2018/19

HSCB Annual Report

Hampshire Safeguarding Children Board

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Foreword

It is my pleasure to introduce the 2018/19 Annual Report for the Hampshire Safeguarding Children Board (HSCB). This will be the last such report published by the HSCB before responsibility for local safeguarding transfers to the named Safeguarding Partners in September 2019. I am pleased to say that plans for the new arrangements are on track and the Safeguarding Partners; the Local Authority, Hampshire Constabulary and the Clinical Commissioning Groups for Health, will inherit a partnership that continues to be robust, innovative and committed to achieving the best possible outcomes for the children and young people of Hampshire.

The strength of the existing partnership is due to the shared determination of the broad range of agencies and organisations from across the statutory and voluntary sectors that come together as the HSCB to ensure children are safeguarded and whose wellbeing is actively promoted. The activity of the Board is effectively and diligently coordinated and supported by the Partnership Support Team, and I would like to record my appreciation for their ongoing energy and enthusiasm.

The purpose of Local Safeguarding Children Boards has been to co-ordinate effective safeguarding arrangements across those agencies, a responsibility that the three Safeguarding Partners are well placed to take on. They are already active and engaged in partnership activity in Hampshire and are well sighted on the good practice that is in place and are open to delivering further improvements for the county's children and young people. I am confident that the transition will be a smooth one and that momentum will be maintained.

The Annual Report provides information as to what has been achieved in Hampshire during 2018/19 and includes updates on local priorities, initiatives and learning. This is built on a wide-ranging audit programme, detailed performance data from partners and importantly, feedback from service users including children and young people. The Report also includes relevant information on national issues and the development of shared activity across the whole of Hampshire that involves Portsmouth, Southampton and the Isle of Wight.

Throughout the last year, the HSCB has worked together to deliver its key priorities; further embedding a 'Family Approach', refining our assurance processes, better understanding the lived experiences of children and preparing for the transition to the new arrangements. I would also want to highlight the development of the ICON programme, a vitally important initiative led by Health colleagues and supported by the HSCB that aims to reduce abusive head trauma in young babies.

Safeguarding has never been more important and we, as individuals and organisations, must remain focussed in our efforts to deliver positive outcomes for our children and young people.

Derek Benson
Independent Chair
Hampshire Safeguarding Children Board

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The Board

What is the Hampshire Safeguarding Children Board (HSCB)?

HSCB is the key statutory body overseeing multi-agency child safeguarding arrangements across the Hampshire Local Authority Area. The work of the Board in 2018/19 was governed by statutory guidance Working Together to Safeguard Children 2015 and 2018.

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

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in their area.

- To ensure the effectiveness of what is done by each such person or body for those purposes.

How the Board works

Everything we do is underpinned by two key principles:

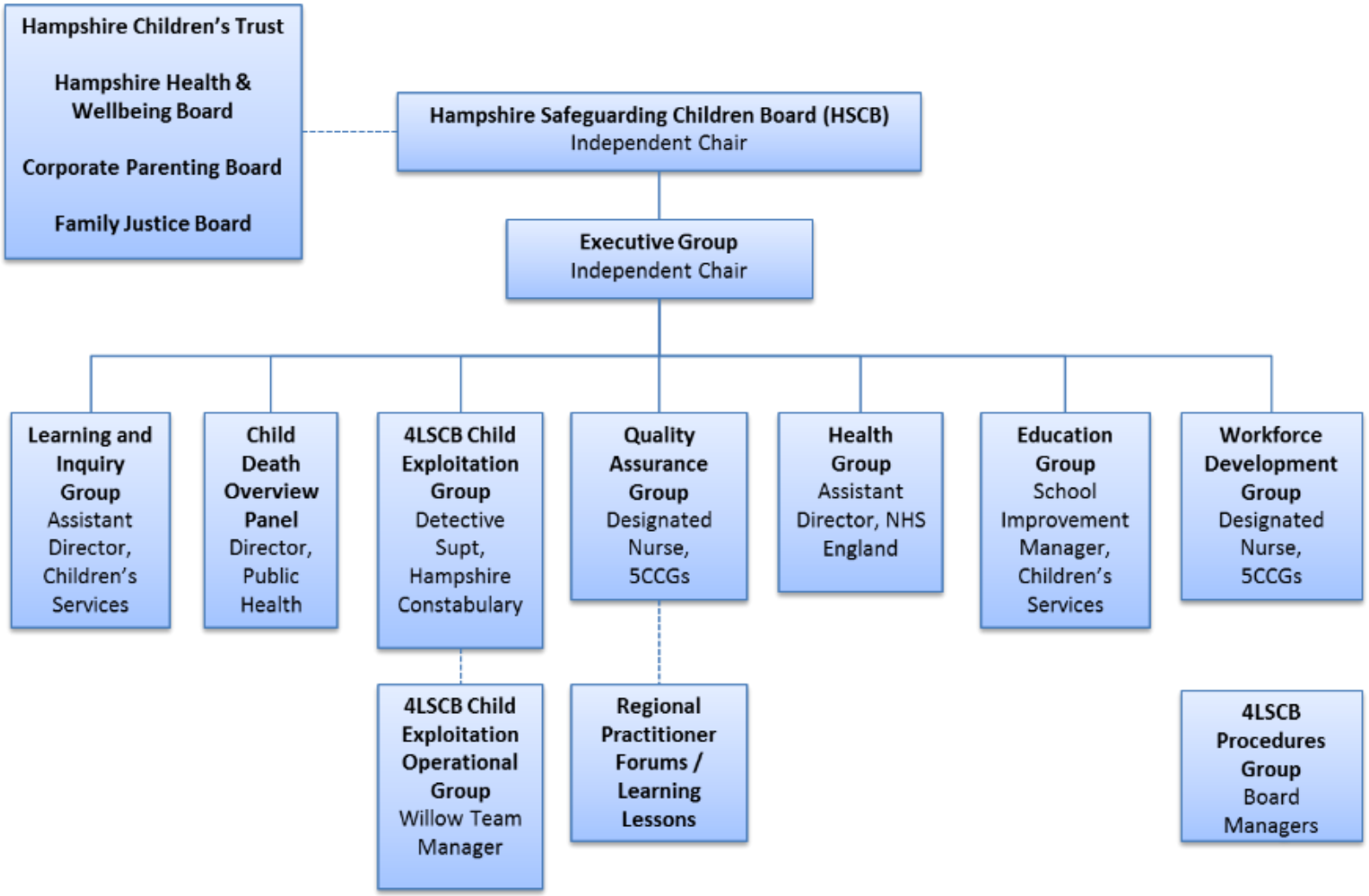
- **Safeguarding is everybody's responsibility** - For services to be effective each professional and organisation should play their full part.

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

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

Structure of HSCB in 2018/19

The main Board is supported by a range of subgroups that enable its functioning. The overall structure is illustrated below.



Day to day, the work of HSCB includes:

Undertaking multi-agency thematic audits and partnership reviews into the effectiveness of services.

Scrutinising quarterly data and producing a partnership analysis so that HSCB is clear on the needs of children and the challenges in relation to safeguarding.

Commissioning, designing and delivering training and learning opportunities that are available for the children's workforce and reviewing the effectiveness of these through evaluations, observations and longer-term impact audits.

Managing completion and publication of Serious Case Reviews (SCRs) and other reviews ensuring that the learning from these improves services for children.

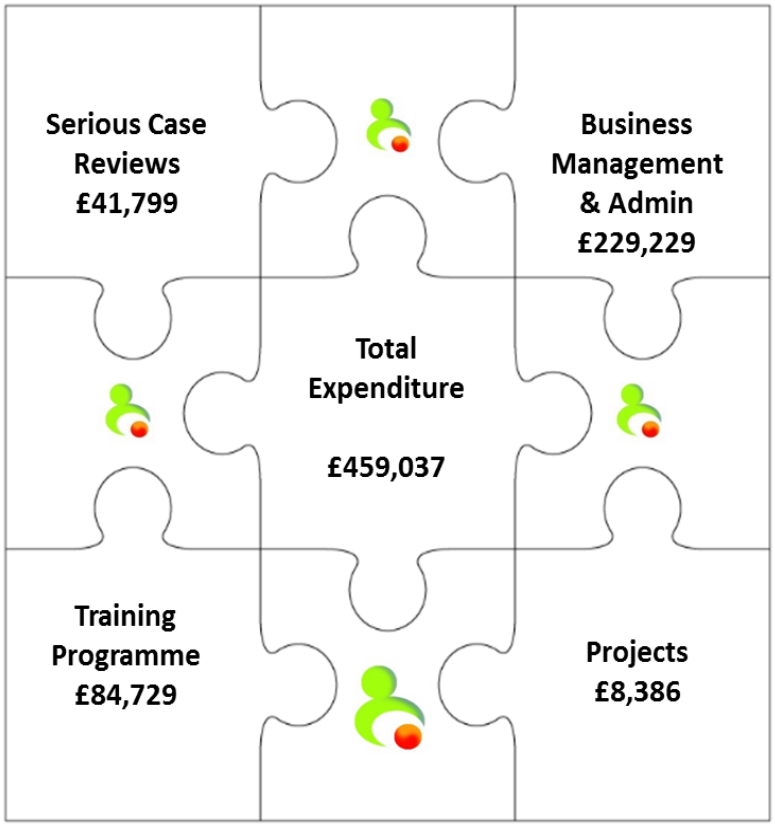
Checking partners are fulfilling their statutory obligations in relation to safeguarding and promoting the welfare of children within their organisations through audits, visits and challenge days.

Coordinating complex multi-agency working in respect of emerging safeguarding themes.

Finance

The budget for HSCB in 2018/19 was £462,825. 1.2 The final outturn for 2018/19 was a carry forward of £98,237 relating to several areas of agreed spend (case reviews and projects) that are profiled across both 2018/19 and 2019/20.

HSCB Expenditure



The Local Partnership and Safeguarding Context

Independent Chair

The Board is led by an Independent Chair, Derek Benson, 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 of the Board and delivery of its agreed objectives. The Independent Chair works closely with the Director of Children's Services and the Executive Lead Member for Children's Services.

Hampshire County Council

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 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 ensuring that the local authority fulfils its legal responsibilities to safeguard children. The Lead Member contributes to HSCB as a participating observer and is not part of the decision-making process.

Hampshire Constabulary

Hampshire Constabulary is steadfast in protecting children, vulnerable people, those who require a policing service and communities across Hampshire and the Isle of Wight.

In 2018/19, Hampshire Constabulary was represented by Chief Superintendent Craig Dibdin, the head of prevention and neighbourhood command, and supported by Detective Superintendent Darren Rawlings, head of Public Protection, Detective Chief Inspector Nick Plummer, head of missing, trafficked and exploited children and Chief Inspector Dave Winter, head of the multi-agency safeguarding hubs (MASH) and safeguarding.

Hampshire Constabulary strongly believe effective policing and the protection of communities can only be achieved through strong partnership working and are committed with, and embedded within, statutory partners and third sector agencies to identifying risk and responding accordingly.

Hampshire Constabulary is a vulnerability led force and the Public Protection Department are currently focusing on strengthening and enhancing partnership approaches, identifying and robustly responding to those who are exploiting children and the vulnerable, how to enhance the timeliness and quality of information sharing with partners to inform risk and the correct partnership response and how to ensure targeted focus remains on those who commit offences against children and the vulnerable.

Clinical Commissioning Groups – Safeguarding and Looked After Children Team

West Hampshire Clinical Commissioning Group (CCG) on behalf of the five Hampshire CCGs employs the expertise of Designated and Named Professionals for safeguarding and looked after children. The CCG Safeguarding and Looked After Children Team provide the CCGs, NHS England, Public Health, Healthcare providers and partners with training, advice and support to ensure that outcomes for children and young people continue to improve.

The Team lead work-streams on the behalf of the Board and CCG team members chair the Workforce Development Group, Quality Assurance Group and the ICON Working Group.

Lay Members

HSCB had two Lay Members on its Board through 2018/19 who played an important role in challenging, supporting and holding partners to account in the way they met their safeguarding duties. Lay Members also assist in developing stronger public engagement and awareness of children's safeguarding issues.

Lay Members help the Board stay in touch with local issues so that its work is relevant to local communities.

'I am now into my second year as a Lay Member on Hampshire Safeguarding Children Board and I continue to be impressed by the great sense of joint purpose, professionalism and commitment of all those who sit upon the board, despite the diversity of the services and agencies which they represent and lead. It has been a year of planning for significant change for the board with the new Working Together 2018 allowing for more flexibility in how safeguarding arrangements are delivered. As a lay person, I have felt fully consulted and involved in this process and I believe the new structures and processes that are being put into place will lead to even greater oversight and less duplication of the work to safeguard the wellbeing of Hampshire's children. At a personal level, I find the reading required for the meetings to be both challenging and fascinating. I continue to feel well supported and valued in my Lay role. My questions, when I have them, are always taken seriously and I am never made to feel that there is not time for my questions.'

(Camilla Pearse, HSCB Lay Member).

'I was appointed as a lay member of the HSCB in 2017. I am a retired healthcare professional, and in my retirement, I became a member of East Hampshire Police IAG (Independent Advisory Group). It was an eye opener to learn how much police time is spent with the vulnerable in society - rather than the criminal fraternity. When an opportunity arose to join the HSCB, I was keen to learn about the interaction of police, social services and health. I wanted to see how the professions work together to protect our vulnerable young people, and how they help prevent them from beginning a downward spiral which ends up with mental health problems, substance abuse or prison.

The role of the HSCB is fundamental in helping to protect our children and ensure the provision of a safe, nurturing environment. I have been very impressed with the quality and dedication of the professional members of the HSCB and they have all been encouraging and supportive of the lay role. Though the Board meetings can be quite daunting, the excellent Chairmanship and administrative team support ensures that I feel comfortable raising issues and challenging performance and priorities. I feel listened to, and I feel that any issues I raise are responded to appropriately. I have observed the open, questioning approach of the HSCB support team as they interrogate Hampshire Safeguarding performance. I am impressed by the way that they experiment with different models of Board activity to ensure maximum engagement of all Board partners. Increasing demands and diminishing resources are sadly an all too common backdrop to Safeguarding, but I have every confidence that this Board is committed to getting things as right as they can be.'

(Claire Cox, Lay Member).

District/Borough/City Councils

The 11 councils were represented on the Board by Bob Jackson, Chief Executive of New Forest District Council. There was also council representation on the Learning & Inquiry Group, Quality Assurance Group and the Workforce Development Group.

'The involvement of District/Borough/City Councils in the work of the Board continues to help improve the welfare chances of children in Hampshire. District Councils can provide a local knowledge of their communities and open up local points of contact which can provide an opportunity for better community engagement. Safeguarding is everybody's responsibility and many of the services provided by District Councils can assist with a child's safety. The importance of access to good quality housing and housing services is one example where a significant contribution can be made to the wellbeing of children. Significant progress was made last year with regard to ensuring there was a coordinated approach to ensuring local Hampshire Taxi Drivers have safeguarding training built in to the licence process administered by District Councils. Being part of the Board helps ensure that the approach to children's safeguarding is more broadly coordinated and, as a result, provides greater opportunity to help improve the lives of children in Hampshire.'

(Bob Jackson, Chief Executive of New Forest District Council).

NHS England (Wessex)

NHS England ensures that safeguarding duties are met in relation to the services that it directly commissions, such as health and justice and specialised services and that the health commissioning system is working effectively to safeguard children and adults at risk of abuse or neglect. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key areas of focus include:

- Provide leadership support to safeguarding professionals.
- Ensure the implementation of effective safeguarding assurance arrangements and peer review processes across the health system from which assurance is provided to the Board.
- Provide specialist safeguarding advice to the NHS.
- Lead a system where there is a culture that supports staff in raising concerns regarding safeguarding issues.
- Ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed, and abuse or neglect is suspected.
- Ensure that locally NHS England teams are appropriately engaged in the Local Safeguarding Children's Boards (LSCBs).

This role is discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for Safeguarding and has several forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group (NSSG).

During 2018/19, NHSE SE has engaged with both the wider health system and multi-agency partnership both at a regional and local level to improve the understanding of safeguarding and ensure it is embedded and reflected in current practice and is central to future planning, commissioning and delivery of services – underpinning this has been an approach to balancing both assurance and improvement.

National Probation Service

The National Probation Service (NPS) are responsible for the management of offenders who pose a high or very high risk of serious harm. In addition, the NPS provide assessments to the courts to inform sentencing decisions and understanding of risk.

The NPS also manage all offenders who are subject to Multi-Agency Public Protection Arrangements (MAPPA) including: most registered sex offenders, people who have committed serious violent offences (receiving more than 12 months custody either served or suspended) and other offenders who present a significant risk where a coordinated approach is required to manage them. As well as the direct management of offenders, the NPS provide a network of hostel places for high risk offenders as well as programmes to address sexual offending.

The NPS works in collaboration with the Community Rehabilitation Company (CRC) who provide some services to NPS offenders through a system called the rate card (the list of available specialist services and programmes that CRCs offer and which the NPS can purchase).

Hampshire and IOW Community Rehabilitation Company

Hampshire and IOW Community Rehabilitation Company (HIOW CRC) supervise offenders aged 18 and over in the community who are sentenced by the court to either a Community Order or a Suspended Sentence Order and are low or medium risk of serious harm. It also supervises people allocated to the service who are in custody and those released from prison on licence. HIOW CRC commissions a service called Through the Gate which aims to help prisoners preparing to make the transition from custody through to the community.

HIOW CRC provides group work spaces for men convicted of more serious or persistent domestic abuse offences, who have been made subject to Community Orders with a requirement to attend Building Better Relationships (BBR) – a 26-week accredited programme targeted at reducing domestic violence. These men are often living within the family home, where children could be impacted by their behaviour. While on the programme, a participant's partner will be visited and supported by a Partner Link Worker.

In addition, the CRC is commissioned by CAFCASS to provide a limited number of spaces on the BBR programme to men ordered by the Family Courts to undertake a targeted domestic abuse intervention.

Diocese of Winchester

The Diocese of Winchester covers most of Hampshire, takes in a part of Dorset and stretches through to the edges of Surrey suburbia, covering 1,048 square miles and 1.27 million people. The diocese has 407 churches and 102 schools.

The Diocesan safeguarding team works across all of these, advising the Bishop of Winchester on safeguarding policy and processes, acting as link to statutory agencies, taking a multi-agency approach, making referrals and ensuring that all concerns are addressed in line with current guidance and legislation.

The safeguarding team has expanded and now has a full-time safeguarding trainer and administrative support as well as a manager and caseworkers.

The Diocese has a multi-agency Independent Safeguarding Panel and it has developed its strategic priorities and published an implementation plan. This includes rolling-out a new national training programme, implementing the recommendations from the successful independent audit, and developing new policies and handbooks to support local safeguarding delivery.

As a result, the Diocese's priorities for the period focused largely on embedding these changes:

- Being Proactive & Strategic - Embedding the role of the new Safeguarding Panel, building a new proactive approach to safeguarding across the diocese, growing links to statutory agencies to ensure an inter-agency approach is taken wherever possible. This includes referrals via the MASH and the Early Help hubs. Diocesan staff have attended multi-agency safeguarding training provided by HSCB and in turn have been able to host a number of these events.
- Raising Awareness - Ensuring a consistent and high level of understanding of safeguarding matters is present in all clergy, ministers and worshipping communities.
- To Embed Systems & Resources - Continue to develop and invest in the operational infrastructure of the Diocesan Team, ensuring systems and protocols are robust and embedded into the daily working of the team.

Andrew Robinson, Chief Executive, is a member of the Hampshire Safeguarding Children Board (HSCB).

The safeguarding manager represents the Diocese and supports HSCB by being part of several working groups including the quality assurance group.

'Safeguarding is at the heart of our mission as a Diocese, and we are committed to ensuring that our churches, schools, and communities continue to be safe places for all. Our strong partnership with HSCB is central to our work in this area across Hampshire, ensuring that we are continually reviewing and improving the processes that we have in place.'
(Andrew Robinson, Chief Executive, Diocese of Winchester).

Key relationships with other partnerships

Hampshire Children's Trust

Hampshire Children's Trust is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The Independent Chair of HSCB is a member of the Children's Trust and the Chair of the Trust sits on HSCB. 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 brings together leaders from the County Council, NHS and District/Borough/City Councils to develop a shared understanding of local needs, priorities and service developments. The two Boards have an established protocol outlining how they will work together including consultation on commissioning proposals that affect how children are safeguarded. HSCB reports annually to the Health and Wellbeing Board and checks how it is tackling the key safeguarding issues for children.

Police and Crime Commissioner

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

and Crime Commissioner's Youth Commission is actively involved in the work of HSCB. During 2018/19, this included attending and participating in the HSCB & HSAB joint annual conference along with several other initiatives.

Corporate Parenting Board

The Corporate Parenting Board (CPB) is a sub-committee of the Children and Families Advisory Panel, created with the purpose of promoting the best outcomes for Hampshire children in care and care leavers. The Board enables detailed Member led engagement and advice to the Panel and to the Executive Lead Member for Children's Services on the key area of corporate parenting. In 2018/19, HSCP agreed a new protocol with the CPB which provides a clearer platform to share information of mutual interest in relation to children who are looked after. Information and data are presented at both HSCP and the CPB to enable joint scrutiny of the service provision provided to Looked After Children (LAC).

Local Family Justice Board

Local Family Justice Boards (LFJB) were established to support the work of the national Family Justice Board by bringing together the key local agencies, including decision makers and front-line staff, to achieve significant improvement in the performance of the family justice system in their local areas. HSCP has, through its shared members of the LFJB, provided briefings on local safeguarding themes and trends to inform a broader understanding of challenges in the safeguarding system in Hampshire. This included a bespoke presentation on the ICON programme, outlined later in this report.

Local Demographics and Safeguarding Context

Local Demographics

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

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

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

Vulnerable groups

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

children, and other vulnerable groups, are outlined below to provide an understanding of local context. [1]

Children with a Child Protection Plan

Children who have a child protection plan (CPP) need 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.

Child Protection	2015/16	2016/17	2017/18	2018/19
Total number of s.47 enquires across the year	4,387	4,211	3,926	4,317
Number of children with a Child Protection Plan (CPP) (at year end)	1,435	1,263	1,294	1,097
Total number of new CPP during the year	1,665	1,582	1,536	1,476

The number of children subject to a CPP has slowly reduced over the last few years, although the number of Section 47 investigations has remained the same, other than a slight dip in 2017/18. Audit and other work consistently confirm that thresholds are consistently applied, and the recent Ofsted focussed visit (2018) and full inspection (April 2019) confirmed that children are protected well.

The HSCB routinely scrutinises child protection activity at a county level and periodically carries out themed reviews to assure itself of the quality of work and that good outcomes are being achieved for children.

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 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 1,644 in care at the end of May 2019, compared to 1,599 children in care at the end of May 2018.

While the total number of children in care has increased, this is in part due to an ongoing increase in the number of Unaccompanied Asylum-Seeking Children (131 at the end of May 2019 which is 8% of the total children in care population). Children's Services also have an increasing number of children who are subject to Care Orders (thus making them 'looked after') but placed at home with parents (147 at the end of June 2018 which is 9% of the total children in care population).

Significant work continues through the Transforming Social Care programme to work with families in an intensive way to ensure that as many children as possible can safely remain at home. The reunification programme is continuing to embed with the training of staff happening

[1] Please note that some figures in this section are subject to official validation.

apace. Children's Social Care have developed, through the Transformation programme, multi-disciplinary hubs consisting of the pre-existing cohort of children and families support workers (now Intensive Workers) and specialist workers from other disciplines. In addition, the department has employed a further 19 Intensive Workers and plans are underway to increase this even further.

All children in care are subject to regular independent reviews to ensure that their circumstances are reviewed, and their needs are met. The local authority, and other agencies, work together to ensure that children are offered the best possible care and this work is coordinated and overseen by the Hampshire 'Corporate Parenting Board'.

Most of these children are placed in foster care (72%). The ethnic profile of children in care in Hampshire is consistent with the general population and the overall profile is like that of England as a whole.

Children who are privately fostered

Private fostering is a statutory status afforded to children aged under 16yrs when they are placed by someone who has legal responsibility for them - or where the child decides for themselves to live- with a carer who is not a close relative and the arrangement continues for 28 consecutive days or more. In such situations, the local authority has a safeguarding duty to these children and is required to assess their situation and monitor their wellbeing. However, the authority can only assess the situations of which it is made aware, so inevitably the role of other agencies, and indeed the public, in recognising and referring such circumstances is of key importance.

Whilst it is recognised that there is no known culture of private fostering in Hampshire, the number of such cases referred to the authority continues to be quite low; fifteen children had a 'Privately Fostered' status at the end of March 2019. This follows an awareness raising campaign which may have contributed to the slight increase in numbers from 10 at the end of 2018. The Board's Quality Assurance Group regularly monitors this data.

Children with Disabilities

The need to safeguard children with disabilities, and to provide effective strengths-based support to children and their families, is a priority both nationally and locally. Hampshire Safeguarding Children Board (HSCB)

ensures that the voice of all children, including children with disabilities, is reflected across the broad subgroups including Health, Education, Child Exploitation, Workforce Development, Procedures and Learning & Inquiries. The Hampshire Parent Carer Network (HPCN) also provides valuable feedback from the parent/carer perspective.

Disabled Children	2015/16	2016/17	2017/18	2018/19
Referrals to Children's Services	2,495	2,765	2,007	1,741
Total number of children who became subject to a Child Protection Plan in the year	80	104	82	49
Number of children subject to a Child Protection Plan at year end	84	84	74	45
Total number of children Looked After by the Local Authority across the year	311	334	311	289
Total number of children Looked After by the Local Authority at year end	245	248	242	224

The Disabled Childrens Teams (DCTs) are acutely aware of the vulnerabilities of children with disabilities and complex needs and have devised ways of communicating with and observing carefully, children who may not be able to easily convey when there is a need for them to be protected. Peer inspections confirm that while the numbers of disabled children who are subject to Section 47 or on child protection plans are low, there is a clear focus on safeguarding in the everyday work of the staff in these teams.

The transformation work that started under the Partners in Practice (PiP) programme has continued to develop and the DCTs have led the way in transforming the way that families and children are supported. The use of technology has had a significant impact on this work and innovative ways of working will continue to be developed.

Children who offend or are at risk of offending

Hampshire Youth Offending Team's priorities are:

- To reduce the numbers of children coming into the Youth Justice System for the first time.
- To prevent children from offending in the first place.
- To minimise the number of children coming into custody.
- To reduce reoffending in those subject to a statutory order.
- To keep children safe.

The number of children who are under the supervision of the Youth Offending Team (YOT) continues to fall. This is the result of a concentrated effort to keep children out of the Youth Justice system and address their needs in a different way.

420 young people received pre-court disposals in 2018/19 and a further 164 were sentenced in court. The Youth Crime Prevention programme worked with 242 young people in the same period. During 2018/19, the number of young people either remanded or sentenced to custody was 22, which is largely consistent with the previous year.

The reduction of first-time entrants (FTE) has been a challenge for the YOT and its partners. The last quarter measured (the year up to December 2018) showed a significant drop of 39 to 214 which is the lowest rate since July 2017.

This reduction in the young people the YOT are working with has meant the needs are more complex and an impact on their offending harder to achieve. The current reoffending rate for the YOT is 43.6% which is slightly above the average for England and Wales. Key to improving outcomes is: timely engagement, thorough assessment, detailed plans and targeted interventions. This is supported by our specialist services which assigns an Education Training and Employment and Restorative Justice Workers to each team.

As a partnership, the YOT is supported by other agencies who second staff. Therefore, each team has access to the skills and experience of the Police, National Probation Service and Child and Adolescent CAMHS.

These partners contribute to the holistic approach to meeting the needs of children under the YOT's supervision.

Early Help

The provision of preventative, integrated support to Hampshire's children and families through the early help offer continued at a pace during 2018/2019 with a further increase in the number of families reached.

As of February 2019, 3,222 vulnerable children were being supported by the multi-agency group at Level 3. Of this number, 56.5% of children's cases were held by partner agencies in the early help co-ordinator role, evidencing continued commitment to partnership working despite the challenges of reduced capacity and resources.

A Hampshire Safeguarding Children's Board Multi-agency Audit of Cases Managed at Level 3 early help evidenced positive feedback from families about the quality of support provided; effective working relationships established with families by professionals; improvements in accessing employment and addressing finances as well as increased education attendance; robust management oversight to track progress and outcomes

for families, and use of the 'Outcome Star' distance-travelled tool to evidence progress made.

Allowing some variation in service delivery across Hampshire's 10 early help hubs has ensured that specific local needs continue to be addressed through the provision of targeted services in districts.

Priority groups during 2018/2019 have included working with elective home education families and special guardians; provision of workshops to share information around county lines and child sexual exploitation; school attendance workshops and adult learning sessions including first aid for parents, confidence building and managing anxiety.

Delivery of early help across the county has faced several challenges to its partnership approach during 2018/2019 because of increasing workloads across all agencies and financial constraints. However shared ownership and a partnership approach remain the cornerstones to maintaining the effectiveness of the early help offer across Hampshire and the Family Support Service continues to support partnership contribution through the professional of professional development sessions and early help coordinator workshops.

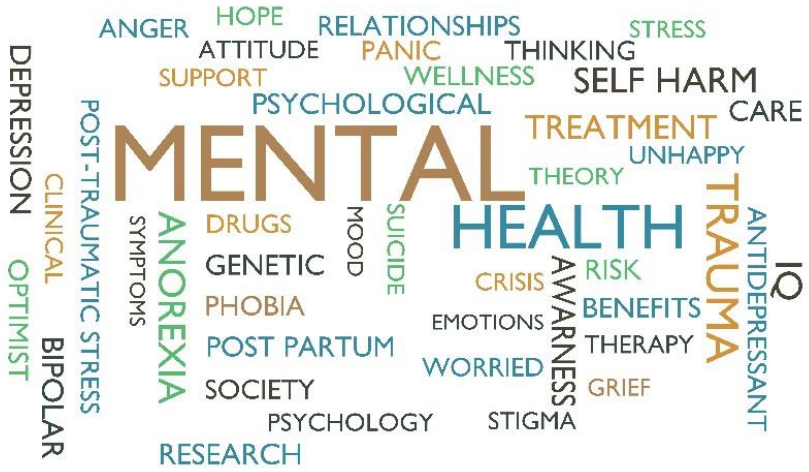
Supporting Families Programme

In September 2017, Hampshire's Supporting (troubled) Families Programme was renamed the Supporting Families Programme (SFP). SFP has operated since 2012 and since its inception nearly 7,000 Hampshire families have been identified and engaged by the programme. Phase 2 of the expanded programme commenced in 2015 and government targets were significantly increased. In 2016/17 and 2017/18, Hampshire was short of their increased target number of families by 670 families, despite the rate that families are identified/engaged being much quicker than the early years of the programme. A recovery plan was put in place and by the end of 2018/19 the had reduced to 353 leaving 630 families to be attached in the early part of the 2019/20 (the final year of the programme) to reach the Government minimum target of 5,540.

The programme remains targeted at families with more complex needs and so far, positive outcomes have been recorded for 2,500 families under the Government's payment by results element of the programme. In 2018, Young Carers and new parents struggling to cope were added as target groups.

Under Phase 2 of the programme, a significant number of families with mental health issues (67%) continue to be nominated to the programme. About half of the families nominated to the Phase 2 programme have children with poor school attendance/exclusion, require early help or are claiming out of work benefits. There are also significant numbers of families where anti-social behaviour, domestic abuse or substance misuse exists.

The Government has yet to decide as to whether to continue to fund the Troubled Families Programme nationally beyond 2019/20. An announcement is expected as part of the Comprehensive Spending Review due in the summer of 2019.



Young people with mental health issues

During 2018/19, 8,230 children and young people were referred to the specialist Child and Adolescent Mental Health Service (CAMHS). This continues to be higher than the anticipated demand which has resulted in sustained pressure on the service. 2,987 initial assessments were undertaken, and 2,166 young people started treatment in this period. More than 75,869 clinical appointments were undertaken throughout the year. At the end of March 2018, there were 7,173 open cases of young people receiving an on-going service, which is approximately 2,000 more than the anticipated caseload.

Waiting times

Hampshire CAMHS waiting times for both assessment and treatment have remained outside of target levels in 2018/19 with the influence of continued higher than expected demand. 33.5% of young people were assessed within the four weeks target and 44.5% were treated within 18 weeks of referral. The service received 692 referrals marked as urgent. Of these referrals, those assessed as urgent were all responded to within four hours of receipt of the referral. Timeliness of assessment and treatment remained a key area of focus for the wider partnership with updates provided to HSCB during 2018/19.

A recent independent review of the service found that '…the service is doing what it can within the current resource to maintain patient flow and tackle waiting times'. Working with partner agencies is ongoing to ensure that the service can reach a sustainable position and reduce waiting time to

acceptable levels. This has included establishing a transformation board which will oversee the development of initiatives to reduce waiting times.

Inpatient admissions

The total number of young people admitted to psychiatric inpatient care in Hampshire throughout 2018/19 was 95; this was eight more than 2017/18 where there were 85. This reflects a general increase in admission numbers nationally, with pressure on specialist eating disorder provision and Psychiatric Intensive Care (PICU) and these admissions tend to be out of area. It is unsurprising that in-area bed usage has remained static as this is a fixed number, albeit with some nuances with Priory Blandford, a specialist provision for young people with learning disabilities and/or autism coming on-line this year and a relatively low average occupancy rate at Leigh House.

The New Care Model across Wessex and Dorset aims to bring patients closer to home, helps them to maintain a better connection with their families and friends and improve how they interact with local services. This programme aims to reduce length of stay and the number of patients who are out-of-area in specialised mental health services. It delegates responsibility for the budget for in-patient services to local provider partnerships so they can ensure funding is spent as effectively as possible. Any expenditure gains are retained by the partnerships to invest in improving patient pathways, including in the community.

The clinical model for this programme has been developed with local stakeholders and is based around a model of intensive home treatment as an alternative to admission, particularly for those groups of young people for whom hospital can cause harm because of medical examination or treatment, such as those with an eating disorder or presenting with emotional dysregulation.

Children Not Brought to Appointments

CAMHS have a significant number of children not brought to appointments. It is a credit to the whole service that they have embraced and implemented this work stream.

All initial appointment letters sent from the single point of access signposts parents/carers to an 'About your appointment' leaflet which explains the importance of appointment attendance. The leaflet can be downloaded from our Hampshire CAMHS website. A letter template for cancellation and rescheduling of appointments has also been developed. The named nurse presented the Child Not Brought work implemented within the service to the HSCB main board attendees. This work resulted in a reduction in the number of children not brought to CAMHS appointments.

Children who are Electively Home Educated (EHE)

The Department for Education (DfE) has published new non-statutory EHE guidance for local authorities and parents including the recommendation that local authorities should contact families at least annually to ensure the education of all EHE children is suitable. The local authorities are considering the implications of the new guidance for Hampshire. The DfE is consulting on the introduction of legislation for a compulsory register of children who are EHE and support for EHE families.

Hampshire has a very busy telephone and email service for Hampshire parents, schools and other professionals. All children who are known to become EHE are registered and a safeguarding system check is completed, liaising with allocated workers as necessary. Parents are provided with an information pack and the offer of an EHE Visitor appointment. Hampshire County Council (HCC) offers to pay a contribution to the cost of GCSEs (conditions apply) and maintains a website.

Team Expansion

The EHE team consists of an EHE Coordinator, EHE Administrator, and 2.4 term-time only EHE Visitors with line management from the Inclusion Support Service Manager.

The three EHE Visitors started training in February 2019 and are delivering home visits. The team are focussing on children listed with Child in Need or Child Protection Plans and children who have had both Free School Meals and SEN. HCC has, where possible, continued to challenge and offer support to parents where a lack of suitable education provision is evident. Other

families can also request support. We have started the School Attendance Order process for a small number of cases.

The EHE register has continued to grow. There are now over 1,529 registered cases. The rate of new EHE cases from April to March is higher than at this point than year - 750 cases compared to 633. There is a trend for parents opting for temporary periods of EHE when dissatisfied with a school or when moving home. Around 14% of the cohort returned schools during September to April 2019.

Where poor practice in schools is identified, such as allegations of 'off-rolling', Hampshire County Council (HCC) has continued to challenge schools. HCC has published new guidance for Hampshire Schools and included a policy for the SEN Service to arrange an Annual Review within one term of a child becoming EHE for children who have an Education, Health and Care Plan (EHCP).
HCC continues to liaise with schools, Social Workers, Youth Offending Teams, Family Support Services, HCC Services for Young Children, the Children Missing Education Officer, School Nursing Teams, Health Visitors, Further Education College under 16 provision and Hampshire School Admissions, SEN teams and some of the home education groups. The EHE Coordinator has attended or provided reports for Child Protection Conferences. There are usually up to 10 Hampshire children who are EHE and on CP plans at any one time.

HCC work with other local authorities and regional forums. The Hampshire strategic lead is the Chair of the National Association of Elective Home Education Professionals (AEHEP) and has represented the AEHEP in communications with the DfE, the Children's Commissioner and is also on the national executive with the Association of Education Welfare Managers (AEWM) with a remit for EHE.

Local Authority Designated Officer (LADO)

The LADO role is statutory, sits within the local authority and plays a key part in ensuring the children's workforce is a 'safe' workforce. LADOs are charged with the oversight of all relevant allegations against adults working with children in a voluntary or paid role, providing advice and guidance to ensure individual cases are resolved as quickly as possible. LADO work in Hampshire is measured over the academic year as a significant proportion of the work relates to referrals involving staff in academic settings. The last full year's data for referrals therefore runs to 31 August 2018. In this period in Hampshire, 748 referrals were received, 42% of which related to school or college settings. This mirrors the proportion in the previous year's data.
Hampshire LADOs also discharge a broader safeguarding advisory role which is much appreciated by those contacting the service.

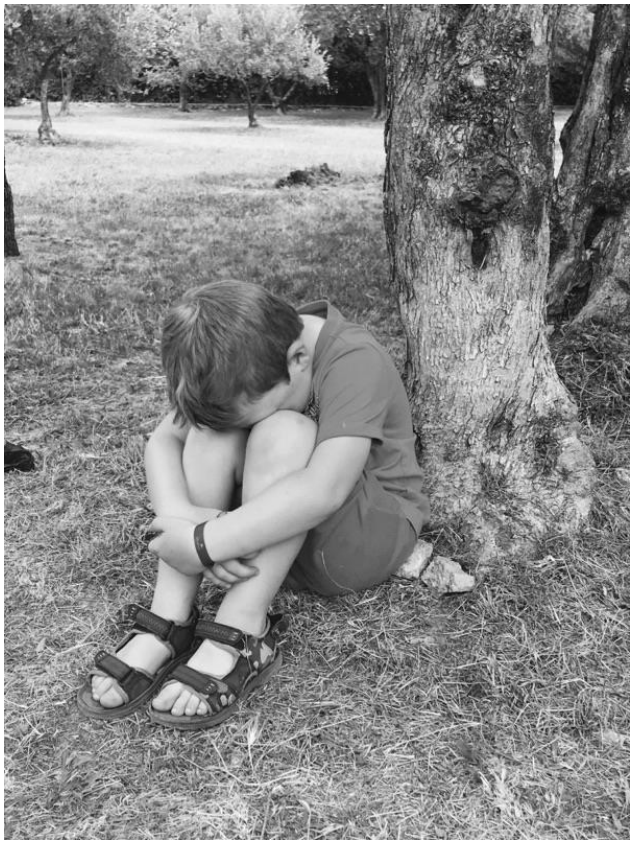
Children's Reception Team

Contacts from professionals/practitioners and members of the public regarding child welfare or safeguarding concerns are reviewed by the Children's Reception Team.

Children's Reception Team Contacts				
	Total CRT Contacts	Police Contacts	Combined Contact Calls/Emails	Out of Hours Contacts (not included in total CRT Contacts)
2017/18	77,602	36,808	40,794	18,124
2018/19	89,340	38,621	50,719	17,008

In 2018/19, the Children's Reception Team (CRT) in Hampshire was managing more than 6,500 contacts per month, peaking at 8,502 in November 2018.

The volume of Public Protection Notices (PPNs[2]) from Hampshire Constabulary accounted for 43% of the contacts received. To address this high volume, MASH is continuing to work closely with the Police to improve the quality of the PPN information and to identify improvements in the information sharing process, which may reduce demand.



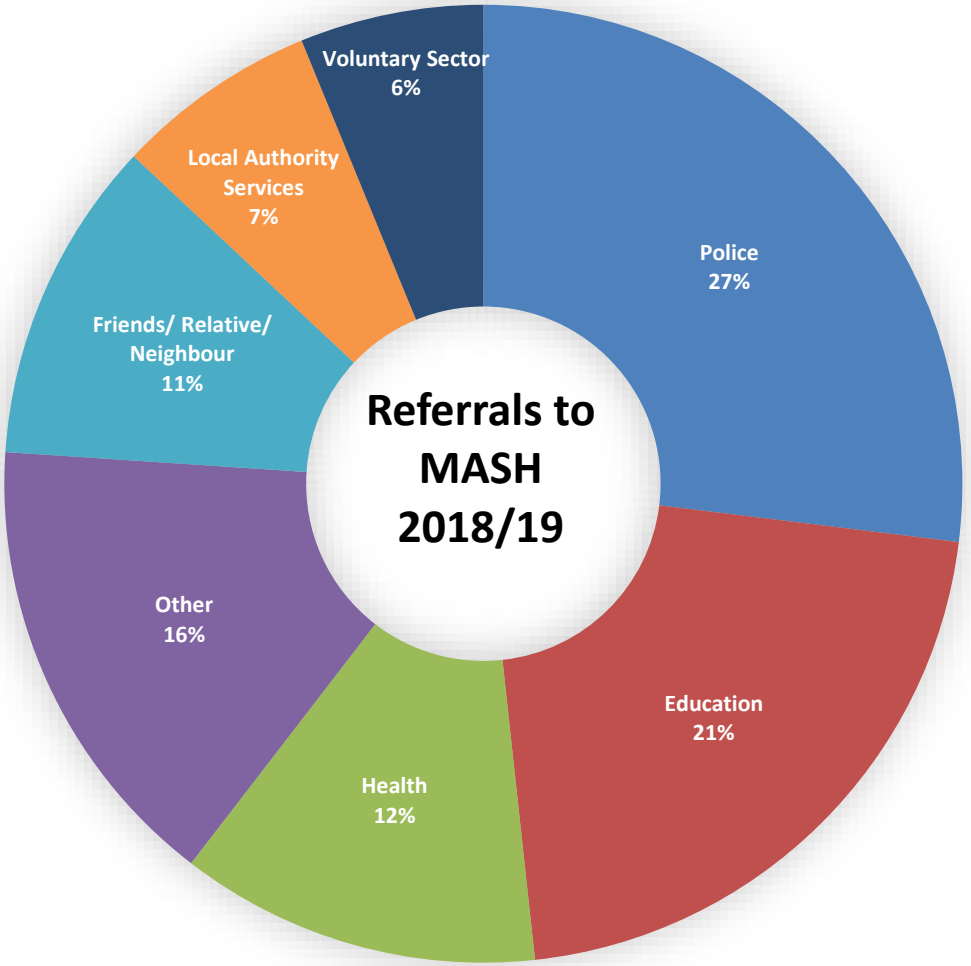
[2] A form completed by officers and staff who become aware of children who are 'at risk' and/or who are either witnesses to, or victims of, a crime. The form is shared with partner agencies via the Multi-Agency Safeguarding Hub.

Referrals to Hampshire Multi-agency Safeguarding Hub (MASH)

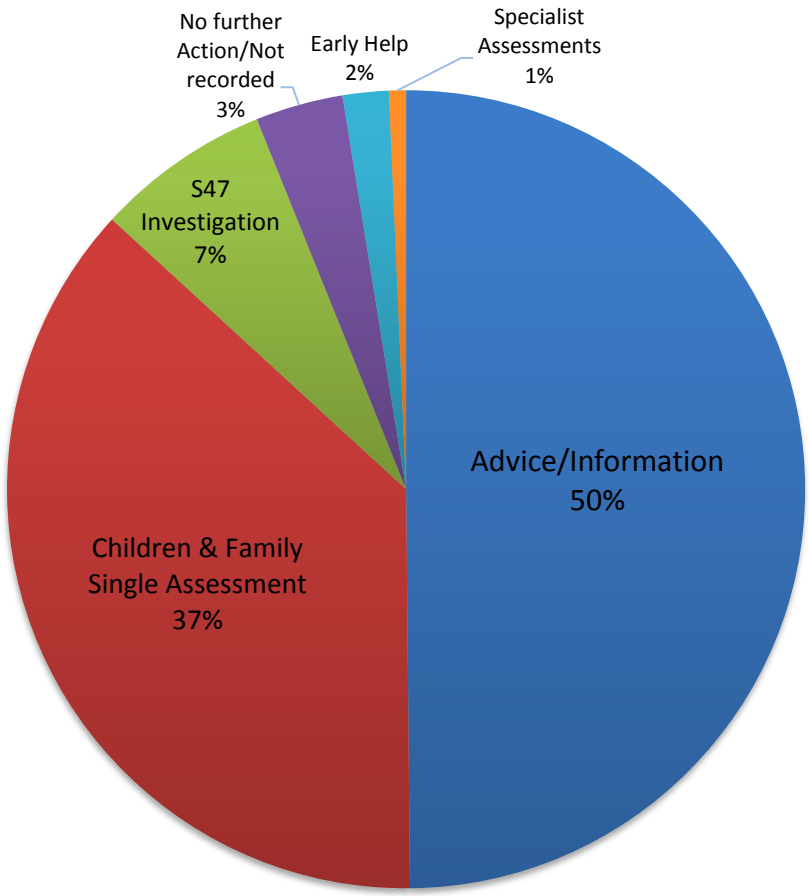
Following a review by the Children's Reception Team, a decision is made as whether a referral to the Multi-Agency Safeguarding Hub (MASH) is required. MASH provides triage and multi-agency assessment of safeguarding concerns. It brings together professionals from a range of agencies into an integrated multi-agency team.

Police and education are the main sources of referrals. Police account for 27% of the total number of referrals into MASH with education making up 21%. As previously noted, fewer than 15% of referrals received from Public Protection Notices (PPNs) result in assessment by a social worker.

Referrals to MASH		
Agency	**2017/18**	**2018/19**
Police	9,492	9,768
Education	6,906	7,734
Health	4,696	4,410
Other	4,566	5,659
Friends/ Relative/ Neighbour	3,610	3,961
Local Authority Services	2,404	2,475
Voluntary Sector	767	2,245
Total	**32,441**	**36,252**



Outcomes Following Referral to Hampshire Multi-agency Safeguarding Hub



Outcomes of Referrals to MASH		
Outcome	**2017/18**	**2018/19**
Advice/Information	16,593	17,995
Children & Family Single Assessment	11,836	13,347
S47 Investigation	2,528	2,558
No further Action/Not recorded	816	1,280
Early Help	349	673
Other Local Authority Child Protection Plan	151	119
Specialist Assessments	155	249
Progress to Assessment (A&OP)	8	11
Referral to Another Agency	4	19
Progress to Post-Adoption Services	1	1
Total	**32,441**	**36,252**

Over the last 12 months, 37% of all MASH referrals progressed to Children and Family Assessments, which remains consistent with figures from 2017/18. Over 2018/19, MASH have managed a total of 36,252 referrals of which 2,558 (7%) progressed to Section 47 investigations.

Figures for 2018/19 illustrates that thresholds within CRT and MASH have remained consistent. This is particularly relevant for the percentage of contacts resolved and those progressed to referral. The MASH continues to complete regular audits of work undertaken along with the multi-agency audit days, led by the HSCB Partnership Support Team, which ensures that the thresholds are consistent and robust. This has been further reinforced

within findings from the recent Ofsted inspection in addition to a previous Joint Targeted Area Inspection in 2015. Ofsted commented that the current MASH was both 'impressive and very solid with children receiving a good response and things happen in a timely way'.

CRT/MASH have worked closely with the Willow Team to review and update the initial sexual exploitation screening tool used at first contact to assist with the identification of Child Sexual Exploitation. This screening tool is completed for all contacts where a child is over the age of ten years and ensures that the need for a full Sexual Exploitation Risk Assessment Framework[3] (SERAF) form is identified where required. The initial screening tool has been used within the Out of Hours Service throughout 2018/19.

All Prevent referrals are managed through CRT and MASH, ensuring a consistent multi-agency response to concerns about radicalisation.

MASH have worked with partners to introduce and embed High-Risk Domestic Abuse meetings into MASH. These meetings ensure a faster and more coordinated response to high risk domestic incidents, enabling a timely multi-agency response.

The online Inter Agency Referral Form (IARF) is now fully integrated and CRT have seen a steady increase in the use of the form since coming into effect. The IARFs have replaced email referrals, enabling staff within CRT to manage contacts and referrals more efficiently. MASH managers continue to be involved in the delivery of threshold workshops, supported by HSCB, which have been delivered to a variety of agencies across the county. These workshops are aimed at improving the quality of contacts and referrals and have been well received by partner agencies.

Transforming Social Care - Partners in Practice Programme

The third year of the PIP programme (2018/19) has seen the previous detailed planning move into implementation and the delivery of direct interventions to families. In line with the development of multi-disciplinary working, four virtual multi-disciplinary hubs have been established across children's social care in which social care teams are enhanced by the co-location of specialist workers from other professions to support families to achieve improved outcomes. Implementing this model has been supported through the adoption of a new approach, this being:

- Recruitment and deployment of additional staff in an 'Intensive worker' role.
- Re-purposing of existing Children and Families Support Workers to the Intensive Worker role.

[3] A screening and assessment tool developed by Barnardo's to identify children at risk of sexual exploitation.

- Targeting of interventions to 'priority cohort' families to have the most impact and increase the number of children living safely at home.
- Working with families for the right length of time to ensure that positive changes are embedded and can be sustained.
- Delivering interventions to families in a flexible manner, including outside of usual business hours.
- Ensuring interventions are evidence-based.

This year has seen the transition of the 'Hampshire Approach' from a concept to a reality impacting upon practice. There has been significant training of staff in the elements which underpin the Hampshire Approach, these being:

- Strengths based working.
- Motivational Interviewing.
- Restorative Practice.
- Brief Solution-focused therapy.

In addition, there has been a review of the Children and Families Assessment and child protection and children in care plans to ensure they reflect the Hampshire Approach and the way in which we want to work with families in a strength-based way that builds upon, and increases, their resilience.

Improvements to existing processes and the development of new ones has brought about efficiencies which have freed up social workers to enable them to spend more time working directly with children and their families. The issuing of hybrid devices to social care staff has facilitated mobile working as well as increasing engagement and participation levels due to the interactive nature of this new technology.

Whilst being a Partner in Practice with the DfE has provided the opportunity to effect change across children's social care in Hampshire, it is not a one-off event, continuous review and scrutiny will drive the agenda for continuous development both into the final year of the PIP grant funding and beyond.

Serious case reviews and child deaths

Serious Case Reviews (SCRs)

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 an SCR. The purpose of an 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.

During 2019/20 HSCB will transition to Hampshire Safeguarding Children Partnership (HSCP). Following this the criteria as set out in Working Together to Safeguard Children 2018 for a Child Safeguarding Practice Review will be followed.

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

During 2018/19, the Learning and Inquiry Group (LIG) has seen a small decrease in the number of cases being referred. Of the cases referred, there was a decrease in the number of Serious Case Reviews and other reviews commissioned. Within 2018/19, the LIG received 8 referrals for multi-agency discussion.

Of the 9 cases referred to the LIG:

- One resulted in SCRs being commissioned.
- Three resulted in Multi-Agency Reviews (MARs) being commissioned.
- A case study was produced based on one case to share learning
- Four did not result in any requirement for a review.

Following the updated guidance in Working Together to Safeguard Children 2018 LSCBs are required to undertake a rapid review of a case if it meets the criteria for a Serious Incident Notification by the Local Authority. During 2018/19 HSCB have undertaken four rapid reviews, the remaining five cases that were referred did not meet the criteria for a rapid review.

Year	Referrals	No Further Action	SCR	MAR/ Single Agency Reviews
2015/16	17	10	1	6
2016/17	12	6	2	4
2017/18	10	2	5	3
2018/19	9	4	1	4

These figures illustrate the impact in volume of work immediately following amendments in the additional guidance and definition of an SCR provided in Working Together 2013, and again updated in 2015.

Working Together to Safeguard Children 2018 was published in July 2018. The guidance sets out the new processes in respect of undertaking case reviews. A national panel has also been established to undertake reviews where it is determined that the case(s) raise issues which are complex or of national importance.

HSCB is committed to exploring and using different methodology for all types of reviews and will consider which methodology is the most appropriate to extract learning.

During 2018/19, HSCB published a SCR on Child K which is available on the HSCB website. Child K died at eleven weeks of age after being placed in his parent's bed to sleep overnight. Both parents were at the time under the influence of alcohol. Some of the key learning arising from the SCR included the need for all practitioners to:

- Ascertain, understand and consider the 'voice', experience and participation of all children, especially including those with additional communication and learning needs;
- Consider all the children and young people in a family and take a 'whole family' perspective when primarily working with or providing services for specific family members;
- Identify and liaise with other services and practitioners who have/had contact, who work/have worked with a child, young person or family when undertaking assessments or providing services;
- Share historic information about a child, young person or family with relevant practitioners and services (where appropriate) and include this in all assessments;
- Act confidently within the current safeguarding arrangements and procedures, including in relation to making a referral to Children's Services, if it is considered that a child or young person is unable to have access to necessary services or may be at risk of harm through actions of parents or carers.

The SCR also recommended that a review was undertaken of the current information provided to parents on 'safe-sleeping' arrangements (including known risk factors, for example alcohol consumption) provided to all prospective and new parents (including fathers or partners) and to the practitioners who may work with them; and consider promoting public awareness through a media campaign. As a result of this SCR, a task and finish group were established to review and develop information given to parents about safer sleep. The learning was also incorporated within a work-stream to develop a multi-agency Family Approach Protocol.

Abusive Head Trauma

ICON was launched across Hampshire in September 2018 as a result of the Serious Case Review of Child U. A further Serious Case Review on Child N has highlighted the importance of this programme for professionals. The launch event had a reach of over 500 professionals and was a massive success. The launch was opened by independent chair of the HSCB, Derek Benson which was followed by Dr Sue Smith (ICON Founder) and Mae Pleydell-Pearce (Parent representative). Several ICON task and finish group members also presented on the day and explained the ICON programme and prevention strategy.

ICON represents:

- **I**nfant crying is normal.
- **C**omforting methods can help.
- It's **O**K to walk away.
- **N**ever, ever shake a baby.

Following the launch, organisations across Hampshire have been working hard to embed ICON into existing pathways. This has been especially important across Midwifery, Health Visiting services and Primary Care

Services. The HSCB presented ICON at Regional Practitioner Forums, Early Years Briefings and Learning Lessons events to share the ICON message.

The latest round of training has centred on a 'train the trainer' model.

In January 2019, the public launch took place, with a week of communication activity. This included promotion via 'Daisy the Bus' in Basingstoke and Havant, stands in hospital entrances and media interviews and presence (including social media). The communications teams from Hampshire County Council and West Hampshire CCG had a media strategy in place to ensure that the message was shared with as many members of the public as possible.

Presentations have been made at national events including:

Family Justice Board

In November 2018, the ICON programme was presented at the annual Family Justice Board Conference. Dr Sue Smith (chief programme advisor), Mae Pleydell-Pearce (parent representative) and West Hampshire CCG Designated Nurse Kim Jones, all shared the ICON message to 150 judiciary colleagues. The feedback has been extremely positive, some examples are below:

'Thank you so much for giving your talk at the conference. I found it thoughtful… moving and hard hitting. I am extremely grateful for your help in making the day be as enjoyable as it was.' - **HHJ Christopher Simmonds, Nominated Judge of the Court of Protection**

'I would like to say that your presentation on AHT was both exceedingly informative, thought provoking as well as highly emotional and one I will never forget. Thank you.' - **Stephen Rowntree, Jigsaw Family Support Trustee and Lawyer at Glenlea Chambers**

Royal College of Paediatrics and Child Health Conference 2019

The Named GP (SE CCG), in collaboration with Designated Nurse (West & North Hampshire CCGs) and the chief programme advisor developed an abstract for the RCPCH Annual Conference. The abstract was sponsored by Dr Geoff Debelle (Officer for Child Protection, RCPCH) and was successful in being accepted for an oral presentation at the conference in 2019.

The focus of the presentation was in relation to the implementation of a standardised assessment for the 6-8-week postnatal check, which includes ICON and other safeguarding risk factors. The template has been endorsed by the Royal College of GPs.

Work continues into 2019/20 increasing agency involvement in the programme.

ICON General Practice Pilot Results

GPs and Practice Nurses routinely see parents of infants at 6-8 weeks coinciding with the peak of normal infant crying, the GP appointment is a vital opportunity to address maternal mental health.

The purpose of the ICON Primary Care pilot was to design and evaluate use of a bespoke consultation template that incorporates the ICON message about coping with infant crying.

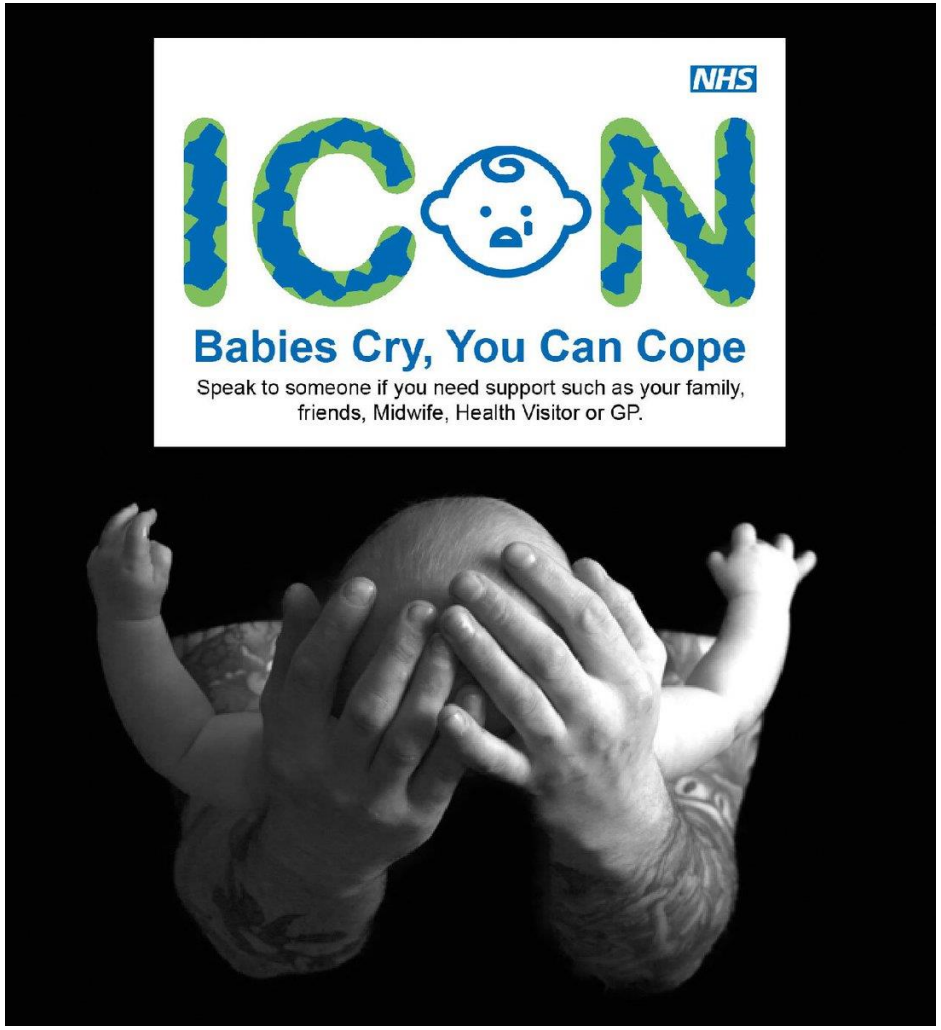
12 GPs covering three practices participated in the pilot over a three-month period. Clinicians were asked to give feedback using a written questionnaire and to encourage parents to provide feedback via a questionnaire to complete post appointment. Key results included:

- 92% of GPs in the pilot felt that using the consultation template had changed their practice.
- 100% of the GPs found that the ICON message and training had helped them to discuss coping with crying.
- 70% of parents said they would change their behaviour in response to their baby's crying after hearing the ICON message from their GP.

Feedback from GPs included:

"I was really sceptical when [the Named GP] came to train us on the template and was worried about asking these personal questions… BUT it's totally changed my practice and has really got patients to open up and ask for help." ***– GP***

"I found asking 'is motherhood everything you thought it would be?' was a great way to get mum to open up" ***– GP***



Use of a standardised postnatal template coupled with training on discussing coping with crying led to a positive change in both clinician practice and parenting behaviour. Following a pilot, roll-out commenced across the whole of Hampshire GPs.

Royal College of GPs: Following the pilot Dr Jenny Rattray presented the Maternal Postnatal Template for the 6-8 week to the Royal College of GPs, who have endorsed them template and plan to include it within their forthcoming RCGPs Safeguarding Children Online Toolkit.

Wessex Healthier Together: Information for parents/carers on coping with crying, including the ICON leaflet and information is available on the Wessex Healthier Together website.

Health Services Journal: ICON leads, West Hampshire CCG, Hampshire County Council and Hampshire Safeguarding Children Board were HSJ Finalists for the Communication Initiative Award.

Royal College of Paediatrics and Child Health (RCPCH) Annual Conference: An abstract was submitted to the RCPCH annual conference, which was successful in gaining a slot to orally present the ICON findings.

Child Death Overview Panel Annual Conference: An abstract was submitted to the CDOP annual conference, which was successful in gaining a slot to present a poster with the ICON findings.

Wessex Public Health Conference: An abstract was submitted to the Public Health annual conference, which was successful in gaining a slot to present a poster with the ICON findings.

Task and Finish Groups

In addition to commissioning and overseeing SCRs and MARs, the Hampshire Learning and Inquiry Group established a task and finish groups in mid-2018 to review information given to parents about safer sleep.
The group have reviewed currently available material and developed a pan Hampshire booklet as well as professional scripts and agreed touch points for conversations with parents across agencies. The programme is due to be piloted during 2019.

Disseminating Lessons Learnt from Reviews

Five Learning Lessons workshops were held during 2018/19 utilising learning from SCRs and MARs completed since 2017/18. These sessions were attended by 61 multi-agency professionals. Case studies were written to include a mixture of the complex needs identified in reviews pertinent to Hampshire. The sessions were aimed at frontline staff and team managers in all agencies involved in working with children and families. The sessions were interactive and required frontline staff to consider what information in relation to a family may be held within other agencies and the importance of information sharing. Learning from SCRs has also been included in the quarterly Regional Practitioner Forums.

Learning from Serious Case Reviews within the CCGs

Vulnerable Family Meetings

The Named GP (WHCCG), in collaboration with midwifery and health visiting leads across provider organisations in Hampshire, developed a practical guide for successful Vulnerable Family Meetings. The guide is supported by a tool to aid discussion and a recording spread sheet. The tool asks professionals to consider the protective factors and risks based on the information known about the child and family. Concerns about the implementation of Vulnerable Family Meetings has been identified in local SCRs.

Early feedback regarding practices who have implemented the guide highlights that it has been successful.

Paediatric Preliminary Opinion Form

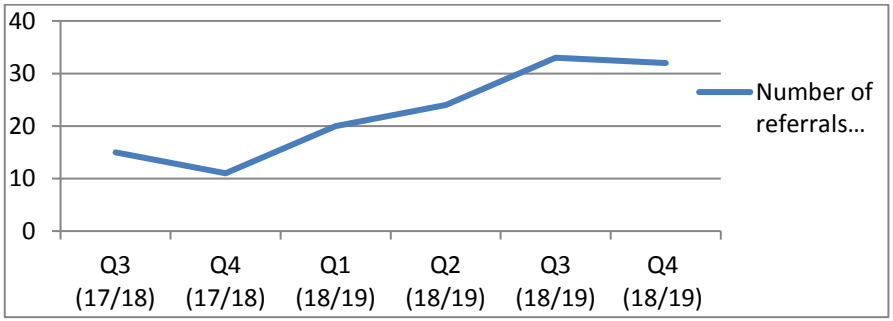
The Preliminary Paediatric Opinion Form was designed by the Designated Doctor for Safeguarding Children with consultation following two learning reviews to give an immediate written opinion for Children's Services and Police following a Child Protection medical. The form will be launched and evaluated in 2019/20.

Bruising Protocol Application

The Safeguarding and Looked After Children (LAC) Team completed prospective auditing of referrals made to MASH under the Bruising Protocol during 2018/19. Data are collated for the HSCB to review the number of

referrals across the geographical area of Hampshire. Since the Safeguarding and LAC Team have been auditing, reviewing and raising the profile of the Bruising Protocol, alongside promotion of the ICON programme and dissemination of lessons learnt, there has been a 191% increase in the number of referrals made to MASH compared to the last financial year.

Number of referrals to MASH under the Bruising Protocol



Inter-Agency Referral Form (IARF)

Following an audit of health referrals into MASH, the Children's Services lead for MASH, the Designated Nurse (WH & NH CCGs) and a member of the HSCB Support Team reviewed the current referral process and form and develop a Safeguarding SAFE Tool to help prompt professionals when making a referral.

The SAFE Tool and proposed changes to the IARF was circulated to relevant health professionals and feedback was collated prior to it being approval at the June 2018 HSCB Board meeting. Following the implementation of the SAFE Tool and changes to the IARF, a further audit will be conducted to establish if referrals made by health professionals are more robust in terms of clearly articulating risks and mitigations.

Child Deaths

The arrangements for the review of child deaths continued from 2018/19 with deaths being reviewed individually by the 4LSCB Child Death Overview Panels (CDOPs) across Hampshire, Isle of Wight, Portsmouth and Southampton. Data and analyses are shared to identify common themes and patterns and to inform the 4LSCB CDOP Annual Report.

The CDOP in Hampshire has worked with agencies to improve the quality and timeliness of notifications and then resulting analyses. The CDOP database, developed by the Board's Partnership Support Team, has also enabled a comprehensive analysis of cases reviewed by the panel to inform this year's CDOP annual report.

A total of 35 child death reviews were undertaken in 2018/19 out of the 50 deaths that the Hampshire CDOP were notified of. The remaining 15 cases were scheduled for review in 2019/20. In addition, the Hampshire CDOP reviewed 35 child death reviews from 2017/18. These deaths were included in the 2017/18 CDOP annual report addendum.

Overall, the number of child deaths reported has reduced when compared with 2017/18 when 91 notifications were received.

43% of the reviews completed during 2018/19 were of children who died under the age of one. Of those cases, 60% were for neonatal deaths (under the age of 28 days) and 40% for children aged between 28 and 364 days at the time of death.

This year, there was an equal preponderance of child death reviews among boys (51%) compared to girls (49%). The majority were of white ethnicity (77%) with some mixed, Asian and unknown ethnic backgrounds.

None of the reviews identified children as being subject to statutory orders or subject to child protection plans at the time of the child's death. There were no children with an asylum-seeking background across the cases reviewed in 2018/19.

Of the 35 deaths reviewed by the Hampshire CDOP, nine (26%) were identified as having modifiable factors including:

- Smoking in pregnancy/in the household
- Safe Sleep
- Mental health issues and complex social factors
- Substance misuse
- Parental capacity

Information on the full range of recommendations made to HSCB can be found in the CDOP Annual Report 2018/19 available on the Board's website.

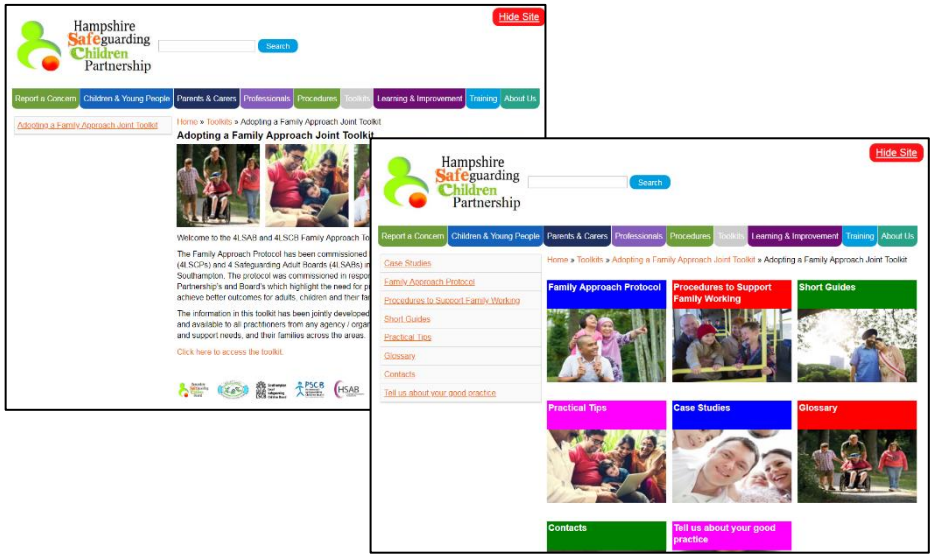
Progressing the Board's business plan

Adopting a Family Approach

In response to learning from the Child K SCR, as well as audits and other reviews, HSCP developed a multi-agency Family Approach Protocol. The Protocol was developed in partnership with the Local Safeguarding Children, and the Local Safeguarding Adults Boards across Hampshire, Isle of Wight, Portsmouth and Southampton in response to findings from a range of reviews across all Board's which highlight the need for professionals to work effectively together to achieve better outcomes for adults, children and their families across all areas. It is the first area of collaborative work between all eight safeguarding boards.

A Family Approach is one that secures better outcomes for children (including unborn babies), adults with care and support needs, children and their families by co-ordinating the support they receive from Adult and Children and Family Services. The support provided by these services should be focused on problems affecting the family as this is the only effective way of working with families experiencing the most significant problems.

The Protocol sets out high level principles of how the members of the safeguarding boards, and individual agencies, will work together to best achieve a family approach. The Protocol was formally ratified by all 8 Boards between January – March 2019 and launched to the multi-agency workforce as part of an online Family Approach toolkit in May 2019. The toolkit contains a range of resources and information to assist frontline professionals embed the principles and ways of working outlined in the Protocol. The Family Approach protocol and toolkit will be rolled out via a serious of workshops over 19/20 and this will be included in the next annual report.



In addition to the planned workshops on a Family Approach, HSCB, in partnership with the Hampshire Safeguarding Adult Board (HSAB), continued to roll out the multi-agency training on 'Adopting a Family Approach' with 170 delegates attending in 2018/19.

As part of the Board's approach to training, regular evaluations of courses are undertaken. Two members of the Board's Workforce Development Group observed delivery of the course in 2018/19 and fed back that delegates were engaged, enthused and motivated to apply the learning and make changes to their practice.

Self-reported change in delegates' knowledge from before attending the training to afterwards, scored out of a maximum of ten, showed a significant average change of +2.25 points. Prior to attendance average knowledge was scored at 6.5/10 and afterwards 8.75/10. The improvement equates to an average knowledge increase of 34.6% per delegate.

Professionals from across the partnership have also used the toolkit within their own organisations to upskill front-line staff and positive feedback has been received:

'I ran a session on the family approach toolkit with my team yesterday. It is user friendly, easy to access and navigate and has everything that you would need to understand how to apply a family approach in your work. We thought the short guides were a great way to introduce different subjects to people and help them understand it without needing to be an expert in everything'
(Hampshire-based charity).

HSCB and HSAB Annual Conference

The HSCB and HSAB held a joint conference for multi-agency professionals entitled 'The Whole Family (Strengths Based) Approach: Working Together to Achieve Better Outcomes', which was attended by 215 delegates from across HSCB and HSAB partner agencies. The conference included a range of presentations including Hampshire Children's Services strengths-based approach, the HSCB & HSAB family approach protocol and toolkit, the impact of the Mental Capacity Act (2005) on children and adults, fabricated and induced illness, trauma-informed practice within policing and Early Help/Family Support Services.

Evaluations indicated that there was an increase in understanding by most delegates following attendance at this conference with 100% of those responding to the post-conference survey indicating that they could confidently identify the key benefits of a strengths-based approach for clients, their families, practitioners and the organisation.

'…this will inform my future practice – to look for solutions within the family and community'.

Keeping My Friends Safe

In 2018/19, the Board commissioned a task and finish group to develop and promote a set of resources, and good practice principles, to support schools and post-16 colleges in enabling pupils/students to identify and report safeguarding concerns regarding their peers.

Following a survey of designated safeguarding leads within schools and post-16 settings, to benchmark their arrangements in enabling

pupils/students to report concerns, a lesson plan/presentation was developed by a member of the Board's Education Group regarding what it means to be a good friend and to encourage the sharing of concerns/worries about friends and peers. This work will be launched and expanded to secondary and post-16 settings in 2019/20.

Strengthening our Assurance Programmes

- HSCB is assured that the services provided to children and their families in Hampshire are timely, appropriate and effective.

HSCB undertakes regular auditing of multi-agency safeguarding arrangements in Hampshire. This work is commissioned by the Board's Quality Assurance Group and learning is disseminated to front-line practitioners through a programme of events, briefings and conferences. Over the last year, the Board undertook four multi-agency audits to establish how well agencies work together to identify and respond to key safeguarding issues.

Early Help Audit

In July 2018, a multi-agency group reviewed the quality of practice regarding seven cases that had been discussed at Early Help Hubs and tasked to agencies to lead at Level 3. The key strengths identified were as follows:

- ✓ Consistent Application of thresholds at the outset.
- ✓ Outcome-focussed Early Help plans that addressed the identified areas of need.
- ✓ Clearly understood, and agreed, lines of accountability regarding the lead professionals.
- ✓ Agencies/professionals were proactive in supporting the Lead Professional to ensure a robust multi-agency response.
- ✓ Agencies worked together to ensure the children and family received the services they needed to improve outcomes.
- ✓ Children and families were involved/engaged at all stages.
- ✓ Positive comments were received from families as part of the audit process, which highlighted good working relationships between parents/carers, and children, with the lead coordinators. A range of positive outcomes had also been achieved (e.g. feeling more confident with parenting, improved attendance at school, counselling support).

Opportunities for strengthening practice: information-sharing between health professionals and Early Help Hubs.

Multi-Agency Safeguarding Hub (MASH) Audit

In September and October 2018, a multi-agency group reviewed 11 cases referred to the Hampshire local authority area MASH due to alleged child exploitation. The key strengths identified were as follows:

- ✓ Consideration of the voice of the child and their lived experience.
- ✓ Timely and effective information-sharing between partner agencies.
- ✓ Multi-agency involvement in the risk assessment and decision-making processes.
- ✓ Consistent and appropriate application of thresholds.
- ✓ Feedback provided by MASH to referrers.
- ✓ Subsequent actions taken by social work teams.
- ✓ Management oversight within MASH.

Opportunities for strengthening practice: hand-over between local authority areas for county lines cases. This has been taken forward by the Out of Hours Service for children's services.

Section 11 Audit

As part of its statutory duty to ensure the effectiveness of what is done by each organisation in relation to safeguarding and promoting the welfare of children, Hampshire Safeguarding Children Board undertakes annual monitoring of compliance with Section 11 of the Children Act (2004). The purpose of the audit is to support Board partners in achieving compliance through:

- Seeking assurance from Board partners that services are compliant with safeguarding standards.
- Enabling Board partners to showcase areas of good practice where positive outcomes for children can be evidenced.
- Enabling Board partners to reflect on their safeguarding priorities and to identify areas for improvement.
- Providing a feedback mechanism to Boards on progress against areas for improvement including any barriers to partnership working.

The Section 11 audit process was strengthened in 2018/19 through the addition of an all-staff survey and a programme of scrutiny visits to a range of settings to test front-line practice and professional awareness.

A clear commitment to keeping children safe was evident across partners agencies including positive examples of how agencies improve outcomes for children and young people.

When combined, the results of the 37 agency/departmental self-assessments and the staff survey supported further exploration of the following 10 themes:

1. Safeguarding messages within staff induction.
2. Dissemination and implementation of LSCB policies, procedures and resources.
3. Promoting and enabling attendance at multi-agency training/briefings.
4. Knowledge of, and reference to, referral thresholds.
5. Support and resources for working with disabled children and families.
6. Implementing safeguarding practice within the appraisal/annual review process.
7. Conflict resolution/escalation within multi-agency working.
8. Safer recruitment Training.
9. The inclusion of safeguarding standards within contracted services.
10. Safeguarding supervision.

Agencies visited for the 2018/19 process included: University Hospital Southampton NHS Foundation Trust, Hampshire Constabulary, Hampshire Hospitals NHS Foundation Trust, South Central Ambulance Service NHS Foundation Trust and Hampshire & Isle of Wight Community Rehabilitation Company.

Across these visits, there was a good level of assurance that staff at the front-line knew how to recognise and respond to abuse, including onward referral to children's services. The level of safeguarding training, including within induction, was good with some opportunities for further promotion of multi-agency training identified. An increasing focus on a 'Family Approach' to safeguarding and child protection was highlighted as a strength, and there was good evidence that feedback from the evaluation team regarding the self-assessments and survey results had been reviewed, prioritised and embedded within the agencies' action plans.

Safeguarding in Education Audit

In 2018, there was a 96% return rate from education settings, across all sectors, regarding the annual education audit (compared to 97.5% in 2017). The figures below show the return rate across all sectors by the deadline of 30 October 2018:

- Maintained schools 99%
- Academies 87%
- Independent 79%
- Colleges 93 %

The returned audits indicated compliance across all areas and good levels of compliance with statutory obligations under Section 175 of the Education Act 2002, the Education (Independent School Standards) Regulations 2014 and the Non-Maintained Special Schools (England) Regulations 2015.

Settings that did not submit an audit received a letter from the Independent Chair of HSCB and the Director of Children's Services to re-iterate expectations regarding the audit. For academy schools, the letter was shared with the Regional Commissioner.

In the autumn term of 2018, Hampshire Safeguarding Children's Board and the Assistant Director (Education and Inclusion) of Hampshire Children's Services commissioned a quality assurance exercise in relation to the annual school audit process. This looked at a range of information regarding safeguarding procedures and practice in schools, generated through the annual safeguarding audit return.

Ten settings were selected for quality assurance visits. These were a mix of two special schools, two independent schools, two primary schools, three secondary schools and a college.

Quality assurance visits took place between November 2018 and February 2019 and were led by the Local Authority Designated Officers (LADOs) who worked with representatives from the HSCB Education Group. As part of each visit, the quality assurance team interviewed:

- The Headteacher / Proprietor.
- The Designated Safeguarding Lead (DSL).
- A long standing and recently appointed member of staff.
- The Chair of Governors (or equivalent).
- A group of mixed age /attainment pupils.

All settings co-operated well with the process and provided documentary and verbal evidence in the focus areas as follows:

1. The school's approach to undertaking the annual safeguarding audit, including the evidence base used to inform the self-assessment.
2. How closely the school's audit submission reflects practice in the school.
3. The school's use of the audit process to strengthen safeguarding governance, processes and practice.
4. Identification of what is working well and what could be improved/strengthened.

There were two additional thematic areas:

1. Allegations against staff, with reference to whistleblowing.
2. Sexual violence and sexual harassment between children in schools (or 'peer on peer abuse').

Areas of strength

- ✓ Pupils said that they felt safe in school and college and were able to explain how they were taught to recognise risk, and how to get help and support if they need it.
- ✓ There was strong evidence that DSLs are working effectively to ensure all staff and volunteers understand their safeguarding responsibilities.
- ✓ DSLs were highly valued by other members of staff and governors.
- ✓ Where self-evaluation was effective, the process and findings led to informed action planning, pro-active development and improving practice.
- ✓ There was good evidence that the DfE guidance regarding sexual violence and sexual violence between children in schools and colleges was being implemented.
- ✓ There was evidence that schools and colleges had a good working knowledge of procedures for allegations against staff.
- ✓ Where schools and colleges had managed an allegation against a member of staff, there was evidence of thorough record keeping.
- ✓ Where schools worked on the principle of 'it could happen here' there was a clear culture of self-reflection and development.

Areas for consideration

- Policies and procedures need to be regularly reviewed and website information kept up to date.
- The leadership and management of safeguarding should be considered in the same way as for a subject area or departmental/faculty responsibility; it needs the same level of management scrutiny with an improvement cycle of auditing, prioritising, planning, monitoring, evaluating and reporting.
- All staff need to be clear about how to contact the Chair of Governors or equivalent if there is an allegation against the Headteacher/Proprietor.
- All staff need to be clear about the purpose of the whistleblowing policy and how it sits separately from allegations against staff procedures.
- Governing bodies need to be clear about their roles and responsibilities for evaluating the effectiveness of their safeguarding frameworks. This is much better developed in schools and colleges where there is a robust action plan coming from the audit process.
- Governors must have a clear and accurate view of all aspects of safeguarding and the impact of policies/procedures through a formal monitoring programme.

Joint Targeted Area Inspection (JTAI) Dry Run Audit

Hampshire Safeguarding Children Board conducted a JTAI dry-run audit in December 2018 focussing on referral, assessment and decision-making processes for seven cases referred due to intra-familial sexual abuse.

The audit was carried out in line with national JTAI time-scales to identify good practice and potential areas for improvement, and to enable agencies to prepare for the conditions of a multi-agency inspection. Areas of learning were transferred into an HSCB audit recommendation tracker and monitored frequently until completion.

West Hampshire CCG led the coordination of the health response on behalf of Hampshire's five CCGs.

Areas of strength:

- ✓ Timely and effective risk identification.
- ✓ Clear evidence that the multi-agency context of the cases was recognised and understood by the safeguarding partners and a clear sense of shared ownership in respect of the actions required to keep children safe.
- ✓ Professionals working with parents/carers to implement protective strategies.
- ✓ Proactive engagement with children, and associated siblings.
- ✓ Single and multi-agency management oversight.
- ✓ Positive and proactive multi-agency working, which led to children being protected and kept safe.

A learning theme was identified regarding professional awareness of the role and remit of partner agencies in respect of Multi-Agency Public Protection Arrangements (MAPPA).

This area of learning has been taken forward through a programme of MAPPA briefing events led by the Strategic MAPPA Board with support from HSCB. An evaluation of the impact of these briefings is planned for 2019/20.

Overall, this audit provided assurance to HSCB about its ability to work together in assessing and scrutinising the outcomes achieved for children and families.

Adolescent Neglect Audit

In March and April 2019, a multi-agency group reviewed 12 cases referred and/or managed due to neglect.

The audit team held multi-agency case discussions over a two-day period with the social worker/team manager and other professionals in attendance where possible. The key strengths identified were as follows:

- ✓ The impact of neglect on the child's emotional well-being, self-worth and the ability to recognise risk was fully recognised by multi-agency professionals.
- ✓ Multi-agency information sharing regarding adults who had limited parenting capacity due to domestic abuse, substance misuse, mental ill health and/or criminality.
- ✓ Multi-agency plans included outcome-focussed actions to address concerns in relation to parenting capacity.
- ✓ Agencies were proactive in tackling the underlying issues of neglect as opposed to being reactive to the child's behaviour/events in their life
- ✓ Children and families had been involved/engaged throughout agency involvement.
- ✓ The risks associated with neglect had decreased because of multi-agency partnership work.

Opportunities for strengthening practice: application of LSCB resources/toolkits to support the multi-agency response.

Children Living in Secure Accommodation

Hampshire Safeguarding Children Board receives annual reports from two secure establishments in the local authority area (Swanwick Lodge and Bluebird House). A report is also received from Leigh House, which is an open unit that provides acute psychiatric assessment, diagnosis, treatment and care for children experiencing a wide range of psychiatric problems. These reports, which include analysis of the use of restraint, are scrutinised by the Board's Quality Assurance Group.

Swanwick Lodge

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

Occupancy

During 2018/19, Swanwick Lodge did not operate at full occupancy. Staffing vacancies and absence, alongside planned improvements to the premises through a grant award from the Department for Education, and the challenging and complex needs of the cohort of young people accessing the secure welfare estate, have been factors that have impacted on Swanwick Lodge being able to achieve full occupancy. Whilst the building works are ongoing, occupancy is reduced to eight beds with an expectation that this will increase again once the works are completed in November 2018. Due to these issues, the average percentage of occupancy in the home was 35%.

Approach to behaviour management

Swanwick Lodge has a 'positive management of behaviour' policy and procedure and continues to use the Team Teach approach to behaviour management. This approach promotes a continuum of gradual and graded techniques, with an emphasis and preference for the use of verbal and non-verbal strategies being used and exhausted before positive handling strategies are utilised. All care and education professionals receive two days of initial Team Teach training and receive one day refresher training every year.

Restraint is also minimised via individual risk assessments which aim to identify triggers to challenging behaviour and controls to minimise incidents. In addition, all young people have an individual behaviour management plan developed both in consultation with the young person concerned and via input across several disciplines including (embedded) healthcare, psychiatric and psychology services and Team Teach instructors.

All incidents involving the use of restraint are documented on incident report forms which are reviewed (along with CCTV recordings) by Swanwick Lodge management as part of a detailed de-brief. Management review and de-briefing of incidents is used to identify the antecedents to the incident and whether de-escalation strategies were used effectively by staff to

prevent both the occurrence and escalation of the incident. Risk assessments and behaviour management plans are then updated accordingly.

Incidents and the use of physical restraint are subject to regular review via internal performance monitoring arrangements and to external scrutiny Ofsted inspections (twice yearly) and by an Independent Regulation 44 Visitor (monthly).

Use of Restraint

During the reporting period, there were a total of 595 recorded incidents in the home and 434 of these involved two young people. Incidents related to aggressive behaviours by young people towards others, significant damage to property caused by young people, a lapse or breach in security or self-harm. 559 of those instances resulted in the restraint of a young person.

There was a significant increase in restraints during January 2019 due to the dynamics of the two young people who escalated their self-harming and security breach behaviours requiring physical intervention. Both displayed extremely challenging and violent behaviour towards staff, damage to property, as well as significant self-harm that resulted in staff having to intervene physically to prevent harm to self.

Each restraint will usually involve multiple holds. The complexities of the young people over the last 12 months has seen an increase in the use of more restrictive holds; lower level techniques such as guided away, and single elbow have accounted for 59% with the most restrictive holds accounting for 1%.

Summary

There has been an increase in the use of restraint in 2018/19 as compared with the previous reporting period. Internal management reviews of incidents, analysis of trends and Ofsted inspection, suggest that there are no emerging themes/issues that would indicate deterioration in the quality of care or the inappropriate use of restraint.

Swanwick Lodge Young Person's Story

Jayden is a 15-year-old male who had broken down numerous placements due to high substance misuse, prolific absconding, self-harm, fire setting and possible association with gangs.

The placement (Swanwick Lodge) was required to work with Jayden around his substance misuse, aggression, self-harm and consequential thinking as well as to try and stabilise Jayden and to engage him back into education and then the community. Jayden was placed at the home in August 2018 after several short-term placements in open residential homes around the country.

At the start of the placement, Jayden was unwilling to engage in education or take the medication that had previously been prescribed. Jayden had ADHD and without medication his behaviour was dangerous and unpredictable. He behaviour was disruptive, he was unable to concentrate, was verbally and physically aggressive towards staff and he refused to engage with substance misuse services.

The home implemented a routine of boundaries and consistency for Jayden which included a reward-based behaviour programme and took the lead in his plan by identifying what would help him.

Jayden stated that areas that would help him progress were:

- Staff using easy to understand instructions.
- Consistent boundaries.

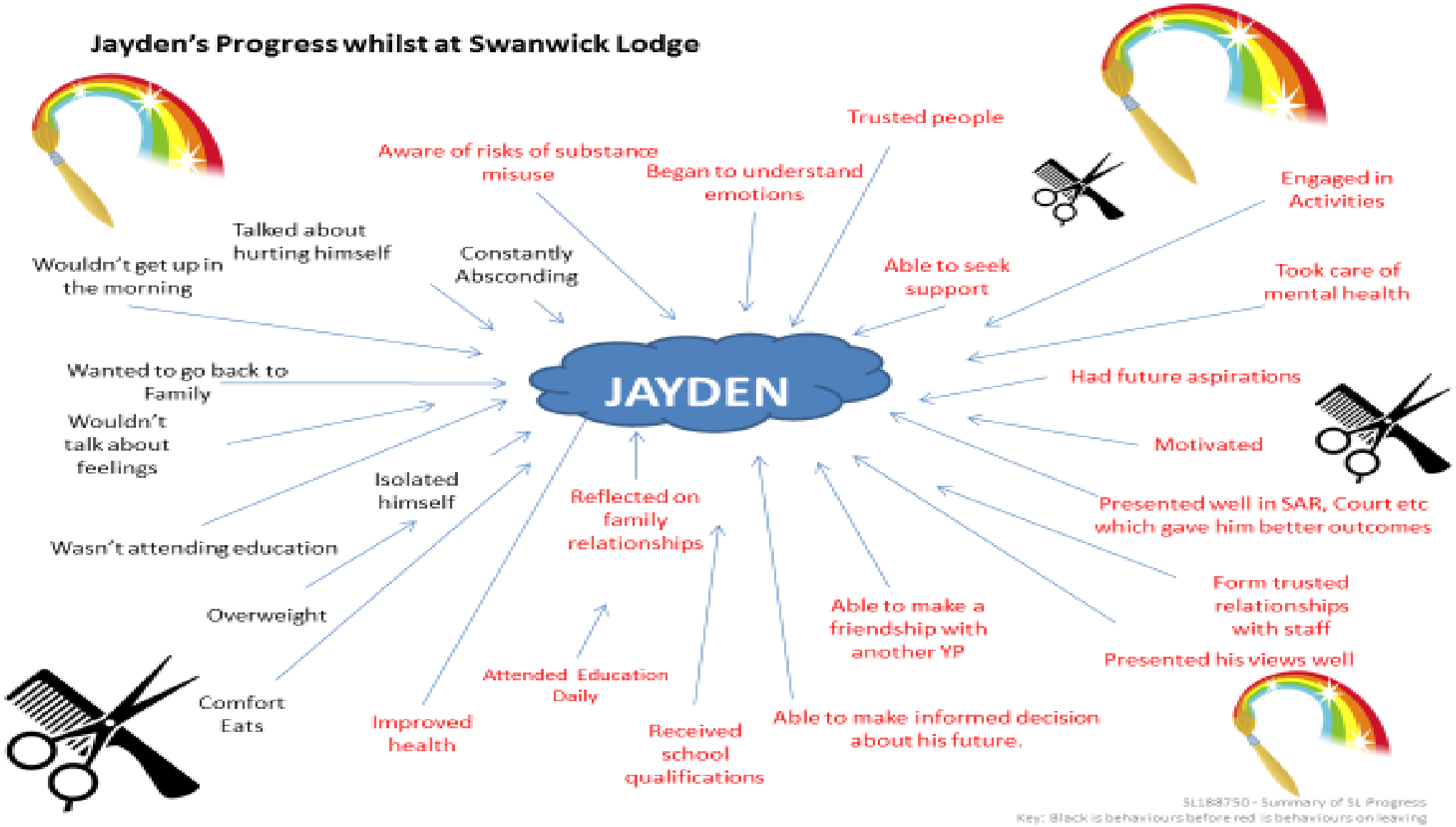
In combination with individual child-focused staff sessions held with an educational psychologist, and a multi-disciplinary team approach put together by the education, care and the health team, Jayden began to attend education and to engage with substance misuse services. Jayden began to take prescribed medication and built positive relationships with staff and other young people in the home.

Incidents of aggression and impulsive behaviour reduced, and Jayden commenced a full community mobility programme which culminated in the successful transition of Jayden to a community placement that he was excited to go to.

Prior to Jayden leaving the home, a consultation was held with the staff team and a progress sheet was put together for him, so he could see how far he had come and the positive progress that he made in all areas.

Some of the areas that really stand out are:

- He had lost weight which had been a concern due to his weight gain.
- He got up for school each day and fully engaged.
- He formed age-appropriate relationships and spoke highly of each staff member.
- He had increased resilience and self-esteem.
- He took responsibility for his future and attended meetings, his statutory reviews and he didn't rush into decisions to ensure he was given the best start to life in the community.


Jayden's Progress whilst at Swanwick Lodge
JAYDEN
Wouldn't get up in the morning
Talked about hurting himself
Constantly Absconding
Aware of risks of substance misuse
Began to understand emotions
Trusted people
Able to seek support
Engaged in Activities
Took care of mental health
Had future aspirations
Motivated
Presented well in SAR, Court etc which gave him better outcomes
Form trusted relationships with staff
Presented his views well
Able to make informed decision about his future.
Able to make a friendship with another YP
Reflected on family relationships
Received school qualifications
Attended Education Daily
Improved health
Isolated himself
Comfort Eats
Overweight
Wasn't attending education
Wouldn't talk about feelings
Wanted to go back to Family
SL18875D - Summary of SL Progress
Key: Black is behaviours before red is behaviours on leaving

Bluebird House

Introduction

Bluebird House is an adolescent forensic medium secure unit, part of the national network of adolescent medium secure services. It is a national unit, commissioned by NHS England, and admits young people from all over the country. Young people are aged between 12 and 18 years, and admission criteria include that they suffer from a mental disorder, are detained under the Mental Health Act (MHA) 1983 and pose a high risk of harm to other people. There are three wards, with 20 beds altogether.

Use of Restrictive Interventions

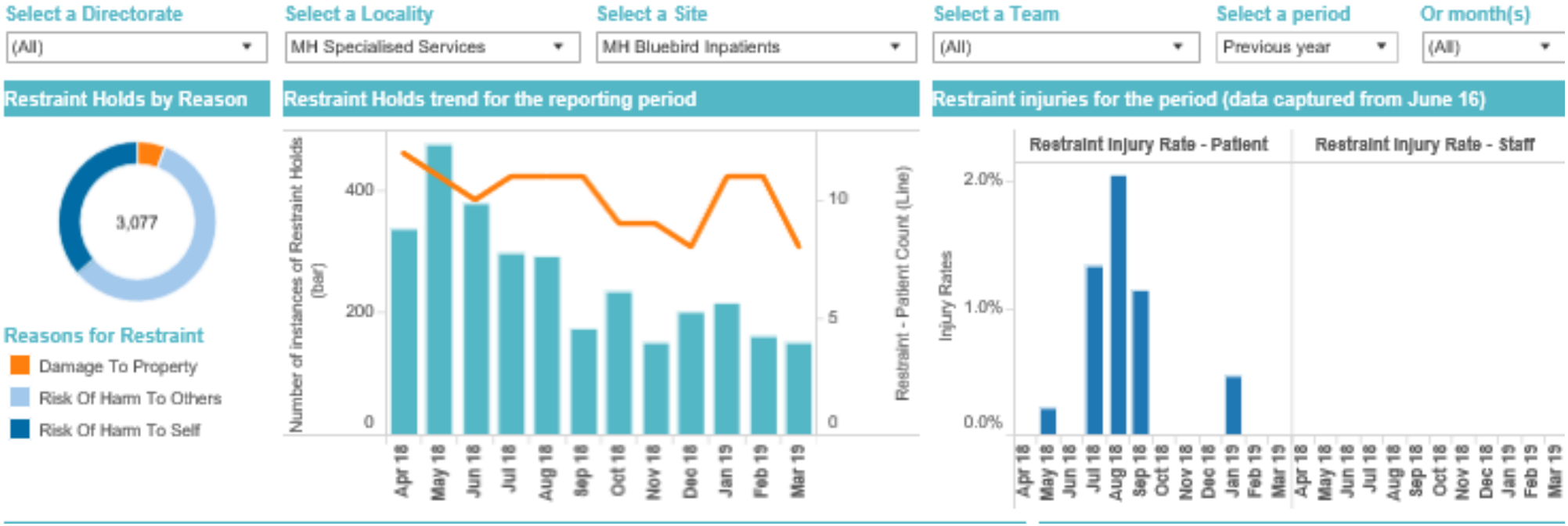
Young people admitted to Bluebird House pose many high risks of harm to others, and as such, present with a range of severely challenging behaviours. This sometimes requires the use of restrictive interventions such as restraint to manage the immediate risk, to keep not only that young person, but the other young people as well as staff members safe. All restraint is carried out in accordance with the legal framework as prescribed in the MHA Code of Practice, and trust policies and procedures.

All incidents, including episodes of restraint are reported on the trust incident reporting system. This information is available to clinical teams in Bluebird House to identify emerging trends, and to track the progress of individual young people.

Although Bluebird house was commissioned for 20 medium secure beds originally, from September 2017 there has been a maximum of 13 medium secure and six low secure beds available for occupancy. This bed configuration has remained the same throughout 2018/19. The occupancy has been 61.38%.

Use of Restraint

There were 3,077 episodes of restraint in 2018/19 and this is a reduction of 679 incidents on the previous year.

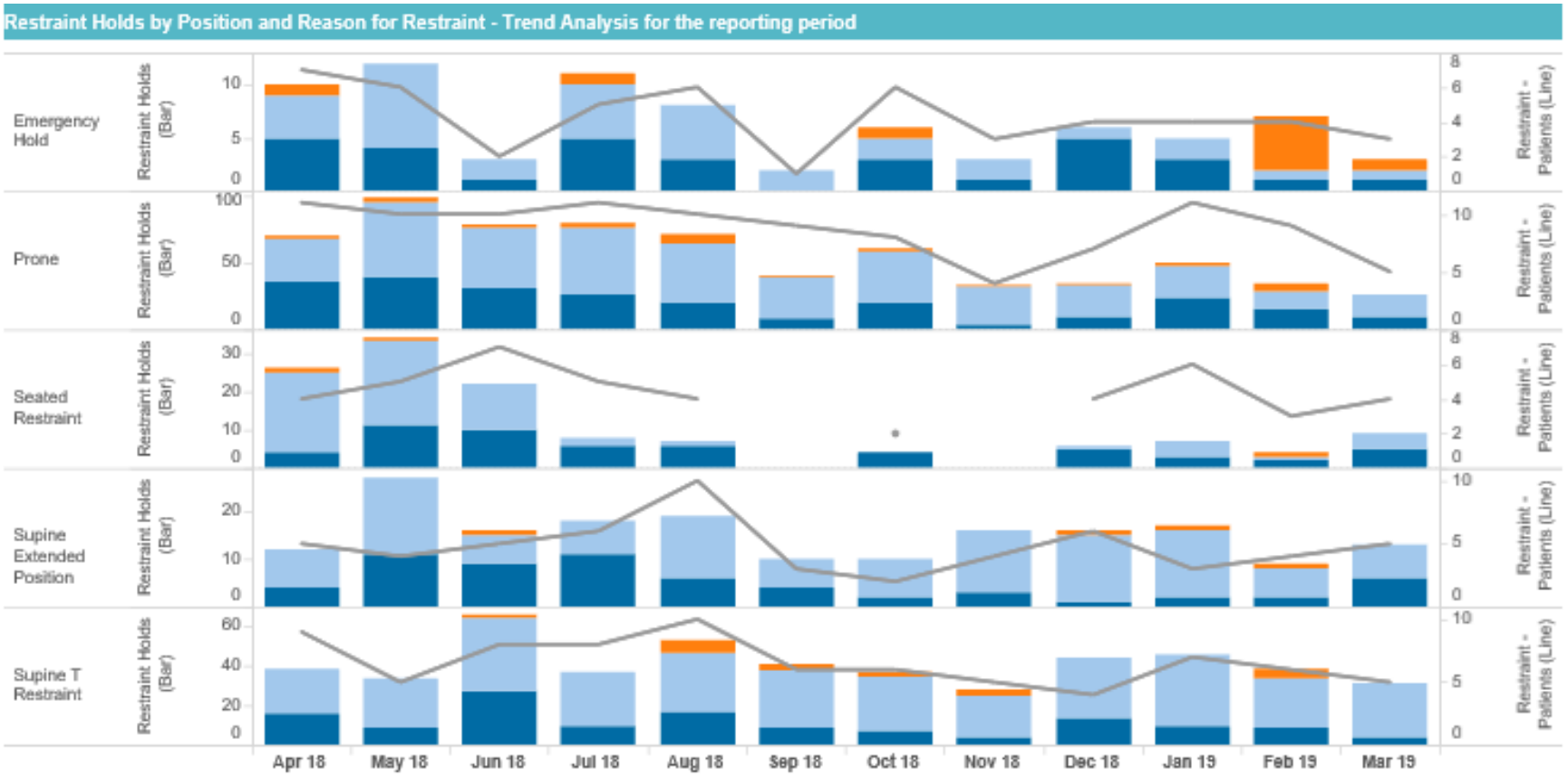


Of these, 1,785 were required to manage the risk of harm to others, 1,114 interventions were to manage risk of harm to self, 178 to stop patients from inflicting serious damage to property, and this year there were no incidents reported where the cause of the intervention was unknown.

Over the last year, the medium secure ward has been involved in the national reducing restrictive practices quality improvement project and this has led to continual review of internal processes including staff inductions. This project has involved frontline staff and young people working together to reduce seclusion, restraint and rapid tranquilisation on the ward.

Of the 3,077 episodes of restraint recorded in 2018/19, 681 episodes involved the use of prone restraint, while 676 episodes involved the use of supine restraint. The hold known as 'walking figure of four' was used 598 times, whilst the hold described as 'seated figure of four' was used 369 times.

The next graph shows the use of all holds across the unit. This clearly demonstrates a shift from the use of prone restraint and team continues to work towards reducing this number further.



Analysis

- Restraint continues to be necessary as an intervention of last resort, when other measures such as de-escalation have failed.
- The use of prone restraint has declined as a percentage overall over the last year.
- Initiatives are in place to reduce the use of restrictive practices described in an action plan which is reviewed regularly through a local governance forum.
- A development programme is in place for all Band 6 staff that covers the duty senior nurse role and management of incidents as they occur within the unit.

Bluebird House Young Person's Story

Jade lived at home in an unpredictable family environment. She moved around London with her mother, had short periods of time where she lived with other family members, moved abroad and at times lived between her mother and her father. When Jade was around the age of nine her mother left her with a suitcase at a children service department. It is reported that Jade's mother turned to her abruptly and briefly said goodbye.

Jade has a history of being extremely violent and causing significant property damage. Jade's violence has been the primary cause of her multiple placement breakdowns. She has some history of self-harm (e.g., superficial cutting/scratching and has attempted to tie ligatures), however this has been a rare behaviour.

Early into her admission, Jade really struggled to build stable and reliable relationships with staff. During this time, to support Jade with day to day life and difficult feelings and emotions, a Zoning Care Plan was completed collaboratively with Jade. This plan has different coloured zones that describe how Jade is feeling in each one (red-crisis, orange-starting to struggle, green-okay, and blue-feeling low) and how she may present when in the zone. It also outlines early warning signs as well as what Jade and the team can to if she requires support. This gave both Jade and staff an insight into how she experiences different emotions and how to best support her. This was especially important during a time when Jade had not yet made positive attachments and thus did not feel safe and able to communicate her needs or when she was struggling. As staff began to get to know Jade better they were able to support her even when she did not seek out support herself. Staff could identify when Jade was struggling and support her appropriately. The support she received then, and continues to receive at the time of writing, enables Jade to feel an increase sense of safety and in return she can have key attachments which she uses for support.

Since being at Bluebird House, Jade has been able to develop new coping strategies that she can access and use instead of violence. Staff can now lone work with her (something that was assessed as high risk previously) and she has also achieved long periods of Section 17 leave. Finally, incidents of violence have significantly reduced and in general there has been a stable continuous decline in all types of incidents.

Engagement

- The Board engages with children, their families, and professionals to receive feedback on its work and to gain assurance that services to support children in Hampshire are fit for purpose.

Multi-Agency Professionals

During 2018, the HSCB ran eight Regional Practitioner Forums. The forums operate twice a year in several locations including the Winchester Diocese, New Forest District Council and Havant Council. The events are free to attend and are supported by the generosity of our Board partners who enable us to use their facilities at no cost.

The Regional Practitioner Forums are aimed at frontline professionals and provide an opportunity to brief staff on learning from reviews and audits (e.g. Serious Case Reviews), increase knowledge of updated policies and procedures and consult on new initiatives and resources such as the Unidentified Adults Toolkit and the Abusive Head Trauma (ICON) campaign. The forums also enable professionals to receive briefings from other agencies and areas of work. This year the forums included presentations from CAMHS, the Family Support Service along with briefings from Children's Services and the Strategic Multi-Agency Public Protection Arrangements (MAPPA) Board. At each forum, attendees are asked for feedback on areas to escalate to the Board and/or its subgroups, as well as themes or agencies that they would like to learn more about at future forums.

The first round of practitioner forums was held during May 2018 and the second round over November 2018. These events were attended by approximately 270 professionals from across the multi-agency partnership. For the November forums, 100% of those completing the post-course survey (48 in total) indicated they agreed or strongly agreed that they were engaged throughout the event and were clear about how to implement the learning to their practice.

'Really well-presented information session'.

'Very informative and relevant training'.

HSCB also arrange the popular Multi-Agency Safeguarding Hub (MASH) workshops over the course of the year. Four workshops were attended by over 180 professionals in 2018/19. Feedback regarding these events has been positive with more planned for 2019/20 given the demand.

Children and Young People

During 2018/19, HSCB has engaged with children and young people on several different areas of work.

HSCB have a proactive relationship with the Police and Crime Commissioner's Youth Commission. HSCB's Partnership Support Team meets with the Youth Commission several times a year to consult with them and receive feedback on different themes.

OPCC Youth Commission

In this reporting period, the Youth Commission were involved in planning for the content of the ICON abusive head trauma Personal, Social, Health and Economic (PSHE) lesson. They provided advice on how to present the materials and engage with young people recommending that it was an interactive session.

The Youth Commission were invited to provide support and independent scrutiny to the work of the pan-Hampshire and Isle of Wight child exploitation group, which was established in the autumn of 2018 to ensure a cross-local authority response to these issues.

Members of the Youth Commission attended the joint HSCB/HSAB annual conference in January 2019. The event was also attended by post-16 students and trainee social workers from the adults and children's sector.

The Youth Commission were consulted on to provide input into the HSCBs work on online safety. The feedback was used to inform the specification for a newly commissioned course for professionals on safeguarding in the context of social media.

In 2018/19, the Board established a network/group to promote a joined-up approach to participation between partner agencies and to coordinate activities, where appropriate, with children, young people and their families.

Youth Parliament

The HSCB met with the Hampshire members of the Youth Parliament to seek their views on our plans to promote the ICON programme within schools. Members had some clear ideas on how this could best work, suggesting that the subject be covered in PHSE lessons rather than in Tutor time, recommending which age groups to target, and suggesting the most effective ways to include factual but sensitive information on abusive head trauma. These suggestions all went forward to inform the lesson plan.

Early Years Sector

The HSCB Partnership Support Team has provided learning and themes arising from SCRs and MARs to support the Hampshire County Council Services for Young People team to develop a termly programme of safeguarding briefings for Early Years providers including nurseries, pre-schools, childminders and nannies.

The support team have also developed briefings on a range of safeguarding topics including Neglect, families that move across borders, 4LSCB online procedures and child and family engagement. The briefings, which also include updates from the Board as well as local and national guidance changes, provide the opportunity for the Early Years sector to inform the work of the Board and request themes for future safeguarding events.

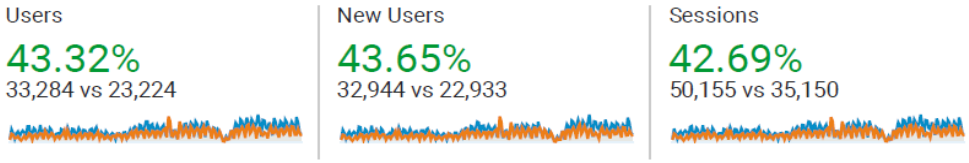
HSCB Website

HSCB continued to develop its website during 2018/19 and the Partnership Support Team developed the following toolkits to support professionals:

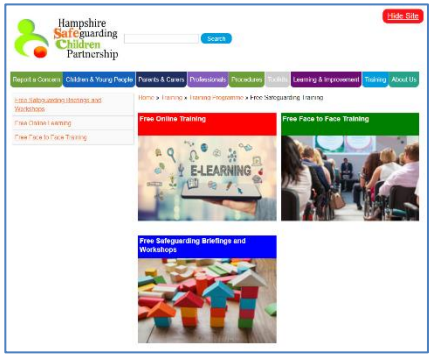
- Female Genital Mutilation (June 18)
- Abusive Head Trauma/ ICON (September 18)
- Adopting a Family Approach Joint Toolkit (January 19)

During 2018/19, there were a total of 50,155 visits to the HSCB website compared to 35,150 in 2017/18. This reflects a significant and positive increase in the reach of the Board's work.

<u>Website Stats in 2018/19 vs. 2017/18</u>



2018/19 showed a 43% increase in unique users and individual visits to the HSCB website. There were 6,731 return visitors to the website, who accounted for 17% of the unique users. The training pages proved the most popular followed by the Report a Concern page.



Communication from the Board

Newsletters are produced after each Board meeting for dissemination across the HSCB network. They provide an overview of decisions made by the Board, signpost to any new policies or resources and give notice of upcoming events and training.

The 4LSCBs across Hampshire & Isle of Wight also produced regular briefing documents (Spotlight On) to highlight changes and promote awareness and understanding of key policies, procedures and other resources. These briefings summarise key learning points from the full protocols and in 2018/19, topics included:

- Child and Family Engagement Guidance.
- Key 4LSCB Procedures.
- 4LSCB Protocol for Protecting Children who move Across Local Authority Borders.
- 4LSCB MET Information Guide.
- HSCP & IOWSCB Neglect Toolkit.
- 4LSCB Bruising Protocol.

Hampshire CAMHS Campaigns

Last year, the campaign 'Everybody' focused upon body image, self-esteem and eating disorders. The aims of the project were to:

- Raise awareness and promote better understanding of eating disorders.
- Improve knowledge and encourage early identification of eating disorders.
- Promote awareness of where and how to make referrals to Hampshire CAMHS Specialist Eating Disorder Team.
- Improve body image acceptance, self-esteem and confidence in young people.
- Promote compassion and kindness.
- Inspire and empower young people to develop positive ways of coping.

The campaign included the 'Great Big Bunting Off'. This project was an inclusive, colourful and ambitious celebration of difference and diversity. The service received over 21,000 flags with at least 91 organisations taking part. School body image workshops were run and approximately 1,800 young people took part. The service produced regular newsletters for schools and topics included: Fitness; Activity and Exercise; Food and Nutrition; Personal Expression and Creativity; Values, Talents and Strengths; Kindness and Compassion; Internet Awareness and Digital Downtime; Friendship and Family; Communication and Connecting with each other. The service produced A5 stickers to raise awareness of eating disorders and distributed them to every GP practice in Hampshire as well as via the school nursing service and other youth organisations. Ambassador events were facilitated, and 268 young people took part. A professionals' conference was also held and 85% of delegates rated that their knowledge and awareness had increased 'very much' or 'a fair amount'.

Leadership and Transformation

- The HSCB leads the safeguarding agenda, challenges the work of partner organisations, and commits to an approach that learns lessons, embeds good practice and is continually influenced by children, young people and their families.

New Safeguarding Arrangements

A key part of the Board's work this year has been to prepare for the change in statutory guidance following the publication of Working Together 2018. Working Together outlines how current Boards will cease to exist during 2019/20 to allow for the design and implementation of new Safeguarding Partnerships, led by the three new Safeguarding Partners: Local Authority, Police and Clinical Commissioning Groups (CCGs) for the health economy.

In preparation for these new arrangements the Board undertook a full consultation with all members and agency representatives in 2018/19. The focus of discussions was to seek views on how to respond to the changes, whilst being clear on which elements of the current Board arrangements were working well, and to use the opportunity to consider how things could be done differently to add greater value.

The themes arising from this consultation were discussed at a development day in January 2019 and informed the new business plan. The new Hampshire Safeguarding Children Partnership arrangements were published on the Board's website.

Key safeguarding issues

Neglect

Neglect seriously impacts on the long-term life chances for children. Neglect in the first three years of life can seriously effect brain development and have significant consequences through adolescence and into adulthood.

Neglect is defined as:

'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy because of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- *Provide adequate food, clothing and shelter (including exclusion from home or abandonment).*
- *Protect a child from physical and emotional harm or danger*
- *Ensure adequate supervision (including the use of inadequate care-givers).*
- *Ensure access to appropriate medical care or treatment.*

*It may also include neglect of, or unresponsiveness to, a child's basic emotional needs' (*Working Together to Safeguard Children 2018).

The table below indicates a reduction in the number of children in Hampshire who are subject to a Child Protection Plans (CPP) under the category of neglect. Despite this reduction, the annual referrals to children's services under the category of neglect increased by 178 and 80 in 2018/19 and 2017/18 respectively. The Board has undertaken considerable work on neglect and its impact in the last two years and the figures show greater awareness of the indicators of neglect among professionals.

Number of children who were the subject of a child protection plan (CPP) at 31 March by initial category of abuse[4]

		2016/17	2017/18	2018/19
Hampshire	CPP	1,263	1,294	1,091
	Neglect	829	950	663
	%	65.6%	73.4%	61%
South East	CPP	7,980	8,980	Comparative data not yet available
	Neglect	4,490	4,930	
	%	56.3%	54.9%	
England	CPP	51,080	53,790	
	Neglect	24,590	25,820	
	%	48.1%	48%	

[4] Each period is a snapshot as at 31 March of each statutory year. Statutory year statistics extracted from DfE published reports.

HSCB commission bespoke multi-agency training to support the implementation of the neglect strategy and toolkit. The training commenced delivery in 2018 with 73 professionals attending between April 2018 and March 2019.

A longitudinal evaluation of the training took place in 2018/19. Overwhelming, all delegates who completed an evaluation form reported that they would describe the course positively to their colleagues. Language used included: excellent, worthwhile, helpful, informative and very practical. In addition, 90% of respondents indicated positive responses for all the survey questions. The opportunity to share ideas, deepen knowledge and reflect with a range of colleagues was viewed as beneficial, which demonstrates the value of the Board's multi-agency training, which is provided at no cost to partner agencies. All delegates who responded to a request for feedback two-months after the course indicated that they could give specific examples of how the learning had been applied in practice, which was positive.

Domestic Abuse

In the Hampshire Local Authority Area, the 2018 needs assessment estimated that the following numbers of people had been affected by domestic violence and abuse in the previous year:

- 15,607 men and 30,083 women aged 16-59.
- 734 men and 2,306 women aged 60-65.
- 1,345 men and 5,615 women aged 66 and over.

This includes:

- At least 544 men and 705 women who identify as lesbian, gay or bisexual.
- 1,000 women and 368 men of Asian origin.
- 481 women and 323 men of Black origin.
- 13,296 women and 5,799 men with some degree of limiting disability or health problem.
- Over 40,000 children affected.

The effects of domestic abuse on children are well-researched and there is a wealth of good evidence on its significant impact on children's mental, emotional and physical health, and on the development of their subsequent

choices and behaviours as adults. The importance of early identification and intervention is stressed in national and local strategies, both to prevent further immediate harm to the children concerned and to promote healthy relationships for those children's futures.

National research indicates that 12% of children aged under 11 and 18% of children aged 11-17 had been exposed to domestic violence and abuse between adults in their childhood. If these percentages are applied to the Hampshire population, it suggests that 21,034 under 11s and 19,351 11-17s have experienced domestic abuse between adults in their homes (40,385 in total).

The Hampshire Domestic Abuse Partnership (HDAP) reports to the Hampshire Safeguarding Children Board and through its multi-agency domestic abuse strategy, places a strong focus on reducing the impact of abuse on children, adults at risk, families and communities. Through this work, they aim to achieve the best outcomes for children, to protect those most vulnerable to the impact of abuse and to reduce the cycle of abuse through a whole family approach.

The greatest development during the last 12 months has been the recommissioning and start of a new domestic abuse support service, aimed at all members of the family (including perpetrators, victims and their children), called the Hampshire Domestic Abuse Service. As part of this service (which is provided by Stop Domestic Abuse and the Hampton Trust), there is a new 'front door' or single way into to all services via the Advice Line. Stop Domestic Abuse will act as the first point of contact, information, advice, assessment and triage for victims, their children, perpetrators and professionals – providing a whole family approach.

In addition to the Advice Line, the Hampshire Domestic Abuse Service will provide early intervention and prevention (including some training to professionals), interventions and support to all members of a family – this may include refuge, one to one outreach, group work, dedicated interventions for children and young people and interventions for perpetrators. The service will also provide some support to the new High-Risk Domestic Abuse (HRDA) process which works alongside the Multi-Agency Safeguarding Hub (MASH) and Multi-Agency Risk Assessment Conferences (MARAC).

Further information about the new service and the wider Hampshire Domestic Abuse Partnership can be found at the new HDAP web pages.

Domestic Abuse Pathway for Health Professionals

A Task and Finish Group led by the Named GP (North Hampshire CCG) and the Designated Nurse (West and North Hampshire CCGs) developed a health-specific screening tool, which includes 'opening questions' and 'screening questions' and a pathway for victims of Domestic Violence and Abuse. The pathway, which was approved by the Hampshire Domestic Abuse Partnership and the Hampshire Safeguarding Children Board, was launched across health in 2018/19. Training regarding the use of the pathway has been delivered across Primary Care at several forums including the Lead GP Safeguarding Training, target events and GP trainee conferences.

Operation Encompass

Operation Encompass, implemented within Hampshire in 2017/18, involves information-sharing between police and schools when a child or young person has been exposed to, or involved in, any domestic incident. This enables schools to make provision for possible difficulties experienced by children, or their families involved in these situations.

In 2018/19, 9,216 Operational Encompass notifications were sent to Hampshire and Isle of Wight schools, which enabled actions to be put in place to support children impacted by domestic abuse within the family home.

Hampshire Constabulary completed an evaluation process by means of a survey to schools to assess the impact of the initiative. 382 responses were received from Head teachers and Designated Safeguarding Leads (DSLs) and 87% agreed or strongly agreed that the Operation Encompass process provided relevant information for schools to enhance their safeguarding of children.

Further work is being undertaken to scope the inclusion of post-16 settings in 2019/20 along with reviewing and refining the processes.

Children at Risk of Exploitation

The multi-agency working to identify children and young people who may be at risk of exploitation and trafficking was a key priority area for 2018/19. Children deemed at risk are managed through the Hampshire Operational Missing, Exploited and Trafficked Group. The work from this group is carried

forward through the multi-agency specialist Willow Team and Hampshire Constabulary's Missing, Exploited and Trafficked Team.

The dominant themes of child sexual exploitation in Hampshire present as:

- **County Lines/Criminal Exploitation** – There is increasing evidence of transient/out of county drug dealers exploiting vulnerable children to commit criminal acts through drug dealing. This will include children going missing and being trafficked and groomed to engage in criminal activity such as shop lifting.
- **On-Line exploitation** – Perpetrators using the internet to groom and exploit vulnerable children with the aim of committing sexual offences as well as enticing children to engage in criminal activity. Given the global nature of the internet, the perpetrators are not always present in the UK.
- **Peer-on-Peer sexual exploitation** - Particularly notable in cyber enabled sexual exploitation offences where there are higher levels of young people communicating on line, using Apps dangerously and sharing sexual images. Peer groups also can have elements of sexual behaviours as part of gang/peer group activity.

Work started in 2018 to bring together the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) child exploitation subgroups in recognition that child exploitation is not limited by geographic boundaries. This group, chaired by the Head of Serious and Organised Crime for Hampshire Constabulary, reflects a commitment to collaborate with other local authority areas on this key safeguarding issue. A cross-area action plan was developed including 14 outcomes to be delivered over a two-year period. The actions are mapped to five domains:

1. Understand and Identify
2. Prevention
3. Intervene and Support
4. Disrupt and Divert
5. Scrutiny and Oversight

These arrangements will be developed further in 2019/20 including continued scrutiny from the Police and Crime Commissioner's Youth Commission who attend the meetings and contribute to delivery of the action plan.

County Lines Workshops

HSCB delivered four county lines and gang exit workshops to multi-agency professionals in March 2019. These sessions were delivered by Junior Smart, founder of the SOS Gangs Project, and colleagues from the children's social care led specialist multi-agency Willow Team and the police Missing, Exploited and Trafficked Team.

These workshops were attended by over 275 professionals and feedback was extremely positive.

Following the workshops, delegates rated their understanding of the subject as positive with learning gains regarding the national picture and how this translates to issues within Hampshire.

95% of delegates indicated that they were clear about how the learning from these events would be implemented in their practice and 99% agreed that there would be value in running similar events over the coming year.

'This event was brilliant, very informative and interesting… I learnt so much more from this training that I will use in my everyday job'.

'Great to have a guest speaker who has direct knowledge/experiences but proof that you can change mindsets and support young people to choose a different path'.

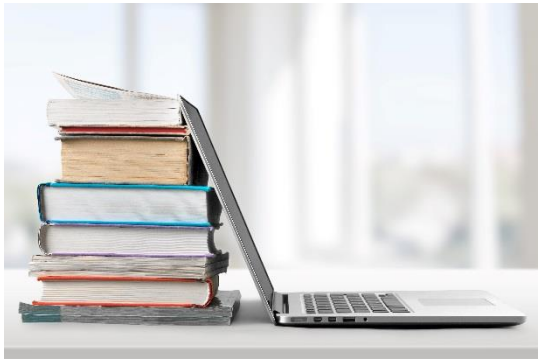
Safeguarding Training for Taxi Drivers

In 2018/19, HSCB endorsed an updated version of the New Forest District Council (NFDC) mandatory training for taxi drivers. This training, which is a requirement of the licence process, is fully embedded within NFDC and ensures that drivers are aware of their responsibilities in keeping children and young people safe and can report their concerns. The number of new drivers passing the safeguarding module and being granted a driver licence module from 1 April 2018 to 31 March 2019 was 200. Further work is being undertaken in 2019/20 to ensure that this approach is more broadly coordinated across the 11 district/borough/city councils.

The Willow Team

The Willow Team is a children's social care led specialist multi-agency child exploitation team launched in September 2015. The team comprises a team manager, three social workers, two specialist CAMHS Mental Health Practitioners, one child and family support worker (CFSW) and administrative support. The Willow Team works collaboratively with Hampshire Constabulary's Missing, Exploited, Trafficked (MET) team, Hampshire's Youth Offending Team, Barnardo's workers and various health teams.

The team operates across Hampshire and works directly with children identified at risk of one or more elements of child exploitation. The team receives referrals from Hampshire's Multi Agency Safeguarding Hub (MASH) relating to children who are not currently open to Children's Services and where concerns are raised that they are at high risk of or being exploited. In addition, the Willow Team supports missing children and those at risk of, or being, trafficked which often goes together with child exploitation.



The team takes cases from the CAST teams within social care for children already open. In these cases, support can be offered in several ways such as:

- Direct work with the child/parent/carers/residential workers.
- Mentoring to professionals including teachers, social workers and school nurses to support them to undertake direct work with the child.
- Consultation advice and support to professional groups.
- Undertaking awareness initiatives.
- Disruption of perpetrators in collaboration with Hampshire Constabulary.

An external evaluation was undertaken by The Institute of Public Care at Oxford Brookes University, which focussed on the quality and impact of support to young people identified as being at risk of sexual exploitation. The report highlighted that:

'Local agencies have a good understanding of the remit of the Willow Team and that there is strong support for a dedicated multi-disciplinary team providing a range of services including 1:1 work with children at risk, or who have suffered from CSE'.

'Where the young person engages with the Willow worker, they and their key carer(s) almost invariably appreciate the warm, non-judgemental approach and the ability of the worker to educate both the young person and the broader family about risks relating to sexual exploitation (through use of one to one conversations, DVD's, and worksheets)'.

Unaccompanied and Separated Children

There were 163 Unaccompanied Asylum-Seeking Children (UASC) at the end of March 2019 compared with 113 at the end of March 2018.
The increase is due to Hampshire Children's Services being proactive in the National Transfer Scheme whereby those local authorities with high numbers of UASC can transfer young people to an authority with lower numbers. In contrast to last year, there has been a reduction in the number of spontaneous arrivals in Hampshire.

Hampshire County Council continues to offer foster care as a first response including all the support that comes with a wrap-around Children Looked After plan. The Willow Team supports all unaccompanied asylum-seeking children and undertakes trafficking assessments. Social workers from the team will also support with age assessments where deemed necessary.

Willow Team also refers to the Barnardo's Independent Trafficking Advocates (ICTA) Service. Children's Services also undertake a Section 47 investigation on all new UASC coming into Hampshire.

Willow Team Case Study

Willow Team became involved in an exploitation investigation in the south of the county. Of interest was the fact that many of the issues were spread across our County Borders so involving other local authorities. Operationally, all agencies worked very well together and for the first-time, social care staff from different authorities became embedded alongside police colleagues in a very close way. This offered cross-border working and joined up approaches to sharing resources.

One family came to our attention due to a teenage female said to be in a relationship with one of the males who we felt was a risk. The family did have several issues of note and when we considered child trauma and 'push' factors, we noted a history of issues around behaviour and the children in the family experiencing neglect and so some traumatic experiences. Different agencies in Hampshire have started to explore the impact of child trauma and having Adverse Childhood Experiences (ACEs). Whilst social care staff have this embedded in their work it's positive that other colleagues are using this model to enhance their communication with children and support for families.

The family of concern was assessed, and we offered trusted Willow Worker relationships which were positive, supportive, and trauma-informed. We worked alongside the female on her relationships and offered her different insights and alternative thinking about her previous experiences with boyfriends. Some of this was around knowing how grooming takes place, power issues in relationships and outlining clearly the risks to relationships not built on trust and respect.

The success for us comes again from her being able to speak openly about her experiences and she has subsequently left that relationship. Other issues in the family are being supported by a multi-agency plan and the worker is confident that this child will be able to make safer choices in her relationships as she continues to grow.

Hampshire Constabulary Missing, Exploited and Trafficked Team

Throughout 2017/18, Hampshire Constabulary's Missing, Exploited and Trafficked Team (METT) has developed a greater focus on perpetrators of exploitation and the trafficking of unaccompanied asylum-seeking children, whilst maintaining the current partnership management of young people at risk from criminal and sexual exploitation.

The METT continues to proactively manage those children who are at the highest risk of Child Sexual Exploitation (CSE) and now those at highest risk of Child Criminal exploitation (CCE). This includes those children involved with drug dealing networks often referred to as 'county lines'. The safeguarding of young people often involves a focused review and management of missing incidents, with a renewed focus on targeting and disruption of perpetrators. The use of Child Abduction Warning Notices (CAWNs) has proved an effective tool in managing and preventing further harm. The team is also pioneering the use of the C5 perpetrator notice to identify and divert those people who display worrying sexual behaviour but whose actions have not reached the threshold for a prosecution.

One of the METT aims is to decrease the demand that frequent missing children place on colleagues by seeking practical solutions to reduce the number of incidents. This is achieved through proactive intervention and effective partnership working. The team also support colleagues conducting missing person investigations, providing up-to-date information on risk management plans and, where possible, offering practical support and expertise.

In addition, the team seek to identify victims and perpetrators at the earliest opportunity and to coordinate the initial police response, as well as raising awareness within districts of vulnerable individuals, directing any intervention and safeguarding work where it is appropriate to do so, allowing leaders to better manage and reduce the risk of harm.

The engagement with perpetrators and management of vulnerable young people allows the METT team to develop a detailed understanding of mechanisms underpinning and driving exploitation of young people. From this process, intelligence gaps are identified and public, police and partners can be tasked to assist with filling those gaps. The public is encouraged to use Crimestoppers or local police to report intelligence, and partners make

use of a bespoke intelligence submission process using a Community Partnership Intelligence (CPI) form.

In 2018/19, the METT was led by Detective Chief Inspector Nick Plummer, with support from Detective Inspector Ross Toms, Detective Inspector Lee Colvin and Detective Sergeants Leith Morrison and Matt Gillooly.

Child Exploitation and the CCGs

During this reporting year, the Hampshire Missing, Exploited and Trafficked (MET) multi agency strategic group who reported into the HSCB changed its title to the Strategic Exploitation Group. This was to ensure that areas of modern slavery, Prevent and child criminal exploitation were incorporated. Further revision was made as the four children's boards within Hampshire, Isle of Wight, Southampton and Portsmouth (HIPS) agreed to amalgamate into a HIPS Child Exploitation Group. The West Hampshire CCG Director of Nursing represented the Hampshire Clinical Commissioning Groups on this group in 2018/19.

The Designated Nurse for Looked After Children represented the five Hampshire CCGs on the HIPS Child Exploitation Operational Group.

Guidance for Primary Care was developed to support the completion of the Community Partnership Information Form (CPI) to share information regarding young people who may be at risk of exploitation.

Suicide and Self-Harm

Hampshire's suicide rate is lower than the England average. Comparable to national data, the male rate is around three times higher than the female rate. Despite the lower than national rates, suicide prevention is a priority for Hampshire. The effects of a suicide on family, friends and community are huge. It is estimated that for every person who dies by suicide, 135 people who knew the person will be exposed. Each suicide affects a large circle of people who may need clinician services or support following exposure.

Every year, Hampshire Public Health conduct an audit of suicide deaths. This is across all three coroner offices who cover the Hampshire County area. The suicide audit provides local contextual evidence, which informs the suicide prevention strategy and action plan.

A total of 344 deaths were audited over a four-year period. 48 (14%) of the suicides were children and young people aged 24 years and under. In the UK, suicide is the leading cause of death in young people, accounting for 14% of deaths in 10-19-year olds and 21% of deaths in 20-34-year olds. The number of children and young people dying by suicide in Hampshire is small and over recent years has decreased. The risk factors identified before suicide are common in young people; most come through them without serious harm.

The latest national report S*uicide by Children and Young People, July 2017* reported that suicide in young people is rarely caused by one thing; it usually follows a combination of previous vulnerability and recent events. This is evident in our local audit; the lives of the children and young people were quite often chaotic and had many antecedents of suicide recorded. Many stemmed from early childhood including sexual/physical abuse, domestic abuse and bereavement. Relationship problems and poor mental health factored in many of their lives. There were only two deaths which appeared to be 'out of the blue'. Self-harm, including attempted suicide, is the single biggest indicator of suicide risk; the local audit has suggested that some children and young people with complex and multi-faceted lives who self-harm may not be known to services.

Key messages and important themes for suicide prevention from the national report resonate with local findings. These are support for, or management of, family factors (e.g. mental illness, physical illness or substance misuse), childhood abuse, bullying, physical health, social isolation, mental ill-health and alcohol or drug misuse.

Suicide Prevention Programmes of Work

Through the work of the multi-agency Hampshire Suicide Prevention Forum, work has been undertaken in the following areas in the period 2018-2019:

Postvention Protocol for Schools and Colleges

This was developed in 2017 to assist schools and colleges in the event of a (suspected) suicide by a member of the school/college community. The protocol was developed with the aim of preventing further suicides by helping staff identify those who might be struggling and signposting them

to relevant support and process. The protocol also helps schools and colleges plan and to think about what they might do if they were ever (tragically) in this position. The protocol has been used in Hampshire to support establishments when the need has arisen.

Sustainability & Transformation Plan (STP) HIOW

Hampshire Public Health has developed a plan in conjunction with Public Health colleagues in Portsmouth, Southampton and the IOW, NHS and other key partners to further develop suicide prevention programmes of work in the following areas:

Suicide Prevention in Primary Care: Embedding robust risk identification and care planning for those at risk of suicide. This is likely to include training, development of comorbidity pathways and other support mechanisms, ensuring that those presenting in primary care who are at greater risk are identified and supported.

Bereavement Support and Postvention: Delivering improvements in quality and capacity of the bereavement support offer. This will ensure, through a more robust pathway between first responders, other key partners (i.e. Coroners, schools, police) and bereavement support services, comprehensive postvention support is available across the STP area.

Workplace Health: Focussing on key employers and those professions where there is a higher risk of suicide identified through local suicide audits (i.e. those that are employers of middle-aged men and minority and more vulnerable groups) to work with them to promote clear pathways of support, training and awareness of suicide.

Self-Harm and Crisis Care: Reviewing the self-harm pathway for adults and CYP to improve assessment and identification and pilot and develop an effective model of support and care. This approach will include training for front-line staff (clinical and non-clinical) to have conversations and provide appropriate level of support / advice for people about self-harm.

Workshop for those with Lived Experience of Suicide: A workshop took place in March 2019 for those with lived experience of suicide. Those with lived experience includes those who are experiencing, or have previously experienced, suicidal thoughts/behaviours as well as those who have been bereaved by suicide. There is a plan to take forward this work to develop a 'team' of those with lived experience who will be able to plan and help implement parts of the Hampshire Suicide Prevention Strategy.

Emotional Wellbeing

Emotional wellbeing is an area of both national and local concern. A local needs assessment for Hampshire Children and Young people has identified:

- Children and young people aged 5-16 with mental health disorders (2015) =15,716.
- Young people aged 16-24 with a potential eating disorder (2013) =17,414.
- Young people aged 16-24 with Attention Deficit Hyperactivity Disorder (2013) = 18,518.

An Emotional Wellbeing and Mental Health Strategy for Children and Young People (2019-2022) has been drafted with a strong theme around

safeguarding and early intervention to stop mental health problems from escalating, this is aligned with the Hampshire Children and Young People's Plan and will be delivered through the Starting Well for Emotional Wellbeing and Mental Health Partnership. The strategy aims to promote emotional wellbeing as well as early intervention. The six Priorities areas are:

1. Children and Young People's emotional wellbeing and mental health is everybody's business.
2. Support for good mental health of parents.
3. Whole school/educational setting approach to mental health.
4. Supporting mental health of vulnerable children and young people.
5. Reducing rates of self-harm.
6. Improvement of service provision.

Workforce Development

HSCB continues to support agencies in meeting their responsibility to ensure professionals working with children and families receive safeguarding training by providing a multi-agency training programme. The development of the 2018/19 programme was based on themes from the HSCB annual training needs analysis, HSCB business plan priorities and national and local learning from case reviews.

Multi-agency training provided by HSCB Workforce Development

The top five interventions attended based on the total number of bookings comprised:

1. HSCB/HSAB Conference - 215 delegates.
2. HSCB Missing, Exploited and Trafficked Children – 211 delegates.
3. HSCB Adopting a Family Approach – 170 delegates.
4. HSCB Working Together and Preparing for Child Protection Conferences – 164 delegates.
5. HSCB Managing Safeguarding Supervision – 74 delegates.

Professionals Attending HSCB Core Learning Events

Group/Sector	2017/18	2018/19
Children's Services	284	582
Health	240	208
Police	99	102
Education	160	105
Others (incl. YOT)	74	62
Voluntary	83	66
Total	**1,018**	**1,162**

Multi-agency workshops, briefings and conferences provided by HSCB Partnership Team

Professionals Attending HSCB Workshops, Briefings and Conferences

Group/Sector	2018/19
Children's Services	273
Health	316
Police	130
Education	524
Others (incl. YOT)	327
Total	**1,570**

The above events included:

- Eight Regional Practitioner Forums delivered by members of the Partnership Support Team alongside representatives from HSCB partner agencies.
- Three Bruising Protocol Workshops delivered by Dr Simon Jones, West Hampshire CCG on behalf of Hampshire's five CCGs.
- Three FGM Workshops delivered by Cynthia Condliffe, West Hampshire CCG on behalf of Hampshire's five CCGs.
- Four conferences for safeguarding leads within schools and post-16 settings. Organised by the Partnership Support Team and Education & Inclusion ranch of children's services along with support from the Local Authority Designated Officers (LADOs).
- Three Abusive Head Trauma Launch events (morning, afternoon and evening sessions).
- Four ICON Multi Agency Train the Trainer events led by West Hampshire CCG and the Partnership Support Team.
- Four Hampshire Multi Agency Safeguarding Hub (MASH) Workshops facilitated by the Partnership Support Team and delivered by colleagues within Hampshire MASH.
- Four County Lines Briefings facilitated by the Partnership Support Team, Willow Team, Police MET Team and Junior Smart from the SOS Gangs project.

Feedback from Delegates (county lines briefings)

'Extremely informative and excellent lecturer. Very relevant to my job'.

'Excellent course with knowledgeable, engaging speakers'.

'This was one of the best training events I have been on in years'.

'Great to have a guest speaker who has direct knowledge/experiences but proof that you can change mindsets and support young people to choose a different path'.

Summary of Impact and Evaluation Reports

Course evaluation is undertaken by Children's Services Workforce Development Team (WDT), supported by direct observations of training events by members of the HSCB and WDT colleagues.

The methodology used is Guskey's model of training evaluation and is designed to incorporate multiple sources of information to provide more

reliable results. All HSCB courses delivered between April 2018 and March 2019 were subject to Level 1 Learning Transfer-Reaction Level. This included self-reports from course participants of the level they engaged with and enjoyed the training.

Longitudinal evaluation

The plan for longitudinal evaluation includes more in-depth evaluation of agreed training events. Specifically, data is collected from the trainer and trainees post course, and at intervals after the training (i.e. three or six months) as appropriate. This information is collated and analysed, conclusions determined, and shared with HSCB and any actions identified, implemented and reviewed.

In this context, two courses were subject to longitudinal evaluation during the 2018/19 and reports were provided to the HSCB. A newly developed course, 'Adopting a Whole Family Approach to Tackling Substance / Alcohol Misuse, Mental Health and Domestic Abuse' was delivered for the first time in June 2018 and continues to be delivered. This course was subject to direct observation on two separate occasions by HSCB partner colleagues and received very positive feedback, including the following comments:

'The golden thread of the family approach was constant during the day with clear links to the trigger trio. Motivating comments to empower delegates in changing culture were very impactful'.

'A very good, well delivered and in-depth course. Delegates seemed engaged and motivated by it'.

And additionally, the following comments from delegates as part of the longitudinal evaluation:

'Brilliant training with a knowledgeable and engaging trainer. Highly recommended'.

'I found this course enlightening and have recommended my colleagues attend this course'.

'Extremely informative'.

The second longitudinal evaluation was completed for the HSCB 'Managing Safeguarding Supervision' course which was re-commissioned in January 2018. The following are some of the positive comments from delegates:

'The trainer was excellent and kept the learning very real. Well worth attending'.

'I enjoyed the course as it discussed some of the realities of making supervision work in today's environment, rather than just being a theoretical look about how supervision should work'.

Priorities for 2019/20

The HSCB Business Plan 2019-20 is intentionally focused on strategic priorities and activities that form the basis of the work already agreed by the Board over the coming year. These priorities support the statutory functions of the HSCB and the partnership response to protecting vulnerable children, preventing harm and promoting their welfare.

The structure of the Business Plan allows the Board to remain flexible to respond to the emerging areas of work and transition into the new statutory partnership arrangements. To support the delivery of the Business Plan, the HSCB have produced more detailed work plans, aligned to the Board's priorities, to be delivered by each subgroup and working group.

HSCB will take a leadership role in the delivery and quality assurance of partnership work in these areas. Progress against this plan will be reviewed and monitored by the Executive Group with chairs of the relevant subgroups reporting on progress against their actions. Where necessary and appropriate, the Executive Group will highlight areas of concern to the full HSCB Board meetings for further action. HSCB will also identify and promote good practice across its partner agencies.

Further embed and evaluate HSCB initiatives

- That the HSCB fully delivers its agreed programme of initiatives to safeguard and protect Hampshire children and their families.
- That staff working with children and families are provided with tools and information to support them in their roles.
- That the HSCB, via delivery of different initiatives, can evidence positive impact and Hampshire children and families.

Strengthening our Assurance Programmes

- HSCB is assured that the services provided to children and their families in Hampshire are timely, appropriate and effective.

Leadership and Transformation

- *The HSCB and the new Safeguarding Children Partnership, leads the safeguarding agenda, challenges the work of partner organisations, and commits to an approach that learns lessons, embeds good practice and is continually influenced by children, young people and their families.*

Hampshire Safeguarding Children Board

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