004 and ensuring that agencies are able to contribute to the HSCB's work programme with appropriate resources and personnel
- The HSCB needs to understand the impact of any organisational restructures on your capacity to safeguard children and young people in Hampshire

Messages for District Authorities

- Ensure that your district completes the HSCB endorsed safeguarding audit
- Review your licensing regulations to ensure that they keep children protected
- Consider your response to tackling CSE and children missing

Messages for Head and Governors of Schools

- Ensure that your schools are compliant with 'keeping children safe in education' (DfE, 2015) which outlines the processes which all schools, in the maintained, non-maintained or independent sector, must follow to safeguard their pupils
- Complete the HSCB endorsed safeguarding audit for your setting
- Ensure your workforce is trained
- Understand and know how to deal with safeguarding concerns like self harm, sexting, online safety, child sexual exploitation and radicalisation
- Make sure you record when children go missing from school

Messages for the Children's Workforce

- Ensure you are booked onto, and attend, all safeguarding courses and learning events required for your role
- Be familiar with, and use when necessary, HSCB Threshold and Safeguarding procedures to ensure an appropriate response to safeguarding children and young people
- Be 'professionally curious' with other practitioners and when working with young people
- Proactively initiate the sharing of information with colleagues in other agencies to inform the overall jigsaw of any one child
- Use your representative on the HSCB to make sure the voices of children and young people and front line practitioners are heard

Messages for the local media.

- Communicating the message that safeguarding is everyone's responsibility is crucial to the HSCB and you are ideally positioned to help do this
- The work of HSCB will be of great interest to your readers and listeners

Board Membership 2014/15

Partner Agency	Representative
Armed Forces	Gareth Davies
CAFCASS	Gillian Heath
5 Clinical Commissioning Groups	Heather Hauschild
Designated Nurse	Patricia Dennison
Designated Doctor	Simon Jones
Hampshire CCGs	Andrea O'Connell
District Councils	Martin Devine / Bob Coleman
Hampshire Constabulary	David Powell
Hampshire County Council	
• Adult Services	Jane Duncan / Jo Lappin
• Children's Services	John Coughlan
• Executive Lead Member	Councillor Keith Mans
• Serious Case Review Chair	Steve Crocker
• Quality Assurance Subgroup and MET Chair	Lin Ferguson
• Public Health	Ruth Milton
• Education Subgroup Chair	Glyn Wright
• Troubled Families Programme	Ian Langley
Hampshire Fire and Rescue	Steve Foye
Hampshire Probation Service	Melanie Smith
Hampshire Community Rehabilitation Co	Barbara Swyer
Hampshire Hospitals NHS Foundation Trust	Trish Lefluffy
Hampshire Youth Offending Team and Workforce Development Group Chair	Alison Smailes
Lay members	Lisa Hayes / Diana Spencer
NHS England (Wessex Area) and Health Subgroup Chair	Nicky Priest
South Central Ambulance Service Trust	Tony Heleston
Southern Health NHS Foundation Trust	Nicky Adamson-Young
Sussex Partnership NHS Trust	Simone Button
Voluntary sector (The Children's Society)	Jenny Hine