LSCB
Southampton
Local
Safeguarding
Children Board

Southampton Local Safeguarding Children Board

Annual Report 2017-18

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Foreword from the Chair

It is with real pleasure that I write this foreword to the Local Safeguarding Children Board's Annual Report. This is my fifth year as Independent Chair of the Board, a period in which real and demonstrable change and development has taken place. The report contains many examples of the impact that the Board has had on making children safe in the City and is an accolade to the hard work and professionalism of Board members. I continue to be impressed by the high level of critical challenge that Board members offer, both to others on the Board and out to the very many people who dedicate their working lives to keeping children safe. This is all within the context of reduced resources for all partner agencies and a challenging economic environment in the City for families struggling on low wages and the pressures of life.

In the last report I commented on the planned changes to the safeguarding system which will be required by central Government. These changes are now set out in new guidance for the introduction of the Children and Social Work Act 2017. Throughout 2017/18 discussions have been held about how the City will respond and the general agreement is that all partners are keen to maintain the progress we have made and to introduce changes only where they will positively add to our collective ability to safeguard and protect children in the City.

The priorities for the Board in this period remained unchanged from the year before. Real progress has been made:

- The **"Think family"** (working across both Adult's and Children's Boards) approach was developed throughout the year, with additional training opportunities offered, the dissemination of learning from the various relevant reviews of practice and a joint working protocol put in place.
- **Neglect** has been a continuing key theme for attention, building on the successful earlier partnership work. New training has been developed, regular audits of frontline activity inform practice and the subject of neglect has been highlighted in schools and in public presentations, including during the Safeguarding Week.
- **Improving the lives of vulnerable young people** has been a key priority. The Board set out to constructively challenge the reshaping of the front door, MASH services and the concentration on helping to avoid the need for young people to come into the care system. There has been attention given to improving school attendance and to addressing the incidence of exploitation of young people through the partnership work in the Missing, Exploited and Trafficked Group. Also, there is increased monitoring and oversight of foster placements, provided both directly by the Council and through independent agencies.
- The **Quality Assurance** work of the Board has been greatly enhanced by the adoption of a new approach to the Section 11 audit process. Partners are now invited to open meetings where detailed discussions take place about the audit returns. This has received very good feedback, with participants saying that it is a useful way for them to question their safeguarding policies and practices.
- The report gives many new examples of the ways in which the Board **engages with children and young people.** This is at the very core of what the Board does. It is only by having a real grasp of what life is like for children and young people in the City and what helps to keep them safe, that the Board can be assured that it is making a difference.

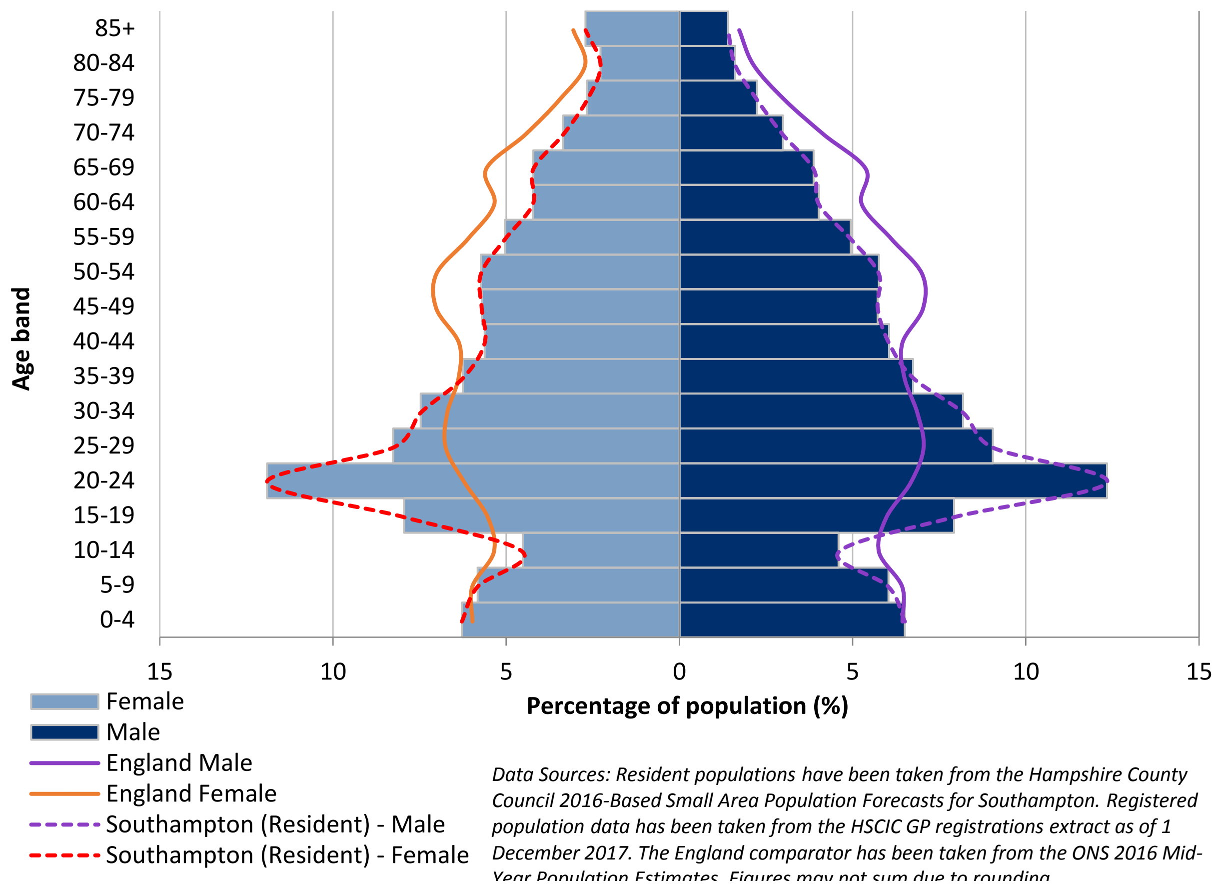
This annual report includes much more detail about what individual organisations are doing to help achieve the Board's priorities.

I am particularly pleased to see that the Government is actively considering changes to the safeguarding arrangements for children who are educated at home The vast majority of children educated in this way are in positive and nurturing families but some are not and the monitoring arrangements need to be strengthened in order to protect them. The Board has made representations on this important issue, particularly following the findings of a Serious Case Review in the City which was considered by the standing Parliamentary Select Committee.

I hope that you find this annual report of the work of the Board interesting. We are trying to reach out to as many people as possible and the report has been written in an accessible style with that in mind. We are particularly keen on ensuring that we hear the voices of children and young people in the City so that we understand better what helps to keep them safe.

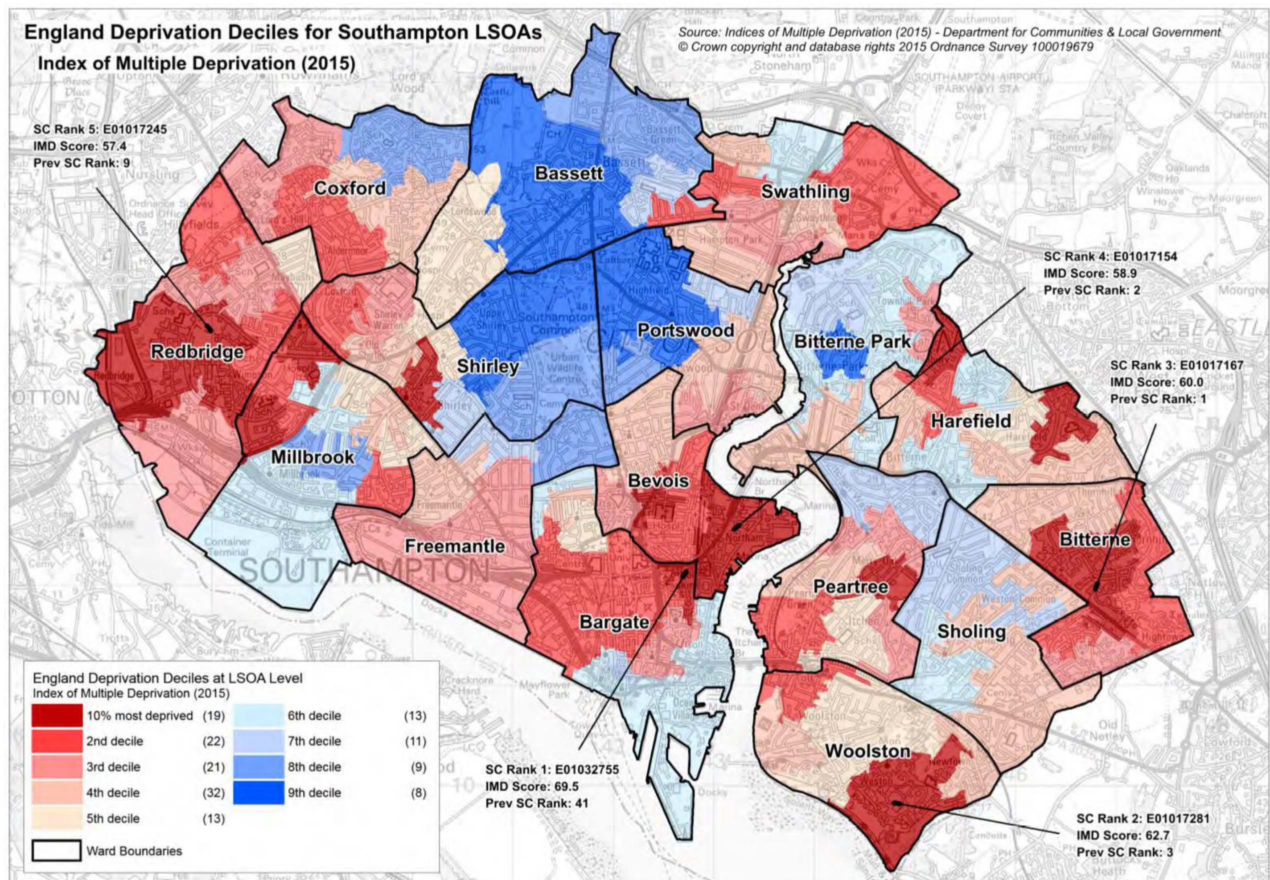
Southampton Context and Demographics

The current population of Southampton is 254,275 based on the Mid-Year Estimate 2016, of which 129,879 are male and 124,396 are female. The city comprises 98,300 households; 57,600 children and young people aged (0-19 years), 53,000 residents who are not white British (22.3%) and 43,000 students. The city has a young demographic, with 20% of the population are aged between 15 and 24 years, compared to just 12.4% nationally. The Southampton population in 2016 (as updated 2018) is shown in this population pyramid:



Overall, comparing local indicators with England average, the health and wellbeing of children in Southampton is worse than England. The infant mortality rate is similar to England, with an average of 13 infants dying before age 1 each year. However in recent years there have been seven child deaths each year on average. The teenage pregnancy rate is higher than the regional average and the rest of the country. More school pupils have social, emotional and mental health needs than the national average.

More children in Southampton live in poverty than the national average (19.7% for Southampton, compared to 12.5% for the surrounding Hampshire area, and 16.8% as the national average). Since 2010 Southampton has become more deprived and in 2015 it was ranked 67th out of 326 Local Authorities in England, with 1 being the most deprived. The City is a patchwork of deprivation and pockets of affluence. It has 19 neighbourhood areas (known as Lower Super Output Areas) which are within the 10% most deprived in England and none in the least deprived. The map below shows the most (red) and least (blue) deprived areas in the city:



There is increasing ethnic diversity within the school aged population with 33% of school pupils in Southampton from an Ethnic Group other than White British[1] (compared to 26.3% in 2010) and 25.7% of pupils language is other than English.

There are certain issues in the city where outcomes for children and young people have made steady progress, and others where there are still issues of concern for children's wellbeing and safety. Areas of concern are:

Looked After Children

Southampton has a high number of Looked after Children, something which the City Council's Children & Families Service are working on to reduce where possible and where it is safe to do so. For 2017/18 the end of year figure for the number of Looked after children was 522 which when translated to the 'rate per 10,000 population under 18 years old', was the lowest rate for the last 4 years at 104.

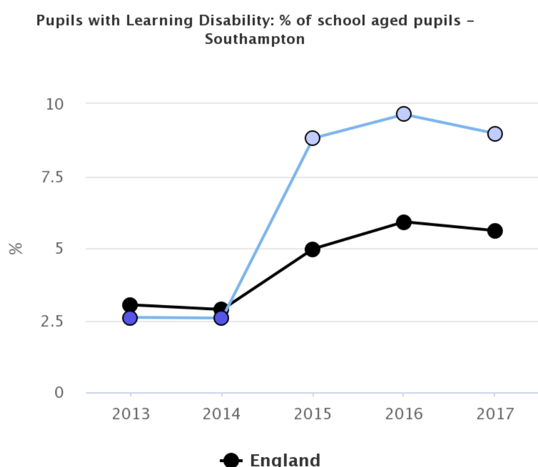
[1] Based on those with an ethnicity recorded

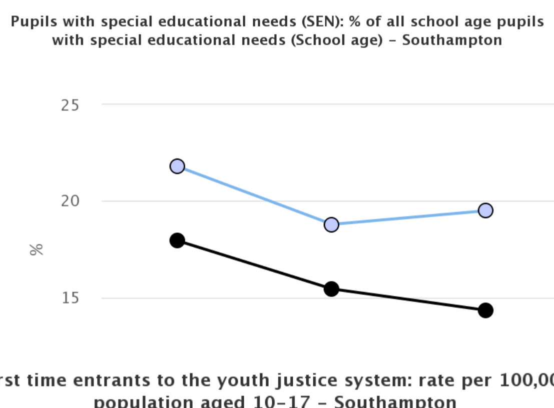
Despite the decrease in the number of Looked after Children, Southampton still maintains a rate that is much higher than that of statistical neighbours (69), 34% higher. This average is also higher than the England (62) and South East Average (41).

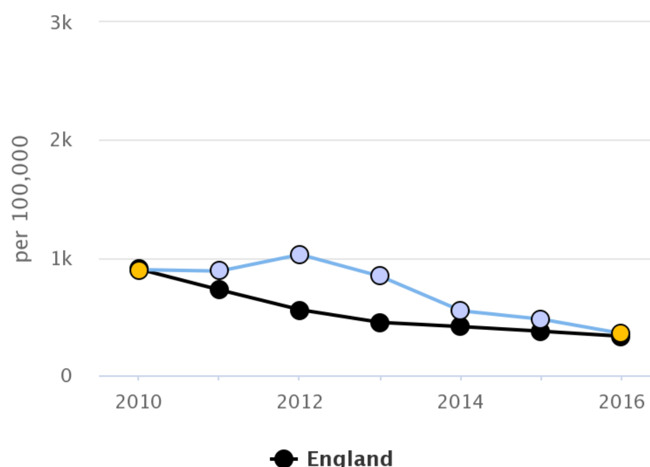
Given the poor outcomes for looked after children this remains an area of concern, national research evidences these poor outcomes. Children in Care are 4 times more likely to develop a mental health difficulty than their peers[2], and are less likely to go on to education, employment or training compared to the general population[3].

Children with Special Educational Needs or Disability

The City also has an increasing number of children of school age children with a learning disability, which has risen from below the national average in 2013/14 to above the national average in 2017. The number of school age children with Special Educational has decreased between 2014 and 2016, but remains significantly above the national average. This is significant to safeguarding because research shows that disabled children are at an increased risk of being abused compared with their non-disabled peers. Also, published case reviews highlight that professionals often struggle to identify safeguarding concerns when working with disabled children







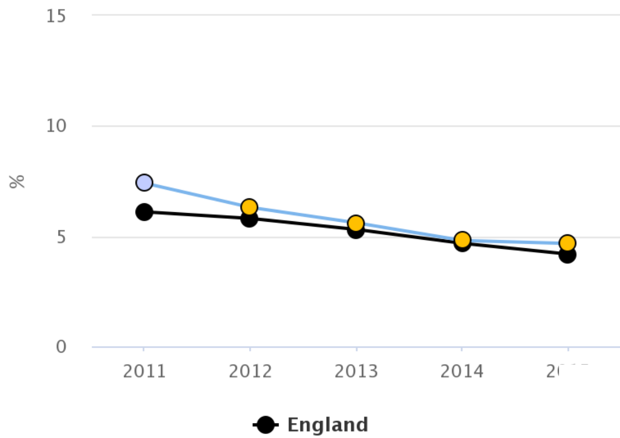
Youth Offending

Southampton has worked hard to reduce the number of its young people entering the youth offending system and numbers have steadily reduced from 2012 to come back in line with the England Average in 2016. The city is seeing the effects of child criminal exploitation,

[2] Calculation based on Office for National Statistics https://www.nspcc.org.uk/preventing-abuse/child-protection-system/children-in-care/

[3] Department for Education (DfE) (2017) Children looked after in England (including adoption) year ending 31 March 2017 and Department for Education (DfE) (2017) Participation in education, training and employment by 16-18 year olds in England: end 2016. (PDF)

particularly with regard to County Lines drug supply, and this issue *may* result in some increased figures as it has been confirmed that local children are involved.

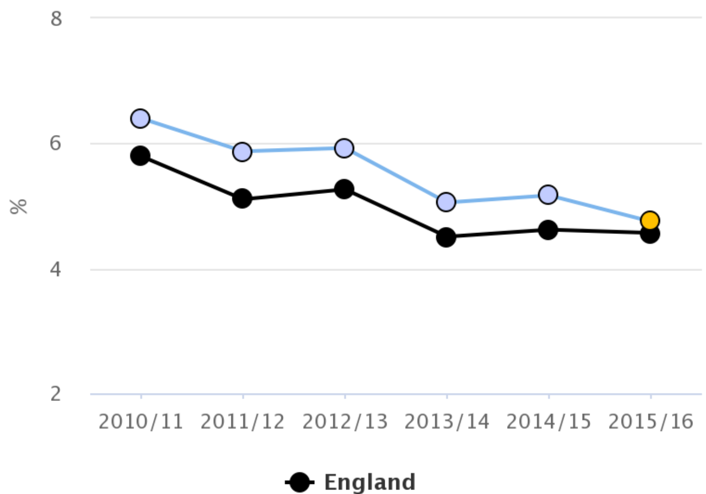


Children not in education, employment or training

While the number of young people (16-18 years) who are not in education, employment or training (NEET) remain slightly above the national average, the city is showing a steady trend for improvement with numbers reducing from 520 in 2011 to 320 in 2015.

Children missing from school

This is a safeguarding concern because where children are absent from school there is a concern around who they are with, and what they are doing instead. This area is improving in Southampton, which whilst still above the national average is showing a decrease of 6.4% in 2012/13 to 4.75% 2015/16. This is, for the first time, almost in line with the national average. The is important with relation to Missing, Exploited and Trafficked Issues for children in the city, as it would seem to indicate less instances of children being missing from education (and so less incidences of children being subject to MET issues).



Business Planning

The Local Safeguarding Children Board agreed to continue with the same four themes as previously agreed in 2016. This was to ensure consistency and embedded action across the multi-agency partnership. The themes are agreed as:

LSCB Themes:	
1.	Develop responses to encourage a 'think family' approach where there is adult mental health, substance / alcohol use and domestic abuse and this is impacting on Childrens' safety
2.	Improve identification and responses to neglect of children in Southampton
3.	Focus on improving safety and outcomes for vulnerable children including; • Looked after Children • Those at risk of going missing, being exploited or trafficked (MET)
4.	Improve communication between services at senior and practitioner level

LSCB meetings were themed to correspond to these four issues and agencies were asked to provide service assurance at each quarterly meeting. Below is a summary of information received at these meetings, alongside an update of business planning actions achieved during the last year.

'Think Family'

a. The LSCB provides a training programme which includes topics such as substance misuse, alcohol use and adult mental health training as a regular feature. Domestic and Sexual Violence Training is offered by the PIPPA Service – a course that the LSCB has quality assured. Further work is required to develop training on disability and child mental health.

b. The Boards ensures that the learning from audits and case reviews is disseminated regularly to the local network of professionals across adult and child. Our learning newsletter is published quarterly, our training programme includes learning from case reviews and audits and 6 Step Briefings with online videos to become a regular method of distributing learning.

c. A joint working protocol has been written and has been agreed by Board. This has been uploaded to the 4LSCB policies and procedures website and shared with the partnership.

d. The LSCB receives regular updates regarding the MARAC/MASH process - this includes updates on the adult focussed services within the MASH.

e. A themed meeting of the LSCB took place, specifically looking at Think Family and the multi-agency response. For example, Hampshire Constabulary shared details about how they have joined their adults and children's safeguarding training and how they now have joint strategic meetings. Public Health shared that they have a view to link up mental health services and substance misuse services more. Solent NHS are looking at aligning Making Safeguarding Personal work in Adults to ensure a Think Family approach also including the combining of children and adult safeguarding training and co-location of staff. UHS have merged children and adults safeguarding teams. Their hope is that it will provide a more efficient collaborative service.

‘Neglect’

a. The LSCB ensures that multi-agency responses to child neglect are good quality and appropriate through case audits, learning from reviews and through quantitative feedback at Board level. The Joint Targeted Area Inspection (JTAI) focus on Neglect has provided a robust framework from which to carry out case audits and development work in response to the findings much of which was completed during this year, and resulted in a proactive and multi-agency action plan. Findings and actions have been shared with the LSCB and the action plan is monitored regularly by the LSCB.

b. The Board provides a quarterly multi-agency neglect training session entitled ‘Introduction to Neglect’ which is free at the point of access to professionals working in the City.

c. The Board coordinated focussed activities during Safeguarding Week and on other key dates to raise public awareness of ‘what to do if you are worried about a child’ focussing on neglect indicators.

d. A themed meeting of the LSCB took place during the year specifically looking at Neglect and the multi-agency response. Individual board member feed into this was: The Quality Assurance Unit of Southampton City Council’s Children and Families Service are involved in a multi-agency Neglect group (led by the LSCB) and lead on inspection readiness for JTAI. In addition, SCC and Solent NHS developed a new 0-19 service which will aim to reach harder to engage families. . A review of the LSCB neglect toolkit has taken place particularly focussed on how to ensure this is used more consistently. The Designated Safeguarding Lead working with Schools in Southampton is reviewing how neglect is incorporated into safeguarding training for schools. There is a reviewed training and induction offer for Children & Families Service in respect of neglect and they are using audit activity to identify practices. Health providers updated on their training which includes neglect as a theme. Solent NHS had a themed steering group meeting based on neglect, specifically looking at the issue of ‘what not bought’ and what impact this has on the child.

‘Improving the Lives of Vulnerable Young People (LAC and MET)’

a. The Board received assurance from the Local Authority regarding plans to safely address the number of children looked after. This included a presentation from Professor David Thorpe, who evaluated the new Front Door service and Multi Agency Safeguarding Hub (MASH) process.

b. The LSCB received an annual report from the Corporate Parenting Committee with updates on how this work is progressing. Children Looked After data is monitored at the LSCB, including the attainment levels for Children Looked after (CLA) at all school levels and Further and Higher Education.

c. The Board sought assurance that the Education department have a detailed action plan to address attendance rates and attainment – where information demonstrates ‘gap’ against national averages and for priority groups including CLA.

d. Through the Missing Exploited and Trafficked Strategy Group, the Board regularly reviews the quality of Partners work to protect children at risk of going Missing, being exploited and

trafficked via delivery of the Missing Exploited and Trafficked (MET) Action Plan – through audit and data activities.

e. The LSCB Monitoring and Evaluation Group has developed a system to monitor and quality assure Foster Carers and Independent Fostering Agencies used by Southampton.

f. A themed LSCB meeting took place for this area, seeking assurance from partners on how they ensure that LAC and MET young people are safeguarded appropriately. Example of responses included an update from the Police MET team, County Lines, shoplifting and drug dealing. The Police have worked with partners to update the 4LSCB MET Protocol. The CCG (Clinical Commissioning Group) is doing work with the mental health and sexual health team who work with looked after children. They are looking at why young people who come for health checks can't also discuss contraception and support. The CCG are also working with providers to make sure they can evidence how they address CSE and make sure they are involved in the MET operational and strategic groups, they are having a dialogue with GPs about learning and working with NHS England around missing alerts.

'Improving Communication'

a. The Board has further developed communications systems to gain views of multi-agency frontline professionals and convey key messages, including:

- Staff survey
- Focus groups
- Team visits by Board members
- Information exchange opportunities such as Weekly Wednesday Workshops
  Newsletter, website and social media.

b. The LSCB is in regular communication with other key partnerships including LSAB, Safe City Partnership, Health and Wellbeing Board and Scrutiny Panels regarding issues of concern for the LSCB and to develop peer scrutiny across these boards

c. Both locally and across the 4LSCB areas of Southampton, Portsmouth, Isle of Wight and Hampshire, we regularly refresh 4LSCB safeguarding working procedures and highlight key documents via a launch.

d. The LSCB has been working with Education leads within Local Authority to design best system for gaining assurance regarding safeguarding responses in education settings in Southampton – including duties under legislation for schools and education settings. This has helped to improve communications between Schools and the Board greatly. The Board has noted a reduced attendance from Education representatives and settings (see appendices below).

e. A themed LSCB meeting took place for this area, seeking assurance from partners on how they are working to improve communications. Examples of responses include the Children and Families Service prompting debate regarding the effectiveness of Core Groups and relevant agency attendance... National Probation Service explained how they are working to improve communication to front line staff when learning from reviews is shared. Hampshire Constabulary reflected a focus is to build better relationships with young people, to build confidence in the police, reduce the risk of threat and harm to young people and to stop young people coming into the justice system. The Chief Constables Council (CCC) and the Children &

young Persons national strategy states that every interaction is both an intervention and an opportunity.

Quality Assurance - Impact of safeguarding partners working together

The LSCB had a Monitoring and Evaluation subgroup during the year. The group are responsible for the scrutiny of key performance indicators on the LSCB dataset and Section 11 audits which is a safeguarding self-assessment completed by partner agencies that have a duty under Section 11 of the Children Act in terms of safeguarding. In addition to these, the Monitoring and Evaluation Group also have oversight for any multi-agency case audits undertaken, and the review of improvement actions taken as a result.

Section 11 Children Act 2004

The 4LSCBs for Hampshire, the Isle of Wight, Portsmouth and Southampton joined up to provide a refined new process during this year to ensure agencies covering more than one of the four areas reported once. . Agencies working solely within Southampton also completed Sections 11s reviewed locally. Some agencies completed full Section 11 whilst the remaining agencies provided updates on the action plan devised following the previous year's full Section 11. Those agencies completing full Sections 11s or updates on the previous year's full Section 11 audit are as follows:

Full Section 11	Section 11 Update
Solent NHS	Southern Health
Children Services	Hampshire Constabulary
Southampton City CCG and Integrated Commissioning Unit	National Probation Service
Adult Social Care	Community Rehabilitation Company
Housing Services	Hampshire Fire and Rescue Services
Arts and Heritage and Libraries	South Central Ambulance Service
	University Hospitals Southampton
	Immigration Enforcement
	Border Force
	NHS England
	CAFCASS
	British Transport Police
	Southampton Youth Offending Service

The areas where most agencies identified themselves as requiring improvement were:

- Standard 5: Induction, training and appraisal for staff and volunteers on safeguarding and promoting the welfare of children
- Standard 6: Recruitment
- Standard 11: Disabled children

A few examples of Good Practice to illustrate the work undertaken by partners include:

Southampton City CCG and Integrated Commissioning Unit

The CCG partake in annual training on SCRs with Public Health input, raising the profile of safeguarding with commissioners. They also run 'Lunch and Learn' sessions and have developed a programme of safeguarding tutorials with GPs; publish a Safeguarding Newsletter; and carry out "Supervision" with safeguarding leads across the local health economy.

Youth Offending Service

YOS' continued involvement with the Serious Youth Crime Programme as well as the implementation of a diversity policy.

Housing Services

The service have placed two navigators within the MASH as well as introducing a Safeguarding and Anti-social Behaviour co-ordinator. Safeguarding training available to both staff and trade staff also ensuring that the messages from Serious Case Reviews get out. The service undertakes an annual performance review which will also feed in to corporate performance monitoring and with regards to LSCB, there is valuable input to the Serious Case Review sub-group as well as valuable contributions to the audit activities.

SCC Licensing

Licensing have introduced annual safeguarding training and have taken steps to provide targeted child sexual exploitation training and awareness raising for taxi drivers.

Hampshire Fire and Rescue Services

Following the annual review of the HFRS Safeguarding Policy and associated guidance notes, amendments have been made to the HFRS Safeguarding reporting form to ensure the feelings and wishes of the child of concern is actively obtained and recorded. This has also been embedded within internal safeguarding operational procedures and captured electronically within HFRS data management recording systems for future reporting and Quality Assurance mechanisms.

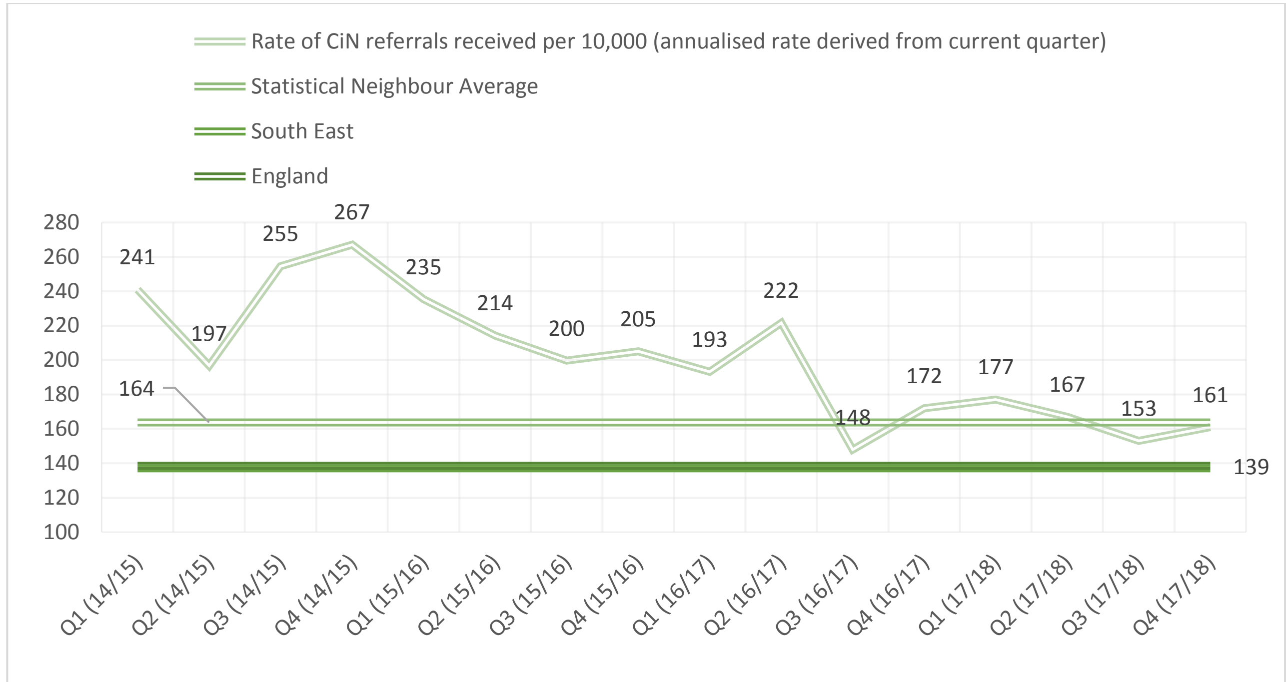
Over the past 6 months HFRS have developed a network of 'Station Based Safeguarding Advocates'. Primarily this network has consisted of key frontline staff from our city stations that have a lead responsibility for the safeguarding activities of their respective teams / watch's. Key responsibilities including facilitating 'bite size' training sessions on various safeguarding themes such as CSE, Modern Day Slavery, PREVENT and Indicators of neglect.

University Hospital Southampton NHS Foundation Trust

Monthly opportunity for any staff who safeguard children to attend and receive supervision / feedback about cases. This also provides the forum to discuss issues or concerns about the safeguarding process and to increase awareness of Safeguarding agenda and feedback from Serious Case Reviews.

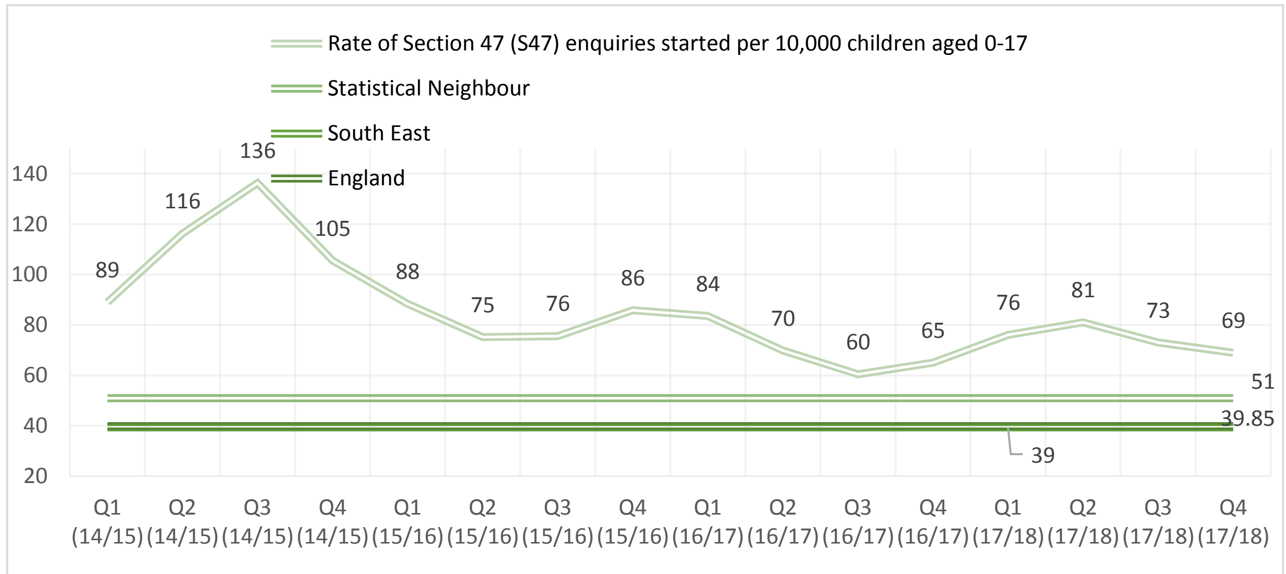
Key Performance Indicators

Child in Need Referrals

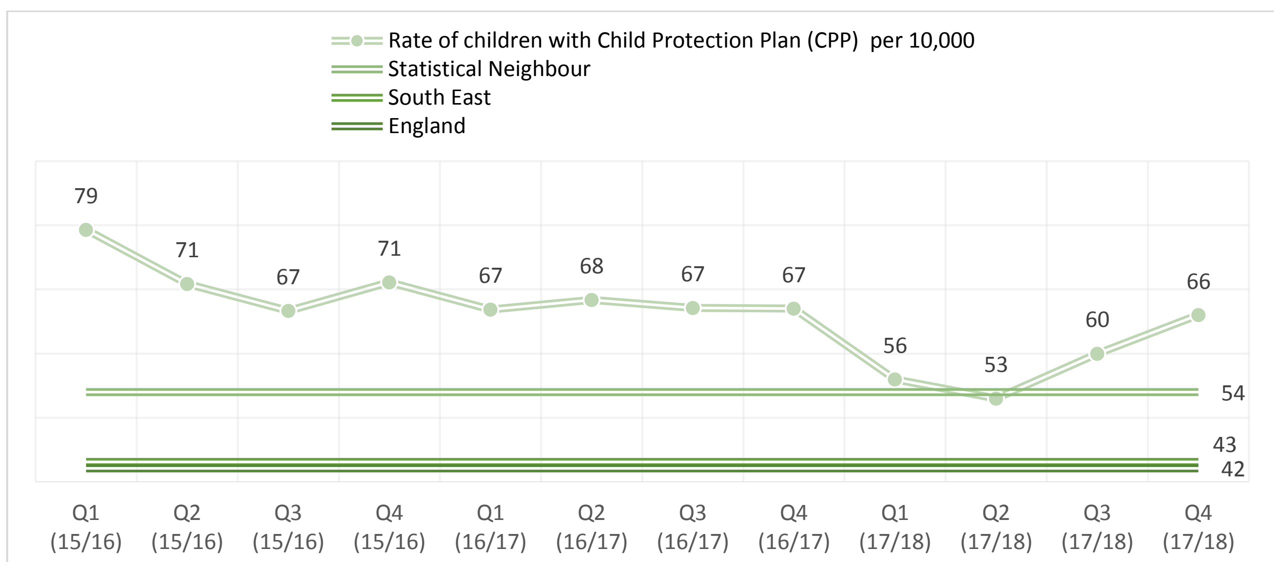


The rate of Child in Need referrals shows a decreasing trend overall. Over the course of 2017/18 this figure has decreased but shown a 5.2% increase over the last quarter.
Southampton's figure of 161 (per 10,000) is comparable with the Statistical neighbour average of 164 (per 10,000), however it is higher than the South East and England averages.

Child Protection

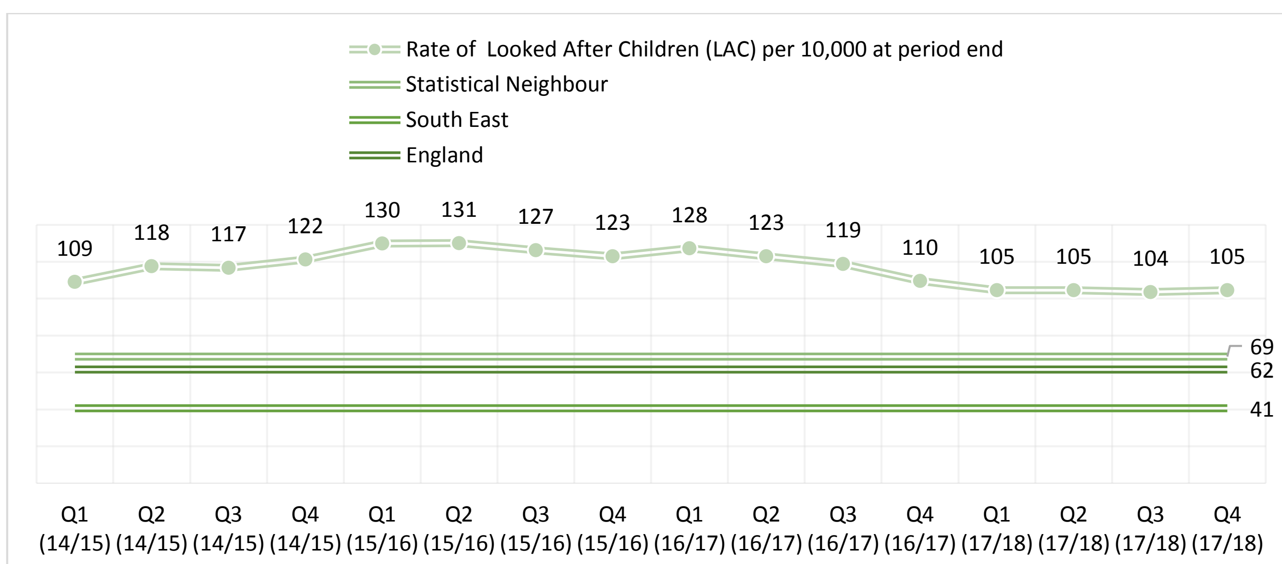


Over the course of 2017/18 the rate of Section 47s initiated has decreased from 76 in Q1 to 69 in Q4 but with a peak of 81 in Q2. Overall there is a decreasing trend in this figure. At the end of Q4, Southampton's rate of S47s started is 26% higher than that of the Stat Neighbour Average (51). Southampton's rate is also higher than the England (39) and South East (40) Averages



2017/18 has seen an increase in the rate of children on a child protection plan from 51 in Q1 to 66 at the end of Q4. Q4's figure of 66 is still lower than the rate at any other point in 2016/17 or 2015/16. This rate is 18% higher than the Statistical Neighbour rate (54) and higher than the England and South East averages too.

Looked after Children



Over the course of 2017/18 the rate of Looked After Children did not change appreciably. Quarter 3 2017/18 saw the lowest rate of Looked After Children over the last 4 years.
Despite the decrease in the number of Looked After Children, Southampton still maintains a rate much higher than that of Stat neighbours (69), 34% higher. This average is also higher than the England (62) and South East Average (41).

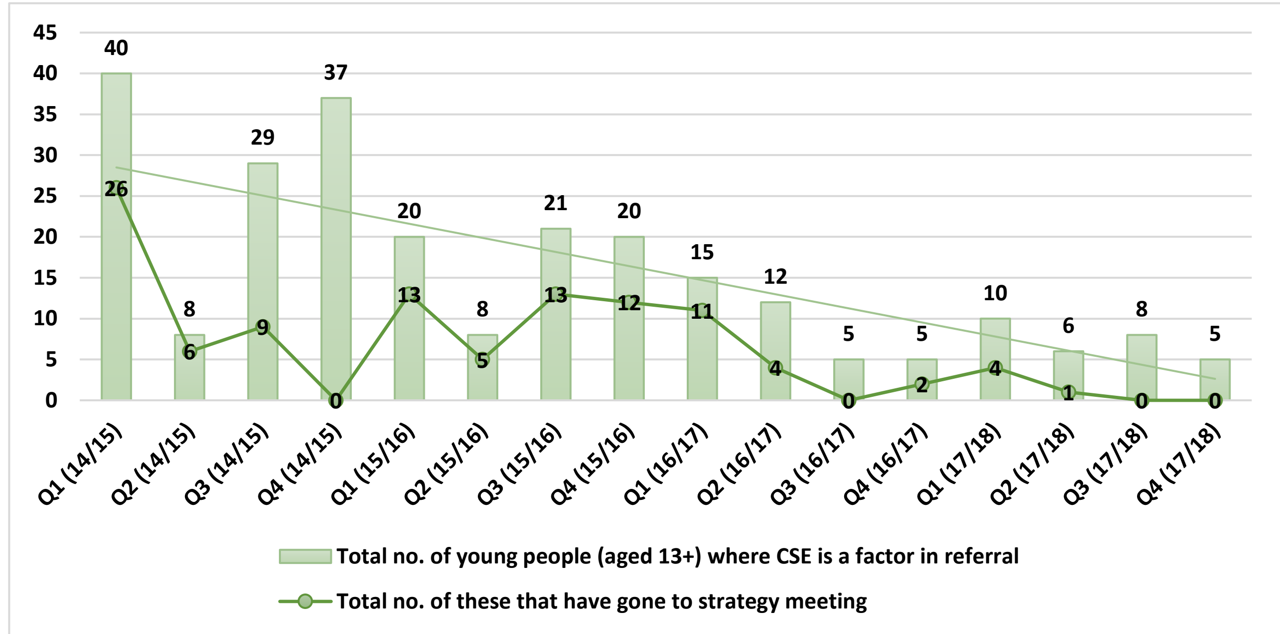
Child Sexual Exploitation

Overall there is a decrease in the number of referrals to MASH where CSE is a factor in the referral. There is also a decrease in the number of these referrals that go to a strategy meeting.

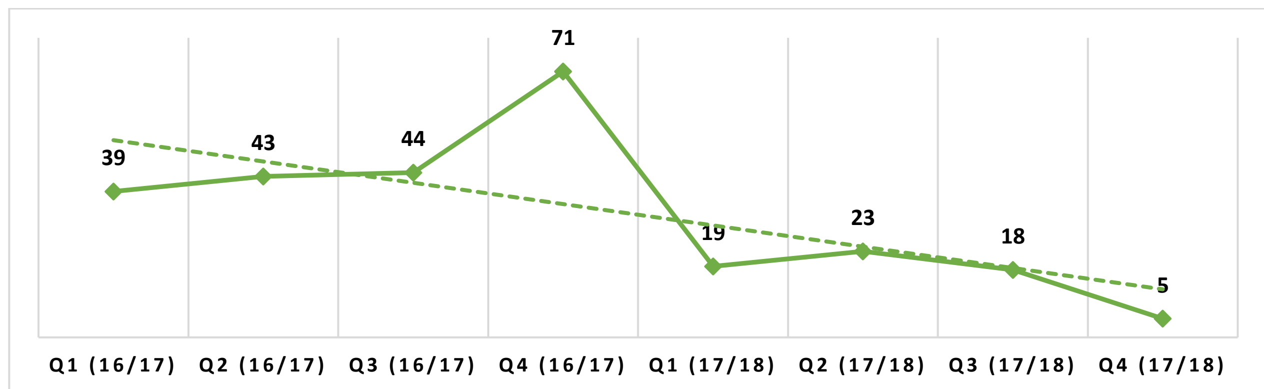
Comparing previous years:

	2015/16	2016/17	2017/18
Referrals	69	37	29
Strategy Meetings	43	17	5

No. of referrals where CSE is a factor

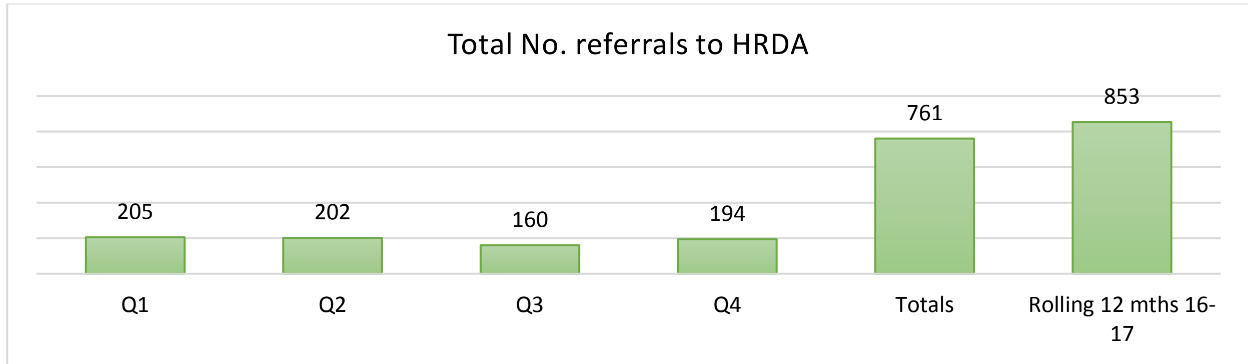


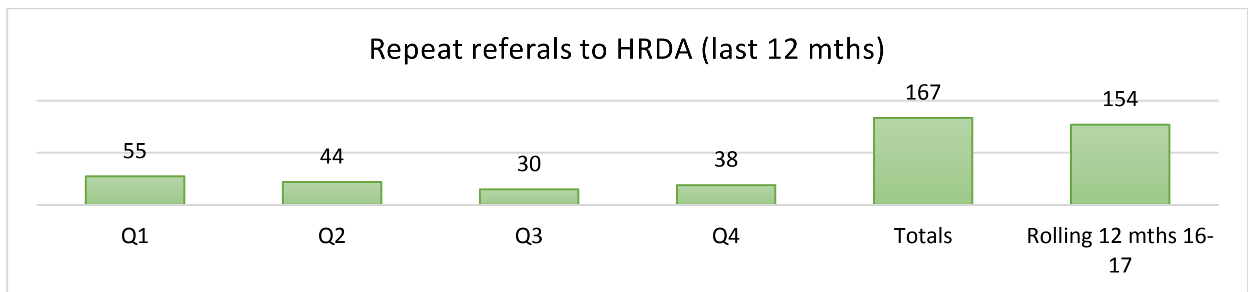
Police - number of children flagged at risk of CSE



The number of young people known to be at risk of CSE by Hampshire Constabulary shows a decreasing trend overall. For Q4 (2017/18) 5 young people are known to be at risk. For the same period last year 71 young people were known to the Police as being at risk of CSE. Police colleagues note that this could be good news reflected also in Hampshire and Isle of Wight data which is showing a 24% drop in online exploitation for Q1 2017 compared to Q1 2018. However this could be an intelligence gap issue. Southampton LSCB MET group are working with Hampshire Police to raise awareness of the Community Intelligence form and process with partner agencies.

Think Family – High Risk Domestic Abuse (HRDA)

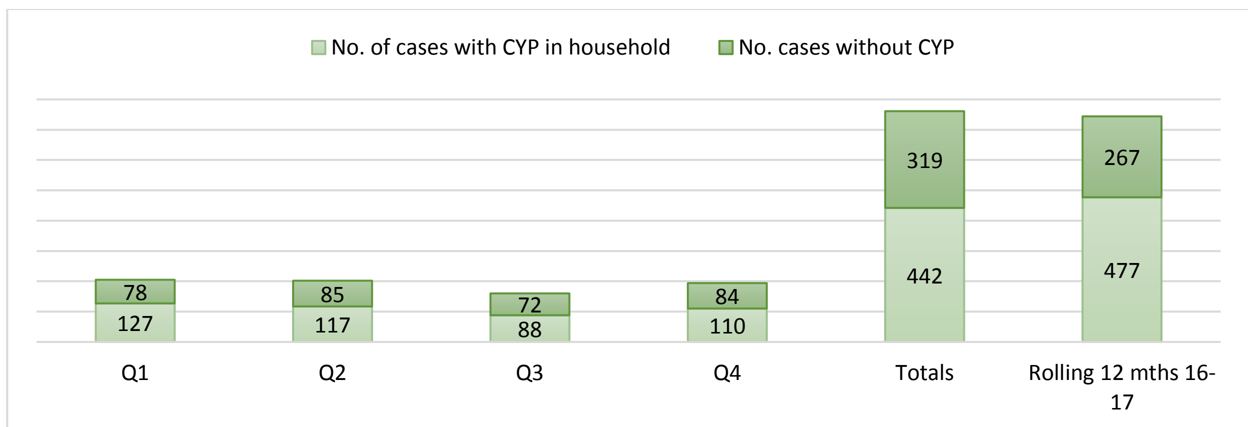




Regarding the total number of referrals that have come in there has not been an appreciable change over the course of the year, although there was a decrease in Quarter 3. There was a 12.0% decrease in the total number of referrals from 2016/17 to 2017/18.

Regarding repeat referrals, the percentage of repeat referrals per quarter:
Q1: 26.8%
Q2: 21.8%
Q3: 18.8%
Q4: 19.6%
2016/17: 18.1%
2018/19: 21.9%

So although there was a decrease in the total number of referrals from 2016/17 to 2017/18 there was an increase in the percentage of these referrals that are repeat referrals.



The percentage of all HRDA referrals that:

- Have CYPs in the household:
  - Q1: 62.0%

    - Q2: 58.0%
    - Q3: 55.0%
    - Q4: 56.7%
    - 2016/17: 64.1%
    - 2017/18: 58.0%
- Without CYPs:
    - Q1: 38.0%
    - Q2: 42.0%
    - Q3: 45.0%
    - Q4: 43.3%
    - 2016/17: 35.9%
    - 2017/18: 41.9%

Audits

Joint Targeted Area Inspections (JTAI) are thematic inspections carried out by Ofsted, the CQC, HMI for Constabularies and HMI for Probation with a focus on multi-agency safeguarding arrangements. The LSCB has aligned its multi-agency audit schedule to undertake a dry-run of such an inspection according to national themes. This year the theme was Children Living with Neglect. The findings and recommendations of the audit are summarised below:

Theme	Recommendations
The prevalence of the 'trigger trio' was high in the cohort. However, intervention plans in respect of children did not adequately address the parent's behaviour and / or it did not appear to be considered robustly enough by the professional networks. Consequently, it was not uncommon to see unresolved domestic abuse, parental mental health issues and / or substance and alcohol misuse. Where these issues were addressed there did appear to be better outcomes for children – for example, a parent who mental health needs were diagnosed was able to improve outcomes for their children.	This appears to be a multi-agency issue and could be a focus at either Neglect Assurance or Monitoring & Evaluation Group. Key themes include: • Assurance that there is consistent professional understanding of the interface between the trigger trio and neglect. • Multi-agency review of chronologies at all levels of intervention, with explicit identification of risk factors. • Assurance that the right professionals are involved in network meetings or core groups and that planning is robust.
Across the cohort there were children who spent long periods of time subject to intervention planning with limited impact identified. In addition a number of re-referrals were evident. An enhanced level of support was seen to be have an impact (for example, the co-allocation of a family engagement worker in one case had a tangible input on outcomes). However, the overriding issue appears to be how outcomes are tracked and decisions made around levels of progress and the professional response.	In addition to the above, the Children and Families department should explore additional tracking mechanisms for case progression and the Performance Management Board should discuss how these should be used to support management oversight.
Levels of criminality were also high in the cohort, with several parents offending with / in the presence of their children. For young people, pro-offending behaviour appeared particularly apparent for boys (which appears to support the inspection rationale). There were several potential issues identified: firstly, that within the family dynamic, older boys' behaviour could be perceived as 'challenging' or 'risky', without sufficient consideration of their own experiences and	Exploration of the benefits of NPS / CRC contribution to the Neglect Assurance Group. Discussion at the Youth Offending Service Management Board in the first instance which could focus on: effective early intervention / prevention; promoting engagement; case formulation approaches.

needs. Secondly, non-engagement is a key factor, which in several cases appeared to frustrate the professional response.	
Housing needs were identified in just under half the cases. These were not always at a high level; and also included issues such as rent arrears and anti-social behaviour.	Review content of Neglect toolkit to test out how themes arising from the audit are articulated.

These recommendations have been translated into an action plan that is continuously reviewed by the LSCB M&E Group.

The MET Strategic Group also undertook a multi-agency audit on the theme of Return Interviews. Some of the findings include:

- For all cases, the numbers of missing episodes reported were inconsistent between Police, Children's Services, YOS (where they were involved) and Barnardo's over this time period. Barnardo's also reported receiving either late notifications of missing episodes or having not received notifications of missing episodes at all.
- There also appeared to be poor record keeping in terms of Return Interviews, as there was little evidence on Paris to show that a Return Interview had taken place or what the response was to the missing episode.
- The effectiveness of the Return Interview process may have been hampered by the fact that it is a one off intervention.
- The effectiveness of multi-agency working seems to be seems to be dependent on how complex these cases are. Two of the three young people had particularly entrenched family issues involving domestic abuse, substance misuse and criminality. These young people did not engage well with any agencies. The third young person engaged well with

Recommendations:

1. A clear process for the notification of missing episodes to the relevant parties responsible for carrying out the return interviews. In addition, the notification should be timely in allowing for a timely Return Interview.

2. Improved recording of return interviews on Paris as well as the response to or any actions following the missing episode. Where such a system may be in place perhaps with regular quality assurance monitoring this approach can be embedded into practice.

3. The Return Interviews to form part of ongoing work with the young person rather than just a one-off intervention.

4. Seeking out the Voice of the Child. An understandably difficult task when the young person refuses to engage with services. It may be worth exploring different advocacy avenues.

5. Look at options for therapeutic work with children and young people involved in criminality where there has been a history of Trigger Trio elements in their family and a breakdown in their relationships with family members.

The recommendations are being monitored and reviewed by the LSCB MET Group.

Case Reviews & Learning

As part of the statutory framework that the LSCB operated under during this year (Working Together to Safeguard Children and Young People 2015) the LSCB has a duty to carry out Serious Case Reviews.

Where things go wrong and a child or children are seriously harmed or tragically die and abuse or neglect is known or suspected, the LSCB reviews the circumstances to establish if lessons can be learned to prevent similar situations in the future. Although no Serious Case Reviews were completed and published during the timeframe for this report, there have been a number of reviews underway

The LSCB received nine referrals of cases that services felt met the statutory criteria for review or the partnership would benefit from reviewing Six of these referrals were agreed as Serious Case Reviews, one was agreed as a non-statutory Partnership Review and two others required no further action. The following themes have been identified from these referrals during the year:

- Risks posed by non-accidental injury
- Safe sleeping advice needing more focus
- Advice about the complexities of working with large, complex families
- Neglect is a prevalent theme for families in the city.

The LSCB commissioned and completed a thematic report on online safety, following the tragic suicides of two teenagers in 2015. These were both thought to be linked to online bullying, peer to peer abuse and the significance of self-harm. In 2017 – 18, a report was published (www.southamptonlscb.co.uk) and learning was shared widely. The Chair of the LSCB led a workshop with head teachers and designated safeguarding leads in order to share the findings of the report and agree some next steps. An action plan has been agreed and is being carried forward by a task and finish group. A number of agreed recommendations are below:

- All schools in Southampton to use the 360 online safety tool.
- Schools to adopt anonymous report tools such as "Tootoot" or "whisper"
- The LSCB should provide guidance around what online safety education should look like to make coverage of online safety more uniform across the City.
- Coordinated training across the city that links between children's mental health and online technology.
- There should be a more proactive relationship between the LSCB and schools to provide guidance on staff and governor training, with particular focus upon statutory responsibility and legal issues.

Case Review Action Plans

The multi-agency partnership will use recommendations from reviews to form more detailed improvement and action plans. The LSCB Serious Case Review Group have oversight of these plans and review them quarterly.

The SCR Group has agreed that a number of actions have been completed in response to case reviews this year under the following themes:

- Child Protection Procedures
- Education
- Multi Agency Working
- Neglect

Child Protection Procedures

Recommendations of Review	What was done and by whom?	What was the impact on children?
Copies of chronologies need to be part of all CP conferences, cross referencing all significant concerns and again at the review conferences	Children and Families service arranged for Child Protection Conference reports to include the agency chronology.	Professionals working with children will not be fully aware of the chronology of events within that child's life.
That when there are predicted changes in email or other IT systems, managers or workers should ensure that any relevant communications are stored so that they are not lost	The LA to notify schools of this issue and that it was a learning point from recent SCRs	Children's details and case notes will not be lost
If a referral is to be progressed to a section 47 enquiry, the correct meeting structure, including strategy meetings and management oversight, must be applied, otherwise ineffective safeguarding measures might be progressed putting children at risk	New monthly tracker meeting established to review all UBB referrals	Children receive the appropriate support at the right time
That a service is offered to children and young people who express concerns about their caring responsibilities; especially where this is impacting on their right to enjoy and achieve in childhood	A service is commissioned to provide assessments for young carers and young carers are referred to the SVS young carers project	Young carers receive the support they require
That the Local Authority procedures for Child Protection and children in need meetings include an overt requirement for the Chair to ensure that those attending outline the purpose of their attendance to parents and colleagues	The child protection procedures are 4LSCB procedures and this requirement will be passed to the 4LSCB sub group. The children in need procedures will be updated to include this requirement	All in attendance at meetings will be aware of the purposes of the meetings
The LSCB must ensure that letters to clients from MASH are not simply standard templates but are personalised and contain sufficient information to allow the recipient to understand the processes to which they are now due to be subject	The template letters from MASH to be rewritten to allow for the inclusion of details of why the worker will be visiting	Families referred to MASH understand why they have been referred and the nature of the proposed intervention
The LSCB must ensure that Early Help establish a standard of timeliness about the allocation of cases ensuring that regular checks are maintained to allow swift allocation of cases and the prevention of any backlog of such cases	Early help teams will allocate cases within agreed time scales and report to senior management if there are pressures on these	Families receive support in a timely fashion
The LSCB must ensure the staff in those organisations using PARIS are able to access the system efficiently and promptly and all	Advance PARIS training to be set up for all those accessing the system	Staff are well trained and understand how to use PARIS effectively

Recommendations of Review	What was done and by whom?	What was the impact on children?
its applications are understood by those who access the system		
Children and Families Service: That SCC ensures that there is enough CP chairing capacity within the organisation to offer a flexible service, which is not dependent on individuals.	A combined chronology is produced for all ICPCs and updated at every core group.	Children and Families Service: That SCC ensures that there is enough CP chairing capacity within the organisation to offer a flexible service, which is not dependent on individuals.
SCC ensures that there is enough CP chairing capacity within the organisation to offer a flexible service, which is not dependent on individuals	The CPC team is fully staff following phase 3 of the transformation	There is no delay in delivery of child protection conferences.

Education

Recommendations of Review	What was done and by whom?	What was the impact on children?
The case management of the Elective Home Education (EHE) should be reviewed with the aim to: • Reinstate annual contact with the parents of EHE children • Achieve termly visits to EHE children about whom there are safeguarding concerns • Ensure capacity to progress statutory intervention if required and all cases of concern should be escalated to a senior manager who will make and record the decision about legal action.	The Local Authority fulfils its statutory responsibilities in respect of EHE and the lead officer is reviewing local guidance and protocols. Annual contact and termly visits are not statutory requirements and the local authority is not resourced to undertake them. Safeguarding concerns would always be reported by the appropriate mechanisms and there is an annual review for children with Education, Health and Care Plans. Further, if the local authority had concerns regarding the quality of education, it would use commissioned support as part of our statutory processes.	Children who are EHE are supported and looked after appropriately
Re-establish the use of the home circumstances report pro-forma	As Education has no right of entry and no legal right to see the Child for education reasons, this can only be an offer. The LA will ensure where we have no authority to visit, appropriate contact will be made and educational support provided remotely	Contributes to overall safeguarding picture for children at risk of harm.

Multi-Agency Working

Recommendations of Review	What was done and by whom?	What was the impact on children?
The LSCB supports the intention to introduce an enhanced MASH process that includes adult safeguarding and mental health expertise, especially around cases of domestic abuse. This will replace the MARAC process but must be supported by a multiagency response team to provide direct help to clients	All referrals of children and families will be dealt with effectively taking in to account the impact of mental ill health and domestic abuse	The MASH/MARAC will be reconfigured to ensure that an effective multi agency response is provided
The LSCB should seek assurances from all partner agencies that their employees are aware of the current support available for victims of domestic abuse and that they introduce domestic abuse policies and support systems that provide guidance on dealing with victims and perpetrators within the workplace.	HR policies to be amended to include support available l for victims of domestic abuse and actions to be taken relating to perpetrators of abuse	SCC staff know where they can receive support if they are victims of domestic abuse and mangers know how to respond if a staff member is a perpetrator of abuse
Continued work needs to be undertaken to improve professionals understanding of other agency roles and processes. This will help to raise awareness and potentially reduce perceptions held about different agencies. In this case the Maternity Services and Children Services Department need to work to reduce the current identified tensions.	New monthly tracker meeting established to review all UBB referrals; collate feedback on best practice and highlight learning opportunities	Smooth transfer of information between services reduces barriers to safeguarding children.
The LSCB supports the intention to introduce an enhanced MASH process that includes adult safeguarding and the mental health expertise, especially around cases of domestic abuse	High risk domestic abuse screening has been successfully implemented within the MASH. Local arrangements have been recently reviewed independently and is monitored consistently through the MASH and DSA groups	High risk domestic abuse focussed response informs work to protect children, keeping them safe.
All relevant staff and managers are aware of the ned to refer to the LADO to inform decisions relating to child protection procedures	Review and clarification of LADO function in management team meeting	Local LADO processes will be robust and effective in their response to safeguarding concerns
Social Workers to obtain partner agency chronologies (where available) when conducting an assessment	The service actively participated in these activities, with updates provided to the Neglect Assurance Group	Service will contribute to the multi-agency response to neglect

Neglect

Recommendations of Review	What was done and by whom?	What was the impact on CYP?
A multiagency training programme to be implemented to raise the profile of Neglect and support staff to identify and respond quickly to this	Quarterly Neglect training is now offered by the LSCB	Professionals will be better equipped to recognise and responds to neglect effectively
All partner agencies undertake a programme of learning to raise practitioner awareness of neglect in children, underpinned by knowledge and awareness of the Southampton Neglect Toolkit.	Promote and raise awareness of the neglect toolkit.	Staff are more equipped to recognise and response to neglect efficiently
Findings of this review disseminated to all partner agencies of the Safeguarding Children Board to remind them of the importance of the need to recognise, assess and intervene in cases of neglect at an early stage, so that the consequences resulting from chronic neglect are avoided and outcomes for children improved.	Findings briefed	Learning from previous SCRs disseminated and staff can use this knowledge in the future

The LSCB is considering further ways to enhance the way in which it shares learning from case reviews in the future. There will be a number of options considered on a case by case basis to build on the learning package offered and will include:

- Regular learning workshops – general and case specific
- 6-step briefing summary documents
- A learning video recorded by the lead reviewer or a relevant professional (to be accessed via the LSCB website) where this is appropriate to the case.

Child Death Overview Panel (CDOP)

Every child death is a tragedy, the Southampton LSCB sends its condolences to every family affected. During 2017-18 tragically there were 14 reported deaths of children normally resident in Southampton. In each of these cases the Southampton LSCB were notified of the case as detailed in statutory guidance, Working Together 2015. The cases were then referred to CDOP for review as appropriate.

Analysis of the death reviews – During 2017/18, Southampton CDOP reviewed four of the 14 cases and outstanding cases are scheduled for review in 2018/19. The CDOP process requires the panel to categorise the deaths and report these back to the Department of Education annually. It is worth noting that the category agreed does not necessarily reflect the registered cause of death. Tragically 20% of the deaths took place during the pre-viable stage and 40% of the deaths were neonatal. Twenty per cent of the deaths were due to a known life limiting condition and 20% were a sudden unexpected death in infancy. Eighty per cent of the cases were expected. In reviewing deaths, CDOP members consider whether there were any contributory factors known to be associated with increased risk which could be modified to reduce the risk of future deaths. This does not mean that removing these factors would have prevented the death. Forty per cent of the deaths reviewed had modifiable factors leaving 60% that did not.

Forty per cent of the children that Southampton reviewed were male and 60% were female. None of the children whose death was reviewed were ever subject to a Child Protection plan nor were there any Statutory Orders in place. None of the children were known to be asylum seekers.

Learning, issues and actions arising from the reviews:

- Southampton CDOP has not noticed any trends across the cases that have been reviewed.
- The majority of deaths were neonatal and expected.
- The issue of language barriers within services offered to new parents arose from cases reviewed. This was also highlighted last year and been raised with local care providers.
- Appropriate bereavement support across various cultures has also been identified as an emerging learning point when supporting families.

Southampton CDOP is aware of pending national changes with regard to the way in which it operates and is preparing for alternative methods of reviewing child deaths in the local area. This may be through linking with other health agencies or with other geographical areas.

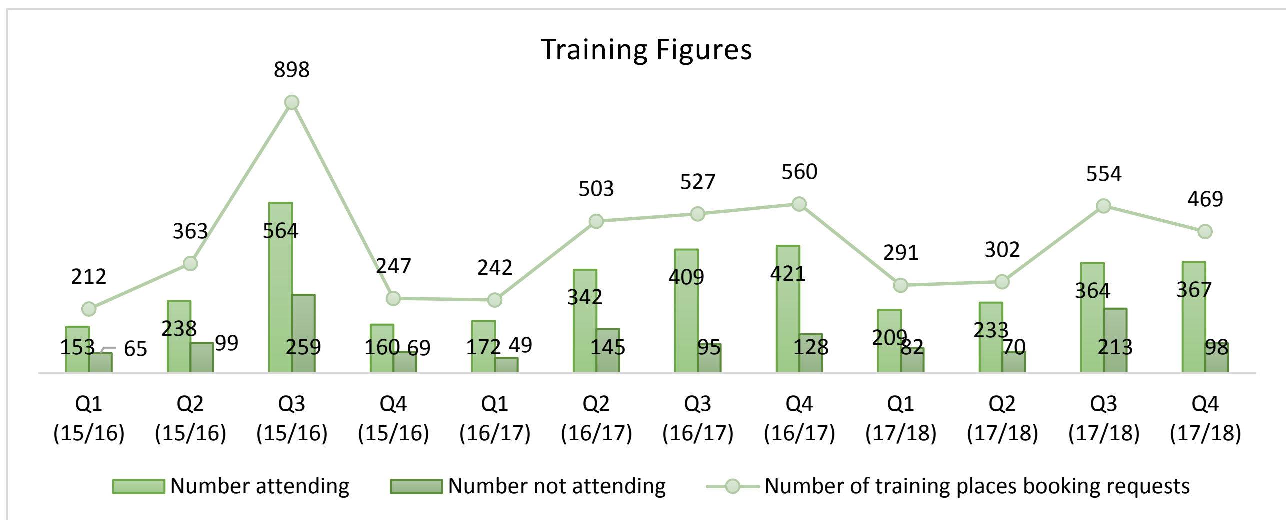
Engagement with Professionals, Public and Young People

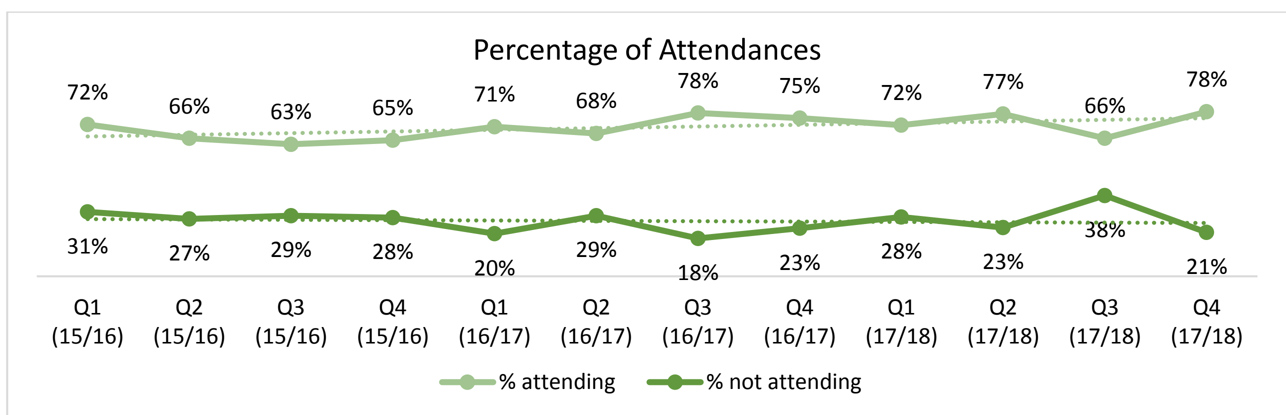
Training

Since 2016/17 the LSB training offer has been consolidated. This offer includes Safeguarding Level 3 training over two days, Level 3 refresher over one day; half day workshops predominantly around themes from case reviews or emerging concerns; and weekly Wednesday workshops which are 2 hour workshops based on emerging themes or topics where professionals have expressed they would like more learning e.g. County Lines, Child and Adolescent Mental Health.

Attendance can be affected by professionals' workload, but there is an increasing trend overall for attendance. Comments from evaluations include:

- “I would love to do more workshops! Great presenter."
- "Very enjoyable."
- "Interactive, interesting session. Great facilitator".
- "Inspiring and motivating trainer".
- "Very informative and engaging."
- "Great workshop - thank you!"
- "Really good informative training."
- "Thoroughly enjoyed today - thank you."
- "Many, many thanks."
- "Excellent session - thank you. Very interesting".
- "Very interesting with lots of useful info".



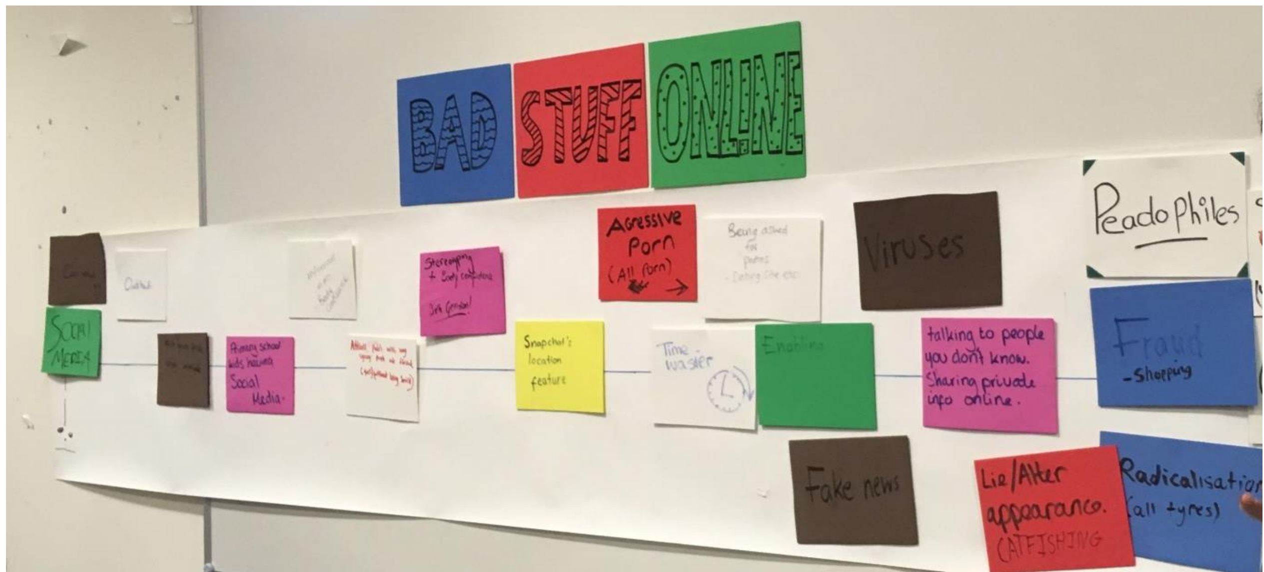


Youth Forum Champions Workshop

The LSCB is keen to seek the views of children and young people in Southampton. In 2017 we wanted to gain young people's views about online safety following Professor Andy Phippen's thematic review on online safety. On 10 October 2017 we ran a workshop for the Youth Forum Champions, asking them to discuss their likes and dislikes about the internet. We categorised this simply as 'Good stuff online' and 'Bad stuff online'. We then asked the young people to identify specific online activities and add it to a scale to show how much they enjoyed it, or how much they didn't like it.

We wanted to emphasise the positive role of the internet in young people's lives. The young people came up with ideas such as, internet dating, shopping, gaming and keeping up to date with current affairs.

The ‘bad stuff online’ was the main focus of the session – we asked what sort of issues young people worried about most?



This provoked some very interesting feedback and discussion within the group. Types of pornography were discussed, for example where ‘aggressive porn’ should like on the scale (it was eventually moved upwards). Top in the list of concerns were paedophiles, cyberbullying, fraud (shopping) and radicalisation. When we asked young people to choose their biggest concern, they all agreed strongly that it was paedophiles. The session had provoked so much discussion, some of which saw the group being very supportive towards each other, that we ran out of time before being able to address what they would like to see done about these issues. All of the discussion in that session has fed into a proposal for what we might do to tackle online safety (along with Head Teacher & Chair of Governors’ views, and Designated Safeguarding Leads’ views). We also asked if any young people would like to come along and speak at the LSCB Annual Conference, coming up the following month, and had numerous volunteers.

Twitter

During 2017-18 the LSCB and LSAB has really focussed on using the joint Twitter account to raise awareness of key safeguarding themes and national awareness raising campaigns including World Suicide prevention Day, Safer Internet Day and Modern Slavery Day. We have grown our following on Twitter following to over 500 followers and tweeted 1774 times since we started the account in June 2016. Both the LSAB and LSCB have 3 active lay members who have engaged with main board meetings, attended weekly Wednesday workshops, the Safeguarding board's annual conference and half day training.

Joint Safeguarding Adults and Children's Board Annual conference November 2017

In November 2017 the LSAB and LSCB organised their Annual Conference titled 'Keeping Safe Online – a practitioners guide 'and 100 Practitioners working in Southampton were in attendance. We invited Key Note Speakers from Get Safe Online and Child Exploitation and Online Protection Command (CEOP) to talk through different types of abuse and exploitation experienced by adults and children online. The conference attendees were able to attend 2 different workshops out of 5 workshops on offer on the themes Cyberbullying, Trading Standards and online financial abuse, Grooming and Radicalisation, NSPCC Young Person led workshop and Adults Safeguarding with focus on online safety. There was also the opportunity to watch a performance of 'In the Net' by Alter ego productions which focussed on awareness of internet safety and the real-world effects of cyber bullying.

Keeping Safe online – a practitioners conference

Date: 29th November 2017

Southampton LSCB LSAB

www.getsafeonline.org

CEOP A National Crime Agency command

ALTER EGO CREATIVE SOLUTIONS

Welcome & Introduction

Keith Makin

Independent Chair of Southampton LSCB

9.35am	Young people's views about online safety
9.45am	Performance of 'In the Net'
10.45am	Break
11.00am	'Get Switched On' – Tony Neate, Get Safe Online Followed by questions from the floor
12.00pm	Lunch
1.00pm	'CEOP and the ThinkUKnow Education Programme' - Jenny Neate, CEOP Followed by questions from the floor
2.00pm	Workshop 1
3.00pm	Break
3.20pm	Workshop 2
4.20pm	Close

Next Steps and Priorities for 2018-19

Southampton Local Safeguarding Board has had a productive and challenging year. The priorities for the Board in this period remained unchanged from the year before. Real progress has been made on these and there is further work to do in some areas to embed these. The LSCB will be considering learning gained during the year and subsequently from its case review and quality assurance work as part of the review of business plan happening autumn 2018.

The recently announced changes to the safeguarding system set out in new Working Together 2018 guidance will also be implemented as part of our review of the Board ensuring that any changes positively add to our collective ability to safeguard and protect children in the City.

Appendix 1: LSCB Finance

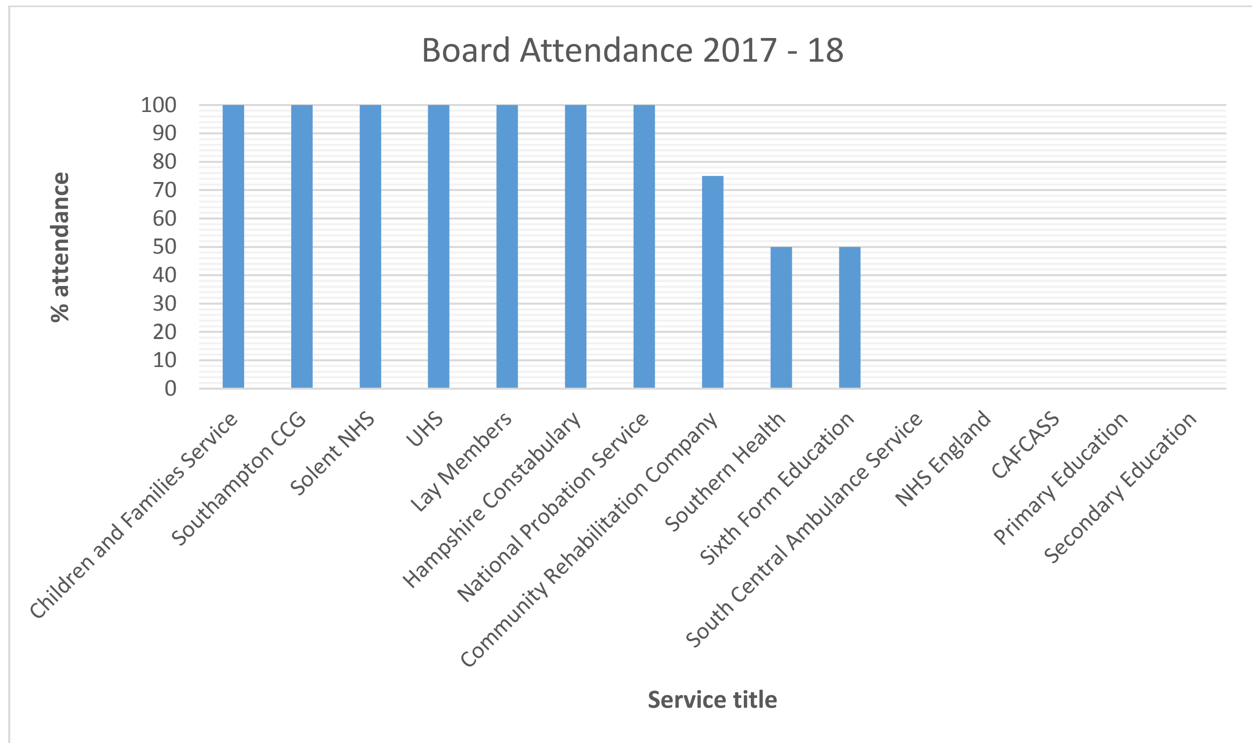
LSCB partners agreed to the following contributions to cover 2016 – 17:

Board Partner Agency	Contribution 2017 - 17
Southampton City Council	**£82,200**
Southampton City CCG	**£34,196**
Hampshire Constabulary	**£13,482**
National Probation Service	**£2,757**
Hampshire & IOW Community Rehabilitation Company	**£1,348**
CAFCASS	**£445**
Total:	**£134,428**

In addition to this, Board partners contributed a supplementary amount for learning and development, totalling £20,144. This funds the multi-agency Level 3 Working Together to Safeguard Level 3 Training and also to help contribute to specialist trainer costs and venues for specific courses and workshops as and when required.

Appendix 2

LSCB Attendance



The above graph shows that the majority of agencies had 100% attendance at LSCB meetings. Partners such as South Central Ambulance Service, NHS England and CAFCASS have discussed attendance with the Chair and are not noted as essential partners at every meeting. These partners are cooperative with other areas of safeguarding work, such as Section 11s and audits.

Appendix 3

LSCB Membership

Agency	Position
Independent Chair	Independent Chair
Southampton City Council	Director of C&F Director of Housing, Adults & Communities
Hampshire Constabulary	Chief Supt Public Protection
Hampshire Probation	Director of Portsmouth/Southampton LDU
Community Rehabilitation Company	Director of Portsmouth/Southampton
Southampton City Clinical Commissioning Group	Director of Quality and Integration/Executive Nurse
NHS England (Wessex)	Director of Nursing
University Hospitals Southampton NHS Foundation Trust	Director of Nursing and Organisational Development
Solent NHS Trust	Operations Director (Children's Services)
Southern Health Foundation Trust	Director of Children and Families Division and Safeguarding Lead
South Central Ambulance Service	Assistant Director of Quality
CAFCASS	Senior Service Manager
Primary School Rep	Primary Heads Conference Representative
Secondary School Rep	Secondary Schools Conference Representative
Special Schools Rep	Special Schools Conference Representative
Further Education Rep	Further Education Representative
Voluntary & Community Sector	SVS – Southampton Voluntary Services
Legal advisor	SCC Legal
Designated Health Professional	Designated Nurse & Designated Doctor
Principal Social Worker	Principal Social Worker
Director of Public Health	Consultant in Public Health
Lead Member for Children’s Services	Lead Member
LSCB Business Unit	Board Manager & Business Coordinator
LSCB Lay Member	Lay Member

Appendix 4

Glossary

4LSCB	Joint working group LSCBs from Hampshire, Isle of Wight, Southampton, Portsmouth
CAFCASS	Children and Families Court Advisory Services
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CPC	Child Protection Chair
CP/ CPP	Child Protection/ Child Protection Planning
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
CYP	Child and Young People
CYP's/CYP Report	Children and Young Peoples 'At Risk' Police Report
EHE	Elective Home Education
GP	General Practitioner
Hampshire CRC	Hampshire Crime Rehabilitation Company
HCC	Hampshire County Council
HFRS	Hampshire Fire and Rescue Service
HMI	Her Majesty's Inspectorate
HMPPS	Her Majesty's Prison and Probation Services
HRDA	High Risk Domestic Violence
ICPC	Initial Child Protection Conference
JTAI	Joint Area Targeted Inspection
LA	Local Authority
LAC/CLA	Looked After Child/Child Looked After
LADO	Local Authority Designated Officer
MARAC	Multi Agency Risk Assessment Conference
MASH	Multiagency Safeguarding Hub
MET	Missing, Exploited and Trafficked
MSP	Making Safeguarding Personal
NEET	Not in Education, Employment or Training
NPS	National Probation Service
PIPPA	Prevention, Intervention and Public Protection Alliance
RSH	Royal South Hants Hospital
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SCC	Southampton City Council
SCAS	South Central Ambulance Service
SHFT	Southern Health NHS Foundation Trust
Southampton City CCG	Southampton City clinical Commissioning Group
Southampton LSAB	Southampton Local Southampton Adults Board
Southampton LSCB	Southampton Local Safeguarding Children Board
SVS	Southampton Voluntary Services
Transition	Refers to a child / young person moving from children to adult services
UBB	Unborn Baby
UHS	University Hospital Southampton NHS Foundation Trust
YOS	Youth Offending Services

Appendix 5 - Structure

LSCB Main Board

Procedures group

4LSCB coordinated work

Future development

LSCB/AB Executive

Serious Case Review Group

LSCB/AB Learning & Development Group

MET Strategic Group

Monitoring & Evaluation Group

Child Death Overview Panel

MET Operational Group

Appendix 5 - Functions

The **Main Board** is attended by panel of senior officers from all safeguarding partners in the city. Together they form the core decision making body for the partnership and have a constitution which details their responsibilities. Meeting runs quarterly.

The **Executive** incorporates Children's & Adults Boards. It is attended by senior representatives from the three key safeguarding partners (Police, Health & Council) plus the Independent Chairs of both Boards. The Executive plans for Main Board meetings, receives reports on progress from each of the Sub Group Chairs to monitor progress and also controls the budgets for each Board. Meeting runs quarterly.

The **Serious Case Review Group** receives referrals for reviews and determines whether they meet criteria for a Serious Case Review. The Group initiates and monitors delivery for Serious Case Reviews or Partnership Reviews where cases do not meet the criteria. It ensures that resultant learning is shared with partners to help prevent the circumstances occurring again and links with Child Death Overview Panel. Meetings run quarterly.

The **Child Death Overview Panel** reviews child deaths and in order to identify learning and/or trends. Meeting runs quarterly.

Learning & Development Group sits across the Children & Adults Boards & ensures that multi-agency staff can meet the standards for safeguarding outlined in pan-Hampshire Safeguarding Policy & Procedures. The Group seeks to ensure that the multi-agency workforce has access to appropriate training to safeguard children, young people & adults at risk of or experiencing abuse and neglect. It also commissions Safeguarding Level 3 training and reviews multi-agency training to ensure it is fit for purpose. Meetings run quarterly.

The **Missing, Exploited and Trafficked Strategic Group** provides strategic guidance to the operational MET Group. It sets the MET Action Plan, focusses on issues including missing children, those at risk or involved in gangs, child criminal exploitation (including child sexual exploitation), and children at risk of or subject to trafficking or modern slavery. Receives the Problem Profile from Hampshire Constabulary and considers responses to highlighted problems. Meetings run quarterly.

The **MET Operational Group** meets bi-monthly to consider MET issues within Southampton and operational responses to these. It is attended by agencies including the Police, Children's Services, Voluntary Sector (including Barnardo's ICTA Service and No Limits) and Housing. Patterns, trends and areas of interest identified from the monthly MET case review are considered at this meeting. The MET case review meeting is held monthly and contributed to by key partner agencies to discuss intelligence and oversee local practice/responses to individual children who are at risk of exploitation, going missing from home or from care, as well as looking at perpetrator and location hotspot disruption.

The **Monitoring & Evaluation Group** delivers monitoring and evaluation activity to drive improvements in services to safeguard and promote the welfare of children and young people. It receives presentations on Section 11s, has oversight of multi-agency data, delivers thematic audits, and shares good practice. Meetings run quarterly.