Southampton Local Safeguarding Children Board

Annual Report

2016 - 17

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Keith Makin's Intro

The Local Safeguarding Children Board has been working hard in 2016-17, in spite of decreasing resources. As this report exemplifies, we have undertaken a variety of pieces of work to ensure that the welfare of children and young people remains paramount in the City of Southampton.

The Board is moving forward during a period of national uncertainty with regard to the Wood Review of LSCBs, whilst sitting in unanimous agreement that the Board should continue in its current structure. Future recommendations will be considered when required.

We are well aware of the increasing demand placed on agencies both financially and physically and are therefore extremely grateful for the consistent work and engagement that the LSCB receives. Partnership working within Southampton has been a strength identified in numerous inspections and reviews and we continue to see this evidenced regularly.

As detailed in the report below, the LSCB completed a partnership review around an emotional and physical neglect case in 2016. Learning is still being reviewed and shared via training and briefings. It has also assisted with the more in-depth work that the Board has been undertaking through its Neglect Assurance Sub Group and Neglect Task and Finish Group. I took on the role of Chair for this sub group and am very impressed by the City's desire and aspiration to work together and improve the outcomes for children who are at risk of neglect. We will be in a position to report back on a great deal of positive work around this issue in the 2017 – 18 Annual Report.

As a Board, we regularly monitor and reflect on challenges made between agencies and by the Board through our quarterly challenge log (http://southamptonlscb.co.uk/about/whatdowedo/). During 2016 – 17, there were a total of 45 challenges made through our main Board meetings, Executive Group and our Sub Groups. I believe that this activity highlights the importance of the Safeguarding Board's work and demonstrates its effectiveness in drawing out key issues and themes that may require more attention.

The Board agreed it's priorities for the year. These are:

- Ensure safeguarding is a whole city theme
- Manage and monitor the impact of austerity measures, increasing demand and changes to service provision on safeguarding outcomes for children and young people.
- Coordinate and quality assure responses to prevent and disrupt the exploitation and victimisation of children and young people
- Embed key learning from case reviews (including SCR's) and audits into local practice
- Ensure a focus on building resilience and raising the aspirations of children and young people in Southampton.

These themes will continue until 2018, as we believe that they are still relevant and we wish to keep our efforts consistent in order to make a robust and lasting impact.

We receive regular updates on sub group work through our reports to the Executive Board and have therefore seen some excellent work taking place. Included in this is the work of our recently developed Education Task and Finish Group. This was established in order to respond to identified gaps in safeguarding issues in schools. During the last year, this group has had oversight of a new child protection policy guidance document, new Elective Home Education processes and a new method for capturing children missing from education data regularly. We have also worked alongside the Local Authority Education Service to develop a 'Safeguarding in Schools' self-evaluation audit. This is aligned to the 'Keeping Children Safe in Education' 2017 DfE Guidance and responses will be reviewed by the Board annually; putting us in a much stronger position with regard to having a full picture of safeguarding within Southampton's schools.

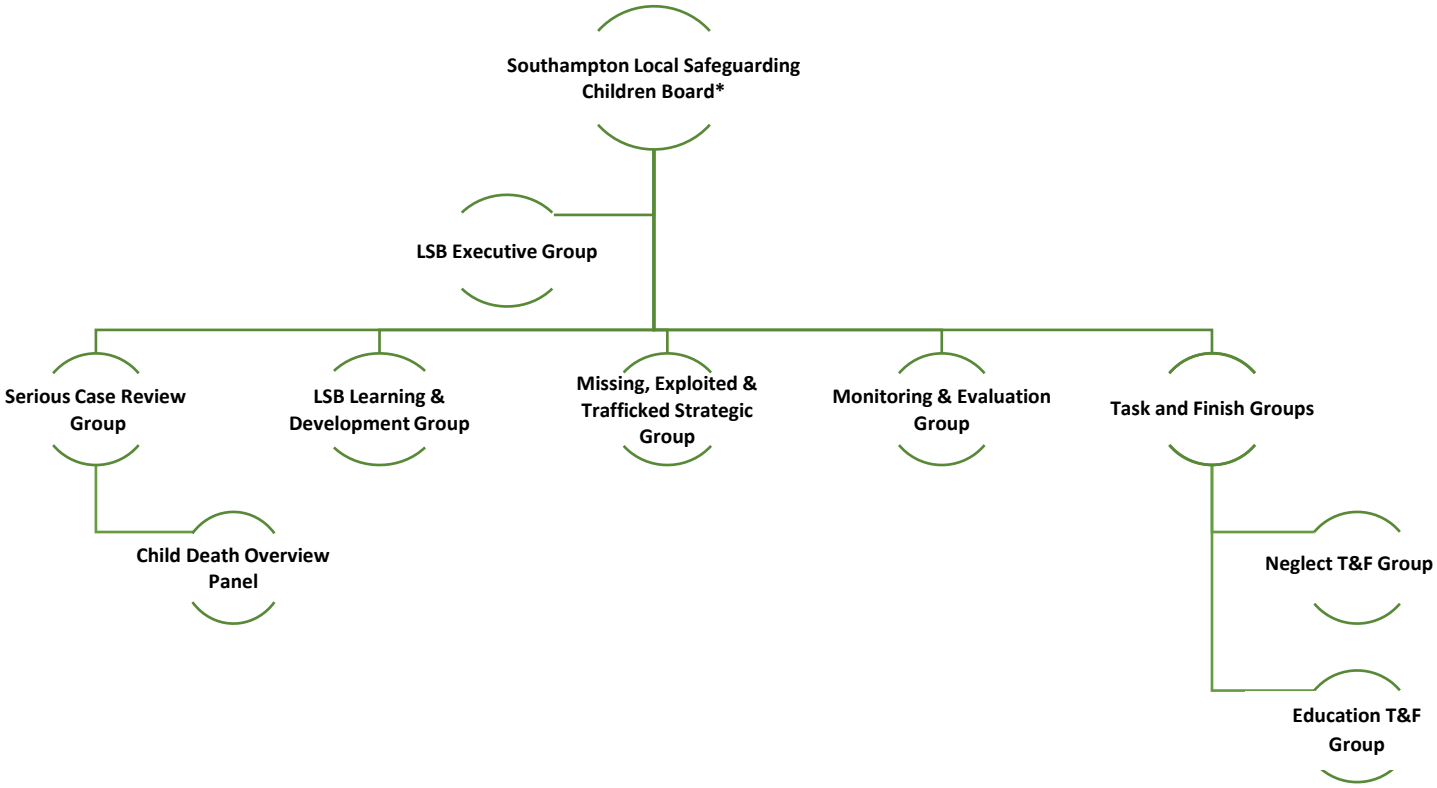
Within the last year, there have been numerous changes to the Children and Families Service's Front Door Arrangements. Professionals and members of the public are now able to reach a Social Worker and discuss any concerns they may have in a much speedier and more direct way. The Board welcomed these changes and was in favour of lessening the bureaucracy and delay at this crucial point in Child Protection. We are already seeing the impact that this has had, with our number of Children on a Child Protection Plan steadily decreasing and our number of Looked after Children lowering to 542 at the end of Q4, as opposed to a high of 611 in Q1. This has been lowering consistently each quarter. The Board has been seeking regular assurance and updates, to ensure that this reduction is safe and appropriate and we will continue to do so.

Each year we work with our Board partners to ensure that our meetings are relevant and efficient. We adapted the style of Board meetings in response to feedback that agendas were too full and that there was not enough time for discussion and group work. Our agendas are now themed and attendees are given time to reflect on what we have heard during the meeting and work in groups to think of new and creative ways to improve things in the City. So far, these discussions have led to the creation of bimonthly multi agency professional's sessions, which will be focussed on improving communication and on the welfare of staff and the implementation of a joint LSCB and LSAB session to review cross-area working and 'think family' issues. This is due to take place in 2017-18. The new style of meeting feels more collaborative and creative and I am excited to see what else is developed here in the future.

Finally I would like to express my thanks to the LSCB partner agencies for their hard work and continued commitment to improving the lives and wellbeing of children in Southampton.

What is an LSCB?

Southampton Local Safeguarding Children Board (LSCB) is a statutory body that leads on keeping children safe and ensuring their wellbeing in Southampton. The LSCB must also continually check that what is done in Southampton to safeguard children works. For example, we try to make sure that the procedures we publish are clear and help staff and volunteers know what to do when they are worried about a child, or that staff and volunteers receive the training they need to undertake their roles. We focus our attention and efforts on a range of agreed priorities taken forward by 'sub groups' and occasionally issues focussed 'task and finish' groups of the main LSCB. During the year 2016 – 17, our **structure chart** looked like this:



This report will detail the work carried out by these subgroups and will discuss their impact in relation to LSCB themes and objectives.

The Team

Southampton LSCB is chaired by Keith Makin and is supported by a joint Safeguarding Children and Adults Board Team. This consists of a manager, two coordinators, an information analyst and an administrator. The amalgamation of support for both Safeguarding Boards has enabled a consistent and robust 'think family' approach to all of our work.

Funding for these posts is covered by LSCB and LSAB joint pooled budget arrangements. LSCB's funding is set out below.

Finances

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

Board Partner Agency	Contribution 2016 - 17
Southampton City Council	**£81,224**
Southampton City CCG	**£33,724**
Hampshire Constabulary	**£13,297**
National Probation Service	**£1,329**
Hampshire & IOW Community Rehabilitation Company	**£1,329**
CAFCASS	**£550**
Total:	**£131,453**

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 allows us to commission independent trainers for specific courses and workshops as and when required.

Business Planning

In February 2016, the LSCB met for a 'Business Planning Day'. This gave the Board a chance to review the 2015 – 18 Business Plan (this can be viewed here or by visiting www.southamptonlscb.co.uk), ensuring its relevance and updating where appropriate. It was also a chance to consider setting new priorities and themes for the year ahead.

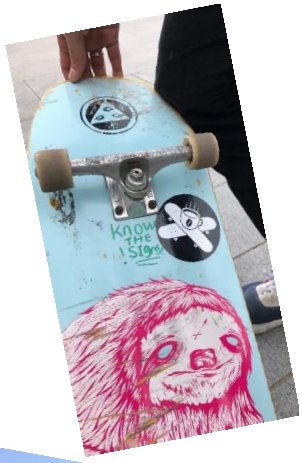
The priorities set for 2015 – 18 remained the same and are as follows:

3 Year Priorities:	
1.	Ensure safeguarding is a whole city theme
2.	Manage and monitor the impact of austerity measures, increasing demand and changes to service provision on safeguarding outcomes for children and young people.
3.	Coordinate and quality assure responses to prevent and disrupt the exploitation and victimisation of children and young people
4.	Embed key learning from case reviews (including SCR's) and audits into local practice
5.	Ensure a focus on building resilience and raising the aspirations of children and young people in Southampton.

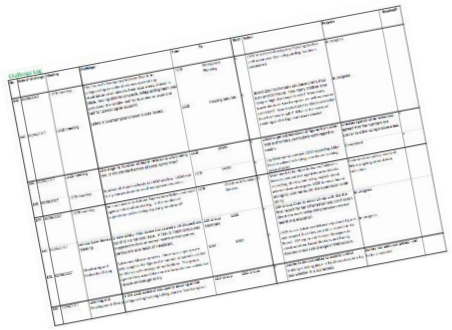
Throughout 2016 – 17, the LSCB tailored its activity to ensure that these priorities remained our key focus. A summary of work undertaken is below:

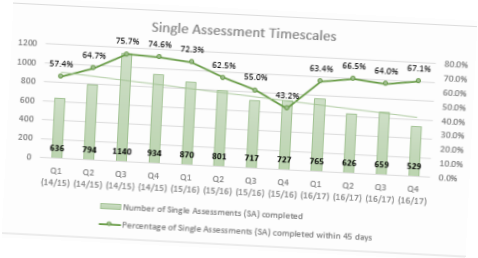
Ensure safeguarding is a whole city theme

- Community engagement strategy in place
- Annual Conference – Neglect
- Community engagement activity:
  - Child Safety Week
  - CSE Awareness Day
  - Online Safety Day
  - Make Safe Campaign
  - Time to Talk (online based)
- Set up a Diversity Advisory Group
- Monthly professionals' survey
- Quarterly newsletters
- 3 x's lay members – linking directly with community and voluntary groups



Manage and monitor the impact of austerity measures, increasing demand and changes to service provision on safeguarding outcomes for children and young people.

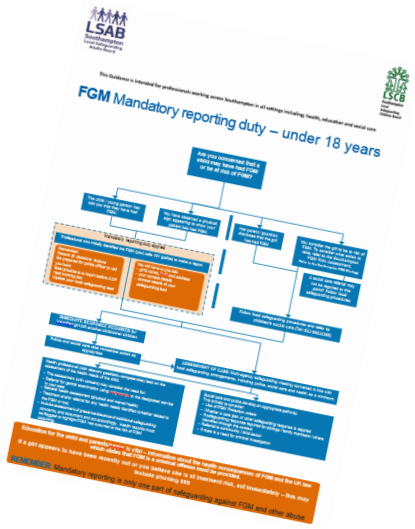


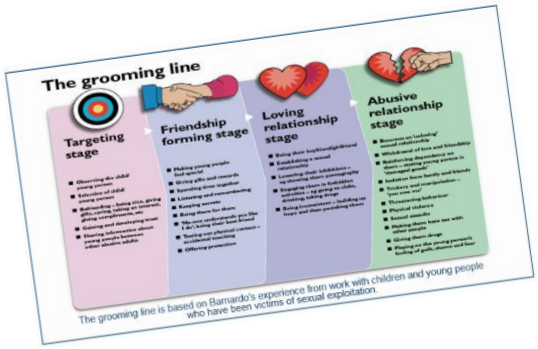


- Regular multi agency audit programme
- Updated the methodology for Section 11 Audits
- Quarterly challenge log reviewed by LSCB and updated to website quarterly
- LSCB main meetings are themed to enable regular assurance on each agreed theme
- Partnership Board Chairs' meeting in Southampton attended by LSCB Chair
- Trends and timescales monitored on multi agency dataset

Coordinate and quality assure responses to prevent and disrupt the exploitation and victimisation of children and young people

- Missing Exploited and Trafficked (MET) Audits
- MET group activity
- Make Safe Campaign
- Specific training for taxi drivers
- MET dataset reviewed quarterly
- Quarterly half day CSE training
- 4LSCB (4 local LSCB areas) renewal of FGM flow chart





Embed key learning from case reviews (including SCR's) and audits into local practice

- Quarterly oversight of multi agency case review action plans
- Multi agency audit schedule
- Training programme influenced by emerging themes from case reviews and audits
- Multi agency audit action plan monitored quarterly
- Workshops on audit findings e.g. JTAI Audits
- Education Task and Finish Group – initiated in response to SCR findings
- Neglect Task and Finish Group – initiated in response to SCR findings
- Section 156 Schools Safeguarding Audits

Ensure a focus on building resilience and raising the aspirations of children and young people in Southampton.

- Education Task and Finish Group set up to focus on:
  - Elective Home Education
  - SEND
  - Children Missing from Education
  - Alternative Provision
  - Virtual School
- School attainment and NEET figures reviewed by LSCB annually
- All audit activity includes a focus on the voice of the child
- Neglect task and finish group initiated in order to review the toolkit, strategy and policy
- Online safety and CSE awareness campaigns
- Public endorsement of the NSPCC Speak Up, Stay Safe campaign

At the business planning day in February 2016 the Board agreed four themes for 2016/17. These represent four key safeguarding areas in Southampton that require a multi agency focus. The themes are:

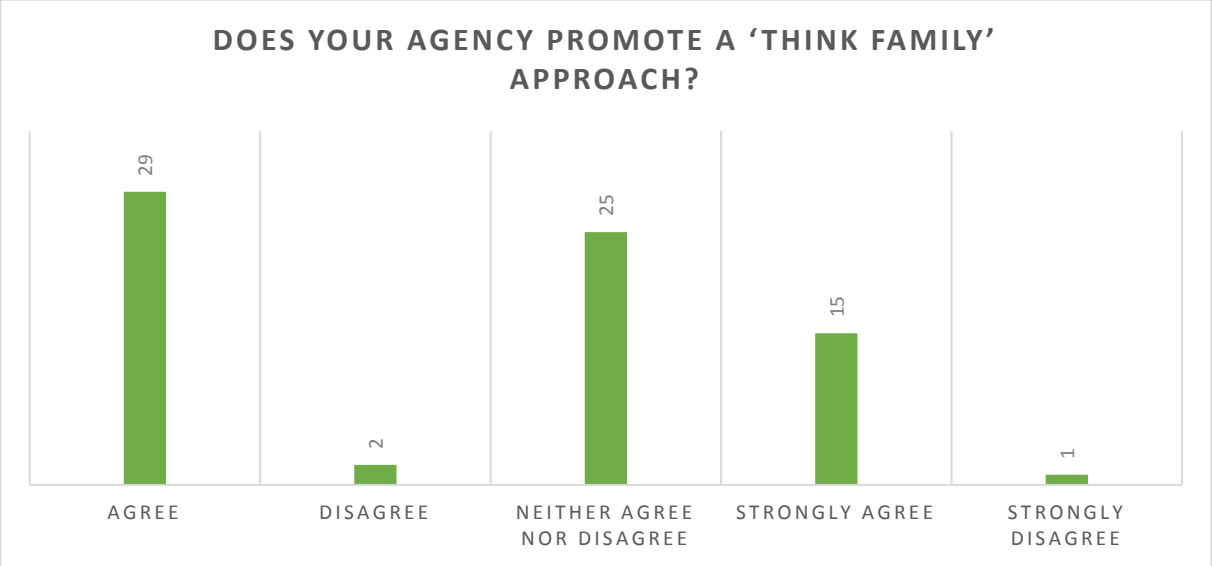
LSCB Themes:	
1.	Develop responses to encourage a 'think family' approach where there is adult mental health, substance / alcohol use and domestic abuse and this is impacting on childrens' safety
2.	Improve identification and responses to neglect of children in Southampton
3.	Focus on improving safety 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

Over the last year the LSCB sub groups have sought to address each of the above themes as follows:

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 a child's safety.**

a. A 'think family' themed Board meeting took place in July 2016. Relevant Board member agencies and services (Children & Families Service, Hampshire Constabulary, Domestic Violence service, Substance Misuse service and SCC Housing Services) provided an update as to how their service area was using the 'think family' approach and data was provided from each which is fed into this report.

b. The Board also conducted a 'think family' professionals survey in June 2016 to raise awareness of the approach and find out if professionals on the ground felt that it was being used. When asked whether their own agency promoted a 'think family' approach, we received the following results:



Further findings from this survey were shared with Board and the Learning and Development Group for further action.

c. The LSCB Serious Case Review Group received feedback on all adult social care case review actions to ensure that these were being carried forward. 80% of their actions were signed off by the group during the year.

d. Adult Services submitted a Section 11 report in July 2016. Feedback to the service included:
'Ensure a service wide awareness of the 4LSCB policies and procedures' and
'Add a statement to the Section 11 stating that adult's social care staff know how to refer to MASH'

e. The LSCB has received regular updates on the MASH, including the changes to the front door process. This has also included regular feedback and assurance on the introduction of the MARAC/MASH process.

f. The Board coordinated four adult mental health multi agency workshops and three substance and alcohol misuse workshops across the year. In total, these were attended by 144 professionals. Both sessions were attended by both children's and adult focussed practitioners and feedback is consistently good.

g. Quarterly joint Safeguarding Boards newsletter to share learning from audits and case reviews (both local and national). The Boards team published five newsletters in 2016 – 17.

h. The Safeguarding Boards Team has joined up work across LSCB and LSAB where appropriate:
- Learning and Development Group
- Community engagement and awareness

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Develop a training offering for disability and for child mental health
- Enhance our method of sharing learning from case reviews and audits such as 6 step briefings, online videos and increased numbers of workshops
- Review the Joint Working Protocol and facilitate the creation of a Southampton 'local' version of this document
- Deliver a joint audit with LSAB on transition from children's services to adult services, with a focus on mental health

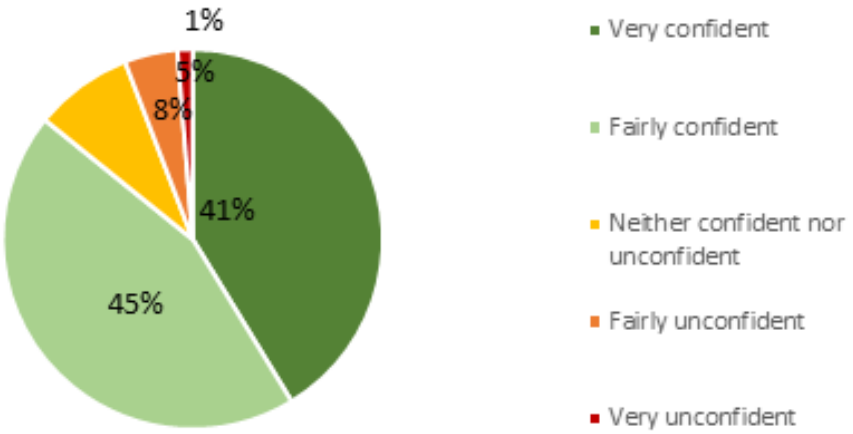
2. Improve identification and responses to neglect of children in Southampton

a. A themed meeting on 'Neglect' took place in October 2016. Assurance was sought from Children's Social Care, Police, Education, Health/CCG and Housing. Information taken to Board included excellent feedback from Housing on how they have rolled out the Neglect Toolkit to their staff and have offered extra training on the issue.

b. The Board has established a Neglect Assurance Group to look at coordinating action in this priority area strategically. This is attended by a large number of agencies including the Police, Social Care, Education, Health, and Voluntary Sector and is chaired by the Independent Chair of the LSCB.

c. In addition to this, a multi agency neglect task and finish group has been developed. This is chaired by a local secondary school head teacher and exists to agree a new city-wide neglect definition, refresh the Neglect Strategy in the City and renew the Neglect Toolkit.

d. The Board conducted a professionals' survey on 'Neglect' in October 2016. When asked 'To what extent do you feel confident in recognising and responding to child neglect?', the response was:



Further findings from this survey were shared with Board and the Learning and Development Group for further action.

e. Quarterly multi agency half day workshops titled 'An Introduction to Neglect' are offered and funded by the LSCB. An external expert trainer has been commissioned to deliver this training in order to ensure a high standard and an independent view. We have run 4 courses over this annual report year with a total of 91 multi agency attendees.

f. The Board have coordinated focussed activities during Safeguarding Week (June 2016) to raise awareness of 'what to do if you are worried about a child' – focussing on neglect indicators. The Board engaged with over 400 people during the week.

g. The LSCB and the LSAB delivered a joint conference in December 2016 titled 'Recognising Neglect, A Shared Responsibility'. This was attended by approx. 175 multi agency professionals. It also promoted the 'Think Family' approach to neglect, focussing on both neglect in children and self-neglect in adults.

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Multi agency definition of neglect to be agreed
- Multi agency revision of neglect strategy to be finalised
- Neglect toolkit to be refreshed in line with the updates to threshold
- JTAI Audit of Neglect to take place in 2017 – 18
- Develop a dataset to understand the extent of neglect
- Explore methods of enabling peer challenge in cases of neglect in terms of thresholds

3. Focus on improving the safety and outcomes for Looked after Children and children at risk of going missing, being exploited or trafficked.

a. A themed meeting on improving outcomes for 'Looked after Children' and 'at risk of going missing, being exploited and trafficked' took place in December 2016. The Board received information from Children and Families Service, Health Providers, Education, police, the National Probation Service and Community Rehabilitation Company on these themes. This included an update from University Hospitals Southampton NHS Foundation Trust on how they have improved staff awareness of their missing and absconding policy and how they run simulations to ensure staff remain vigilant.

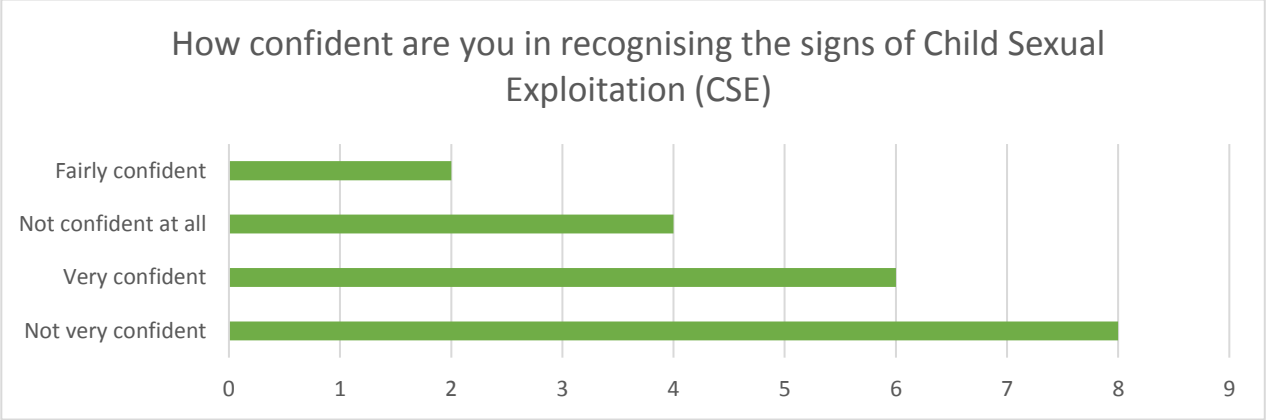
b. The Board also received assurance from the Local Authority of plans to safely address the number of Looked after Children. Southampton Children and Families Service adopted a new Front Door Approach, have planned a staff transformation and have amended the Threshold Document. The LSCB had oversight of all of these changes and challenged as appropriate to ensure that the safety and welfare of the child was always paramount. The Board was broadly in favour of the planned changes to the service and is continuously kept up the date with progress.

c. The LSCB dataset includes Looked after Children data, including annual attainment levels at all school levels and further and higher education. This is reviewed by the Monitoring and Evaluation Sub Group and the Main Board.

d. The Missing, Exploited and Trafficked Sub Group carries out quarterly audits on key themes, to ensure a quality multi agency response in this area. The first audit reviewed Looked after Children that are placed out of area. Recommendations included reviewing any existing arrangements for a child placed out of area who is believe to be at risk of going missing or being exploited, to ensure that this has been properly risk assessed, ensuring geographical, social and environmental factors are considered in planning and assessing suitability of placement and continuing and developing local professional development in this area.

e. The Missing, Exploited and Trafficked Sub Group review a quarterly dataset which is MET specific. Key feedback from this is shared with the LSCB Executive Group on a regular basis.

f. In April 2016, we carried out a professional's survey on Missing, Exploited and Trafficked' issues. When we asked 'How confident are you in recognising the signs of Child Sexual Exploitation (CSE)?', we received the following response:



Further findings from this survey were shared with the Board and the Learning and Development Group for further action.

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Improve links between Corporate Parenting Committee and LSCB
- Ensure that Education have a detailed action plan to address attendance rates and attainment – where information demonstrates 'gap' against national averages and priority groups including CLA.
- Seek the views of children and young people in designing work to raise aspirations and build resilience in this area.

- Work with key stakeholders including schools and Social Care to ensure a strategic and quality response to online safety issues.
- Deliver a thematic review to include an audit of recent cases where peer to peer online exploitation or abuse was alleged.
- Develop a system to monitor and quality assure foster carers and independent fostering agencies used by Southampton.

4. Improve communication between services at senior and practitioner level

a. In March 2017, the Board held a themed meeting on 'communication'. Assurance was sought from Children and Families Service (including Education and Early Help), Hampshire Constabulary, National Probation Trust, Community Rehabilitation Company, CCG and other Health providers. Board discussion led to an agreement to run monthly multi agency sessions for staff to come together and discuss key themes and issues that are arising in front line work. These will be aimed at improving relationships and communication across partners and will be rolled out in 2017 – 18.

b. The Board has developed its methods of communication with multi agency professionals in order to convey key messages and hear their views. This has been achieved through the use of staff surveys, focus groups, Weekly Wednesday Workshops, newsletters and social media.

c. The Board has regular communication with other key partnerships including LSAB, Safe City Partnership, Health and Wellbeing Board and Scrutiny Panels, regarding issues of concern. This is largely through the Chair's attendance at a quarterly Partnership Chair's Meeting.

d. The 4LSCB online policies and procedures are updated on a six monthly basis. Briefings are sent out to highlight these changes either via specific email or through the LSCB newsletter.

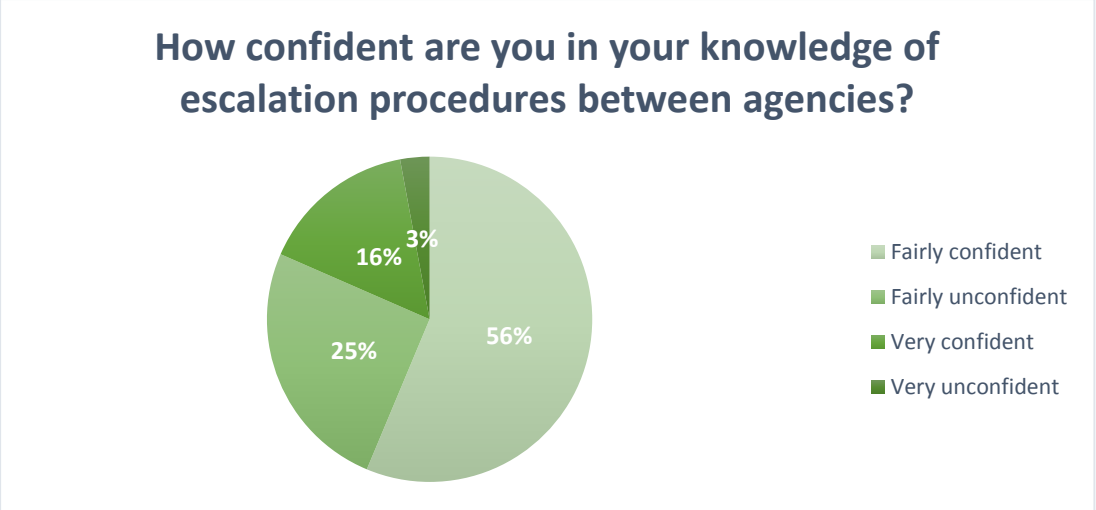
e. The Monitoring and Evaluation Group has linked with Education leads to develop a safeguarding audit tool for schools. This is so the Board can gain assurance regarding safeguarding responses and it includes duties under Section 156 of Education Act. The LSCB Chair and Education leads delivered a joint workshop with Head Teachers in order to build communications and introduce the new tool. Results will be reviewed by the Monitoring and Evaluation Group in 2017 – 18.

f. The Board has delivered a number of audits to seek assurance of current quality of practice in the following issues:

    - Neglect
    - Missing, Exploited and Trafficked cases
    - Female Genital Mutilation
    - Domestic Violence – JTAI

    All learning and improvement from these audits is monitored by the Monitoring and Evaluation Group.

g. In November 2016, the Board carried out a professional's survey on communication. When asked 'How confident are you in your knowledge of escalation procedures between agencies?' staff reported the following:



Further findings from this survey were shared with Board and the Learning and Development Group for further action.

What is left to do?

The LSCB Business Plan incorporates the following actions which endeavour to further this work across the next year:

- Review the results from the Education safeguarding self-assessments and ensure process is robust
- Deliver audits as per agreed audit schedule
- Work with Board members to ensure the needs of diverse communities are met when responding to safeguarding concerns
- Embed a process for multi agency professionals to come together and discuss a variety of topics in relation to safeguarding

Throughout this annual report year, the Board has heard examples of excellent work taking place across a number of agencies regarding these themes. New and innovative ideas have also been developed such as improving communication through multi agency practitioner workshops and the implementation of an annual safeguarding assessment tool for schools.

However as portrayed above, there is still room for improvement and further work to be achieved. The Board continues to monitor this closely and is regularly involved in or kept up to date with progress on these matters.

Learning and Improvement –

LSCB Case Reviews

There were no Serious Case Reviews completed during the year 2016 – 17. The Board received one report from a partnership review which involved the long-term neglect of two siblings. This piece of work significantly informed the work that has since been carried out by the Neglect Assurance Group. Learning from this review is being consistently shared through the quarterly 'Introduction to Neglect' training course that is available to multi agency professionals. All actions are also being monitored by the Serious Case Review Group on a quarterly basis.

There have been a number of reviews underway during this annual report year; 'The Allegations against Foster Carers' Serious Case Review which originally commenced in 2012 but had to be paused due to criminal proceedings. This review was able to continue in August 2016. The report is expected to be shared with the Board in December 2017.

The LSCB commissioned 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. The final report has been written and shared with the Board. Learning is due to be shared with head teachers and then the wider workforce in early 2017/18. The LSCB has also chosen online safety to be the theme of the Annual Conference in November 2017. Any action deriving from this report will be regularly monitored by the Serious Case Review Group.

Three further case reviews were agreed in 2016 – 17:

- A partnership review regarding two children who have suffered emotional and physical neglect. The multi agency panel is in place for this case and a report is expected towards the end of 2017-18.
- 2 Serious Case Reviews, both involving the tragic death of young children. Criminal investigations have meant that parts of these reviews are halted but multi agency panels are in place and reports are likely to go to Board in 2018/19.

The following are key themes that we see consistently within our case review learning:

- The importance of **chronologies -** Knowing the history of a case to inform current practice can prevent future harm – it is vital that the services involved with families and individuals know what has happened in the past. Keep up to date chronologies for cases where there are risks, find out what other services know, this will help identify current risks or harm
- **'Trigger Trio'** - Domestic violence, substance misuse and mental health issues - high risk of serious harm or death for all adults and children involved. The risk of harm is greatly increased when these issues are seen together. This includes risks to victims and perpetrators of domestic violence as well as children involved.
- **Escalation** – Safeguarding is your business until the individual is safe – If a professional is unhappy with the outcome of a meeting, conference or referral, they are responsible for escalating this as appropriate. This may take a number of attempts but learning demonstrates that it is essential to keep these cases on the radar rather than accepting an outcome that one may disagree with.

- Good **communication** between agencies – Professionals and agencies can only act on the information that they are aware of. It is important for professionals to have a good understanding of information sharing and ensure that this is adhered to whenever appropriate.
- The importance of the **voice of the child –** Thinking about what life is like for that child and seeing the world through their eyes. Learning shows that it is easy to get distracted by the parents and their issues and to forget about the lived experience of the children in that household.
- Regular and effective **supervision -** plays a key role in supporting practitioners to identify and manage risks by providing an opportunity to discuss even seemingly 'stable' or 'low risk' cases with more experienced practitioners. Again this review identified an overreliance on staff to recognise the need for treatment review or case discussion which potentially increased the risk to clients in receipt of long-term care.
- **Use your instincts!** Don't just take what you hear from people (workers or clients) on face value, show 'inquisitive enquiry', ask where you are concerned, find out what you need to know and use this to inform what happens next.

Once a case review has been written, the lead author will form recommendations. The multi agency partnership will use these to create an action plan, in order to address these. The LSCB Serious Case Review Group have oversight of these plans and reviews them quarterly. If all are agreed that an action has been achieved, this is turned to 'green', signed off and removed from the plan. At the end of the financial year 2016 – 17, there were 30 outstanding actions on the plan. This is in comparison with the end of the financial year in 2015 – 16 where there were 46 outstanding. However, this isn't a direct comparison as there were a number of new actions added throughout the year.

Outstanding actions include themes such as ensuring current chronologies are kept, used and analysed robustly, attendance at conferences is audited and escalated where appropriate, spot checking and auditing GP READ codes with individual GP practices and considering how information on vulnerable tenants is kept within Housing.

The LSCB is planning to enhance the way in which it shares learning from case reviews in the future. There will be a learning package offered for each case which will include:

- Regular learning workshops
- 6-step briefing documents on each case
- A learning video recorded by the lead reviewer or a relevant professional (to be accessed via the LSCB website)

Child Death Overview Panel (CDOP)

First, Southampton LSCB and CDOP would like to send deepest sympathies to any families affected. During 2016 – 17, Southampton CDOP reviewed 17 of the 26 notified deaths, leaving 6 outstanding (this is due to pending information and these are scheduled for review early in 2017 – 18). This is a significantly larger total of reviewed cases in comparison to the 9 reviewed in 2015 – 16, due to the fact that CDOP now reviews pre-24 week deaths and a backlog of cases from the disbanding of the 4LSCB CDOP was carried over in 2016 – 17.

The CDOP process is a national requirement to categorise the death. The category does not necessarily reflect the registered cause of death. The CDOP process requires the panel to categorise the deaths and report these back to the DfE annually. It is worth noting that the category agreed does not necessarily reflect the registered cause of death. 59% (10) of the deaths were neonatal, whereas 24% were due to Chromosomal, genetic and congenital anomalies and 17% were due to malignancy. 16 of the 17 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. 4 of the 17 deaths reviewed had modifiable factors leaving 13 that did not.

10 of the children that Southampton reviewed were male and 7 were female. There were 15 deaths reviewed in which a Statutory Order and a child protection plan had not been in place at all in the child's life and 2 where the status for both was unknown. None of the children were known to be asylum seekers.

Staffing issues – Southampton has spent this year embedding the CDOP process and agreeing systems and efficient ways of working. The meetings are always well attended and the group benefits from the expertise of a neonatal consultant and the Designated Doctor for child deaths, in addition to a Public Health lead and safeguarding leads from various services in the City.

The CDOP Group has met 6 times throughout the year. They formerly met quarterly but there were a number of extra meetings held in order to catch up with previous backlog.

Trends, issues and actions arising from Southampton cases:

- Southampton has not noticed any trends across the cases that have been reviewed.
- As mentioned above, the majority of deaths were neonatal and expected.
- The issue of language barriers within services offered to new parents arose from cases reviewed. The Hospital Service took an action to review this internally and to ensure that all services are accessible for all. There is a piece of work outstanding for all Boards to double check this in their own areas.
- Another issue that was raised within CDOP cases and thereafter discussed with Public Health is the importance of offering the flu vaccine to all who may be vulnerable, regardless of any other secondary health needs.
- Southampton has written to the Ambulance Service to ensure that the algorithm of the 111 service is appropriate and will result in an ambulance dispatch where required.
- It was bought to the CDOP Group's attention that some staff who are involved in the Rapid Response process are finding it distressing, as they often knew the child personally. This issue has been discussed across the 4 LSCB areas and it has been agreed that attendance at these meetings should fall under management responsibility, or should allow practitioners to have their manager attend for support. Hampshire LSCB are working on producing leaflets for schools who take part in this process and have agreed to share these with the other areas.

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.

Section 11s

The LSCB has a structure in place to receive reviews from key services in Southampton who have a duty under Section 11 of the Children Act 2004. This places a duty on a range of organisations to ensure their functions and any services that they contract out to others are discharged regarding the need to safeguard and promote the welfare of children.

The LSCB Monitoring and Evaluation Group reviewed 16 full Section 11 reviews from partner agencies during this year. These include:

Southampton City Council:

- Children & Family Services; including early help, social care, education & early years
- Youth Offending Service
- Adults Services
- Housing Services
- Licensing
- Sport, leisure and culture services
- Public Health

- CAFCASS (Child and Family Court Advisory Support Services)
- Hampshire Constabulary
- Hampshire Probation Trust
- Community Rehabilitation Company
- Home Office – Border Force
- NHS (including Southampton City Clinical Commissioning Group, Solent NHS Trust, University Hospitals (Southampton) NHS Trust, Southern Health)
- Jubilee Sailing Trust (update requested by the Chair).

The Board also requested a full Section 11 from Southampton Football Club, following on from the national issues highlighted in the media regarding a former coach. This was scheduled and took place in Q2 of 17 / 18.

The following are key areas for development that were raised in more than three submissions throughout the year:

- All staff in our organisation are able to access the 4LSCB on-line inter-agency child protection procedures. Staff are aware of the procedures and use them appropriately

- Staff are clear about the circumstances in which a referral to MASH is necessary

- Records are kept of staff that have completed safeguarding training, including the dates and details

- Staff are made aware of who is the designated lead for safeguarding within our organisation

The Monitoring and Evaluation Group were able to assist with queries where appropriate and referred to the appropriate people if required. Examples of follow up actions include a senior manager from Children

and Families Service attending a team meeting in Licensing, to talk through the referral process, details of all available safeguarding training shared with National Probation Service for use within their teams and more regular 4LSCB briefing document being devised by LSCB Team, in order to raise awareness.

The process for Section 11 auditing has now changed. This is to assist the agencies that work across a number of local LSCB areas (Hampshire, Portsmouth and Isle of Wight) and to avoid duplication. Cross-area agencies now submit one Section 11 to a multi agency, multi-area panel once a year. All local Section 11s are received by a Southampton panel once a year. All feedback is shared and analysed by the Monitoring and Evaluation Group.

Multi agency Audits

Joint Target Area Inspection – Children Living with Domestic Abuse (Dry run)

This audit was undertaken to improve local understanding of case work in light of the current Joint Thematic Area Inspection theme, examining how local partners, including local authorities, police and probation, and health services, work together to protect children living with domestic abuse.

Seven cases were picked (as would be during an inspection). Cases were cross referenced across Children's Social Care and IDVA case systems. Three of these were high risk cases and four lower risk. The children fell across Children in Need, Child Protection, Children with Disability and Looked after Children areas. The ages of the children ranged from pre-birth to late teens.

Agencies contributing to the audit included: Children and Families; Police; Housing; IDVA; Southern Health; Solent NHS; Cafcass; Yellow Door; the Youth Offending Service. Unfortunately, there was no feedback from the National Probation Service or General Practitioners.

Regarding impact of agency involvement: of the seven cases: Two high risk IDVA cases had ongoing risks identified; but, these were being managed through the service and with partners; Risk of DV appeared to have reduced in one IDVA case; Risk of DA appeared static in two lower risk cases, subject to CIN and CP planning; Risk of DA appeared to have reduced in the other two cases.

Core procedures for high risk cases appear to be robust (based on evidence from evidence from MARAC-MASH, IDVA, CP, and police risk management). However, partners appeared to articulate that information sharing and partnership wasn't as clear around lower risk DA. Raising professional awareness around the 'trigger trio' (domestic violence, mental health, substance and alcohol misuse) and understanding the impact of ongoing coercive control on families. In addition, inconsistent critical analysis of the impact of current and historic DA by professionals was another theme.

Auditors from across the participating organisations attended two workshops to discuss the results in February and March 2017. Next steps identified by auditors at these workshops were:

- Consideration preparation for future JTAI – 'dry run' audit and case study activity. Contact lists for participating organisations.
- Consider how to get adult mental health involved in CP / DV processes and provide robust risk assessments to inform good practice and decision making.
- Will take strengths back to the team.
- Analyse audit feedback as part of commissioning cycle.
- Findings will be shared with staff and volunteers.

- Findings will be shared at team meetings
- Information about practice pathway and training will be shared.
- Need to be more consistent in respect of lower risk DA cases. Raise training opportunities across housing.
- IDVA to be contacted for all YOS cases. Training information and feedback from workshop to be shared with practitioners.

The Monitoring and Evaluation Group have oversight of this audit and its actions.

Missing Exploited and Trafficked – Looked After Children Placed Out of Area

This audit is the first thematic audit being delivered by Southampton LSCB Missing Exploited and Trafficked (MET) Strategic Group. Overarching terms of reference for audits of this kind were agreed by the MET Strategic Group who also determined the membership of the Audit Team for this theme. Membership of the Audit Team consisted of:

- Detective Inspector from Hampshire Police, Public Protection Team
- CSE Advance Practitioner from Southampton City Council Children's Services
- Barnardo's Missing / CSE Service lead
- Health (School Nursing and Sexual Health)
- LSCB Manager & Assistant
- Senior Probation Officer, National Probation Service
- Virtual School Head Teacher, Southampton City Council
- Housing Coordinator, Southampton City Council

The aim of this audit is to establish the success and quality of multi agency partnership working in relation to looked after children placed out of area that are at risk of going missing, being exploited and/or being trafficked, especially focussing on

- Level and quality of multi agency partners involvement
- Success in intervention improving outcomes for the young person/s safety and wellbeing
- Experience and views of young people and their families as relevant
- How the intervention has impacted on the quality of life for the child/young person
- Whether appropriate assessments have been carried out and pathways have been followed
- The success of disruption and prevention methods
- Identification of any key learning themes for further action

The Audit Team planned and delivered the audit work, they agreed;

- Audit topic – Children Looked After Placed Out of Area at risk of Child Sexual Exploitation
- Process to be employed – individual research & group discussion using an agreed audit tool
- Case number and source of cases – 3 cases of children looked after out of area that were at risk during these placements of going missing, and CSE. It was also agreed that other 'people of concern' would be shared in order that full searches of probation and police files could be carried out.
- Contact with family / young people and professionals involved – it was agreed that the children along with the carers or agencies responsible for the children during out of area placements would be contacted via lead professionals involved in the case.
- Meeting dates / deadlines for completion of each stage – 2 planning and 2 audit meetings took place during February – March 2016

- Author of overview report to detail findings and recommendations – this was agreed as the LSCB Manager on this occasion
- Timescale for completion and feedback to the MET strategic group – aim to feedback initial findings to the May 2016 meeting

Overview of findings:

- The Audit Team acknowledge that these cases were often being responded to prior to the Goldstone Team and CSE Hub developments. All three cases were deemed to require improvement (RI) by the audit team in terms of quality of interventions and outcomes for the children, and it was felt that with this more recent work, more opportunities exist for multi agency responses earlier in the experiences of children
- Statutory work and planning had taken place in line with procedures that were known by the audit team; however the value of multi agency information was not evident, despite often being available. This would have improved the quality of responses and potentially enabled more timely and appropriate interventions for the three children
- Planning and preparation for placements was not always thorough enough to provide the quality that could be expected. For example, this was often single or dual agency limited to the children's services leads and provider of the placement. Information in the wider network could have informed carers / providers of risks and helped to manage risks during placements that were known for the children
- Emergency placements were evident in these cases – the speed and urgency for these was seen as influencing the above
- In addition, although statutory work was undertaken, relevant agency handover to placement areas was not always apparent – possibly as a result of the lack of involvement in placement planning. For example, conversations from the 'home area' police force to 'out of area' police force, which may have informed decisions about placement, did not take place.
- Placements were not informed by the assessment of CSE risks and issues particular to the child – this would have provided more quality and potentially longer and more stable placements for the children involved
- Earlier identification of CSE risks in cases (prior to being accommodated) were missed in these cases
- Language used to describe risks and issues of concern – in terms of the responsibility for abuse experienced and CSE / missing episodes being on the child.
- Guidance for lead professionals informing those, such as the fostering team who are arranging placements for cases where CSE was a risk (whether emergency or not) was not easily available to the audit team

The MET Strategic Group are due to carry out quarterly multi agency audits around specific issues within the MET agenda. The next audit to be carried out will be focussed on children who go missing. This will commence in early 2017 – 18.

All recommendations and actions from the MET audits are discussed at the Strategic Group meetings and a rolling action plan is monitored quarterly. The Monitoring and Evaluation Sub Group also have an oversight of this activity.

Future Audit Schedule 2017 - 18:

Quarter	Month	LSCB Audit
1	Apr 17	MET: Children who go missing
	May 17	JTAI: Children living with neglect MET: Children who go missing
	Jun 17	JTAI: Children living with neglect MET: Children who go missing
2	Jul 17	JTAI: Children living with neglect MET: Children who go missing
	Sep 17	Transition from Children to Adult Services Core group audit
3	Oct 17	
	Nov 17	
4	Jan 18	JTAI: Interfamilial sexual abuse JTAI: Interfamilial sexual abuse

Southampton's Children

Changes to Continuum of Need and Thresholds

In December 2016, the LSCB approved changes to the existing continuum of need document and threshold. The new continuum introduces four levels of intervention, replacing the existing three, making a clear delineation between prevention and early help & activity requiring a statutory social work response.

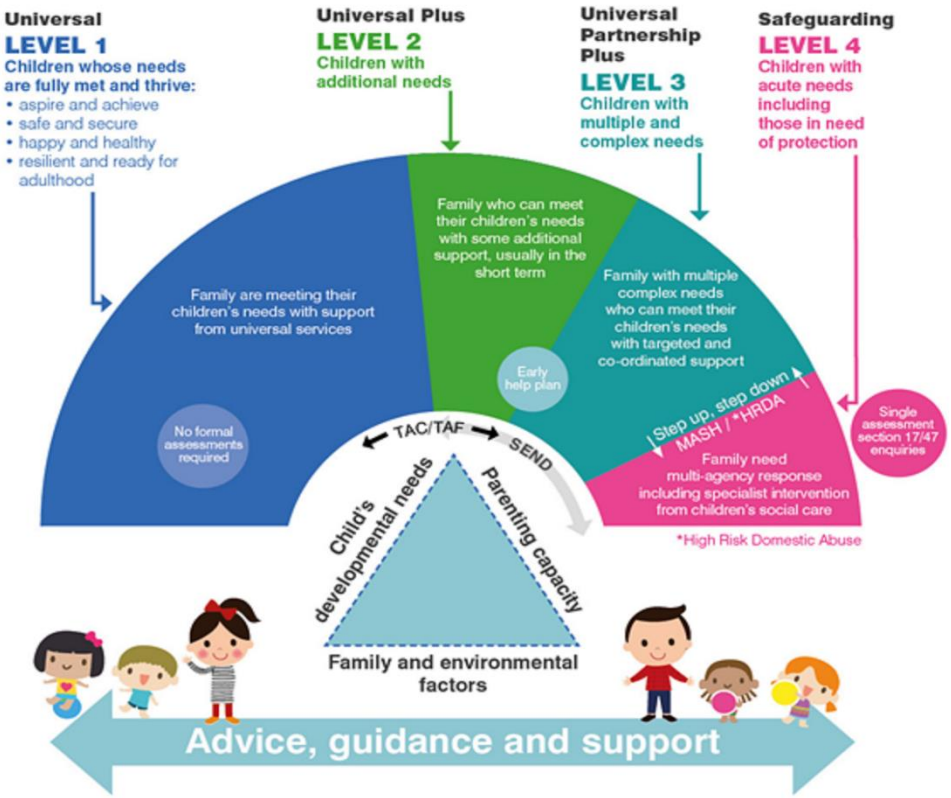
The four levels are:

Level 1 (Universal) – Children whose needs are fully met and thrive

Level 2 (Universal Plus) – Children with additional needs

Level 3 (Universal Partnership Plus) Children with multiple complex problems and additional needs

Level 4 (Safeguarding) Children with acute needs including those in need of protection



This model introduces strength based language encouraging practitioners to think about what a family **can** do. The continuum is complimented by the introduction of a new Early Help Assessment and Plan, replacing the Universal Help Assessment, with refreshed LSCB web pages and supporting guidance.

Alongside the introduction of the new continuum, the 'Front Door' to Social Care was redesigned, following review and consultation from Professor David Thorpe. This was in response to Social Workers carrying high caseloads and rates per 10, 000 of Child in Need and Looked After Children that placed SCC as a significant outlier in relation to national and regional comparators.

Following on from the review by Professor Thorpe, there were no proposed changes to current multi agency MASH arrangements, which were noted to be safeguarding children well. However, this was to be augmented through process redesign and adopting a new way of working using a single number to call, as a central point of first response. This would enable professionals to be accessed directly through a dedicated team of skilled and experienced social workers whenever someone may want to discuss worries they have about a child.

With no need to complete a written referral, it was intended that this approach would promote improved decision-making and joint working relationships.

Whist referring agencies can provide supporting written information and receive a written record of their referral, this new process will ensure that only the most vulnerable children at the greatest risk are assessed by a social worker.

Allowing for a greater emphasis on quality rather than volume, there would be an increased professional social work rigour aided by improved workflow management processes, scrutiny of live data through weekly case review meetings and live supervision of staff undertaking this work.

The LSCB was wholly in favour of these changes and offered its support in its multi agency implementation. To read more about these changes, please visit www.southamptonlscb.co.uk.

Demographics

The information analysed in the section that follows has been selected from a data set presented at each main LSCB meeting during 2014-15. Statistical Neighbour and National Average figures have been used where available and appropriate to provide comparison.

The current population of Southampton is 254,275 based on the Mid-Year Estimate (MYE) 2016 of which 129,879 are male and 124,396 are female. 62,448 are under 19 and usually resident in Southampton, equating to 24.8% of the population. (Population Pyramid Tool: 2017)

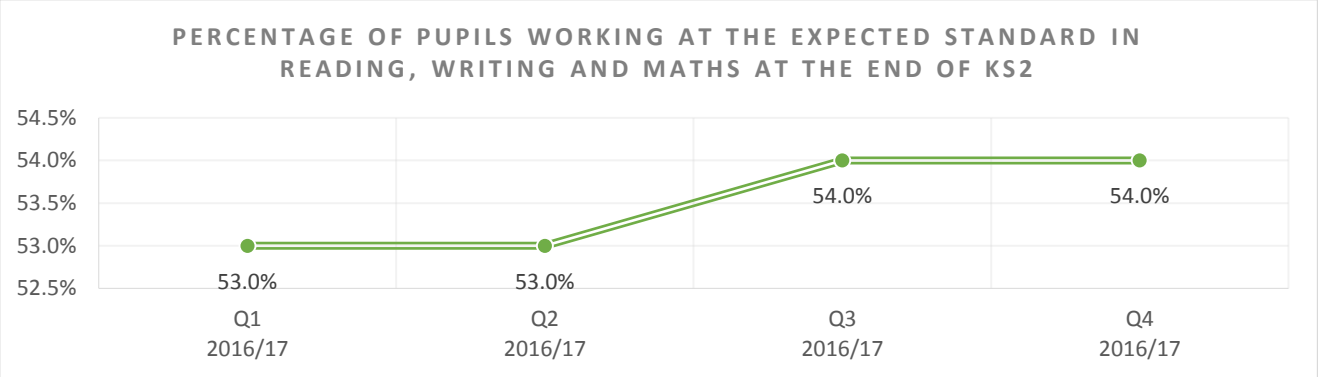
Children and young people from ethnic groups account for 19.7% of all children living in Southampton. The largest ethnic groups of children and young people in the area are Asian or British Asian (2011 Census).

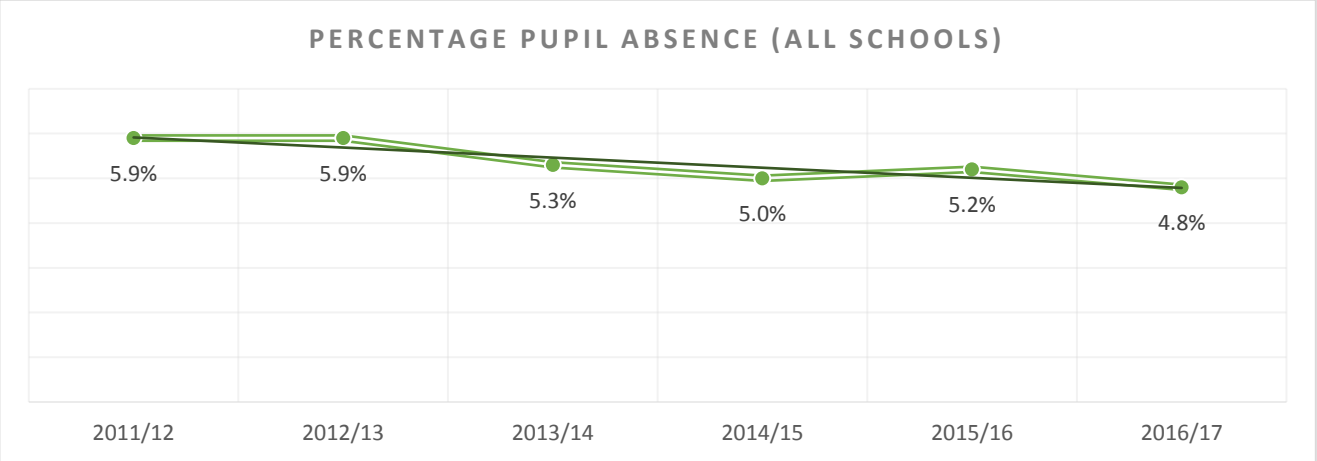
The LSCB receives details of the Child Health Profile for the city as this is published each year by Public Health England. The full report is available via www.chimat.org.uk –the headlines this year for Southampton are as follows:

- 33.7% of school children are from a minority ethnic group.

- The health and wellbeing of children in Southampton is generally worse than the England average.
- Infant and child mortality rates are similar to the England average.
- The level of child poverty is worse than the England average with 23.4% of children aged under 16 years living in poverty.
- The rate of family homelessness is better than the England average.
- 9.8% of children aged 4-5 years and 22.5% of children aged 10-11 years are classified as obese.
- Local areas should aim to have at least 95% of children immunised in order to give protection both to the individual child and the overall population. For children aged 2, the MMR immunisation rate is 94.9% and the diphtheria, tetanus, polio, pertussis and Hib immunisation rate is 97.1%.
- 33.7% of five year olds had one or more decayed, filled or missing teeth. This was higher than the England average. The recent hospital admission rate for dental caries (decay or cavities) in children aged under 5 years is lower than the England average.

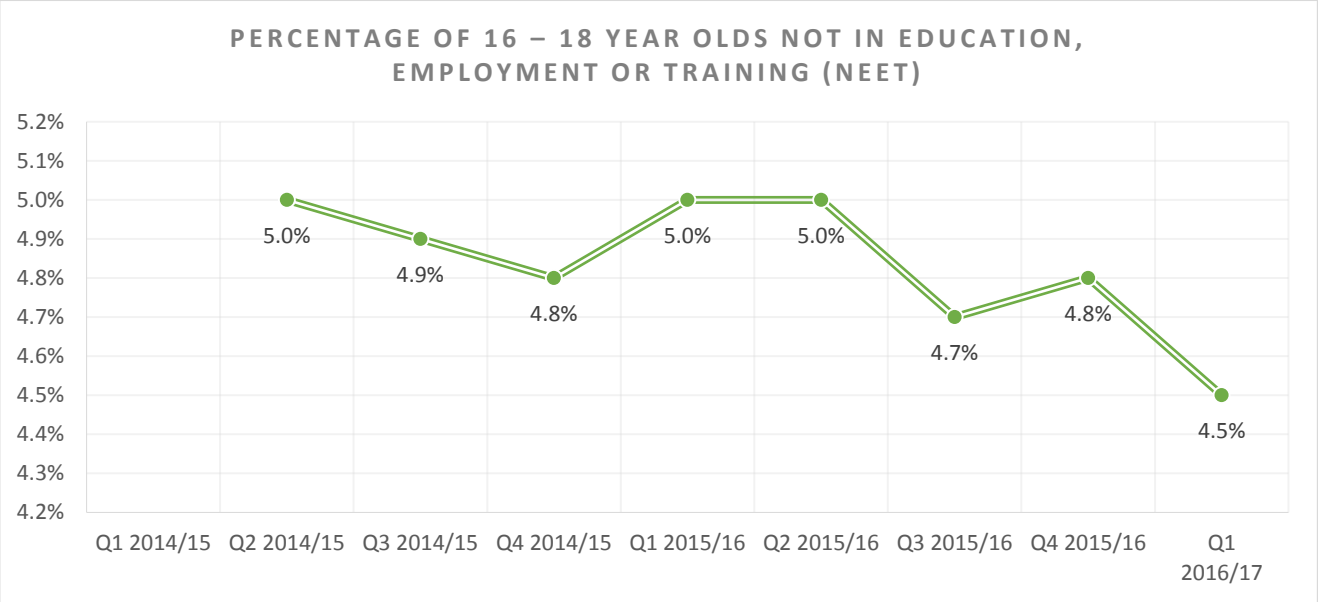
Our Children:



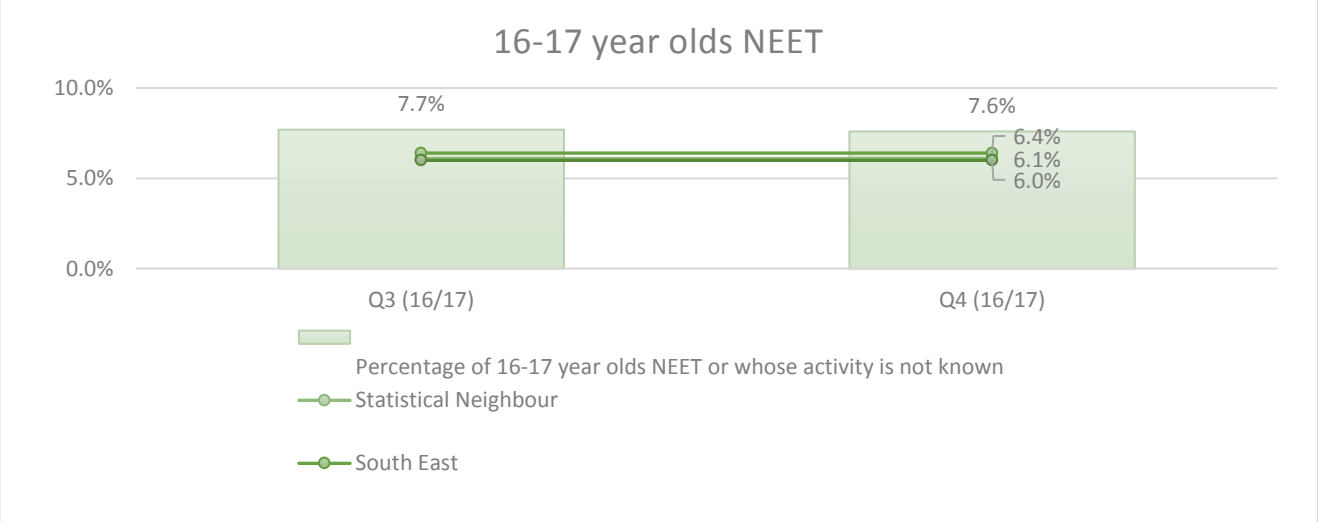


Overall there is a decrease in the percentage of pupil absence across all schools in Southampton. Education data reflects that Southampton is able to demonstrate a trend for improvement in respect of Special Schools, for example, meaning our performance is now an improvement on national averages. The trends

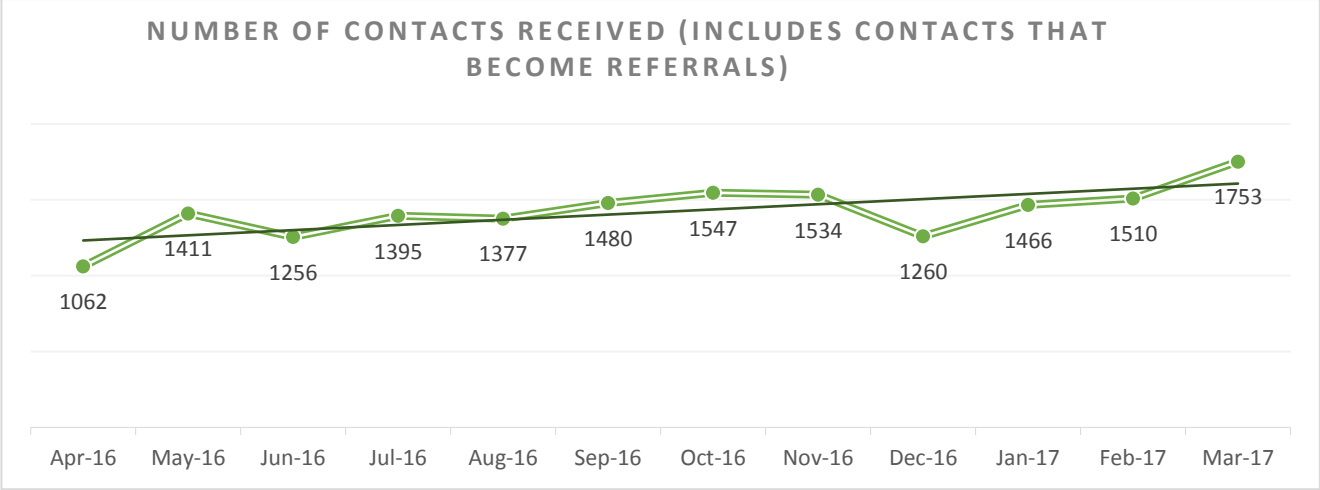
point towards a similar milestone being achieved for both Primary and Secondary Schools. Authorised absence accounts for a substantial proportion of Southampton's overall absence total - we are developing a focus through the school Led, Attendance Action Group to focus in particular on the causes of sickness related absence.



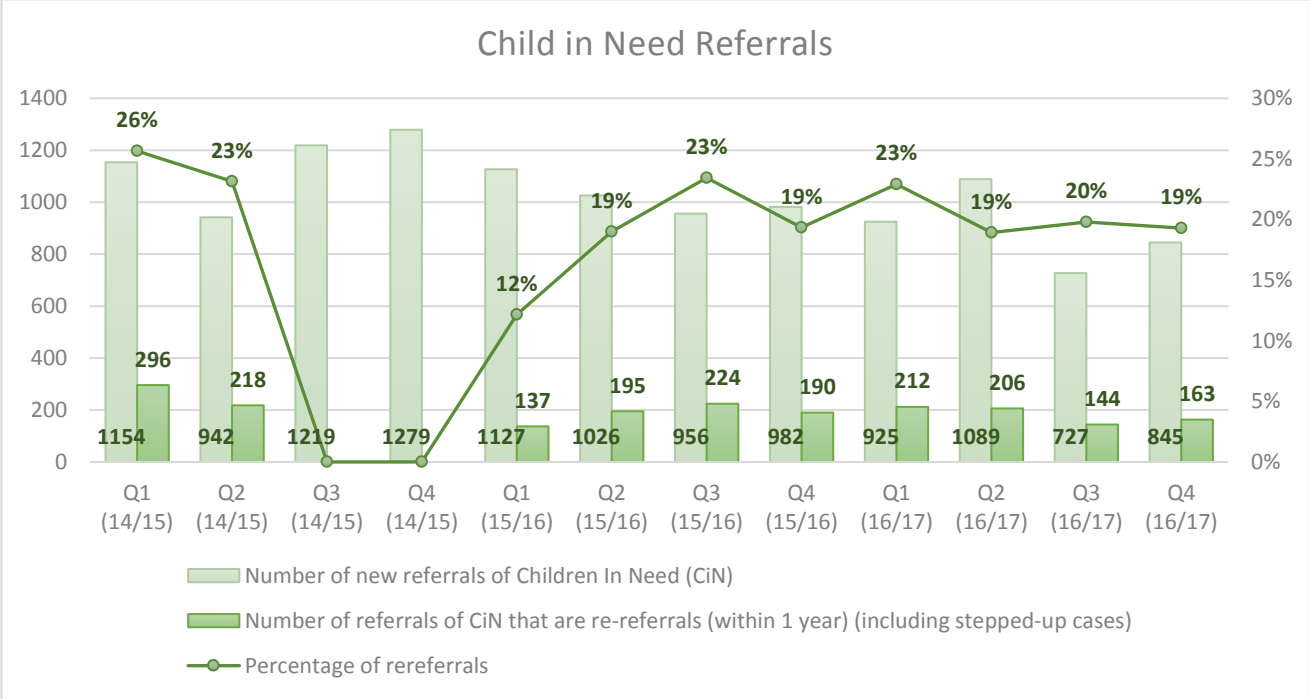
The measure has changed from 16-18 year olds NEET to 16 – 17 year olds NEET however, prior to the change one can see the decreasing trend in the NEET figure.



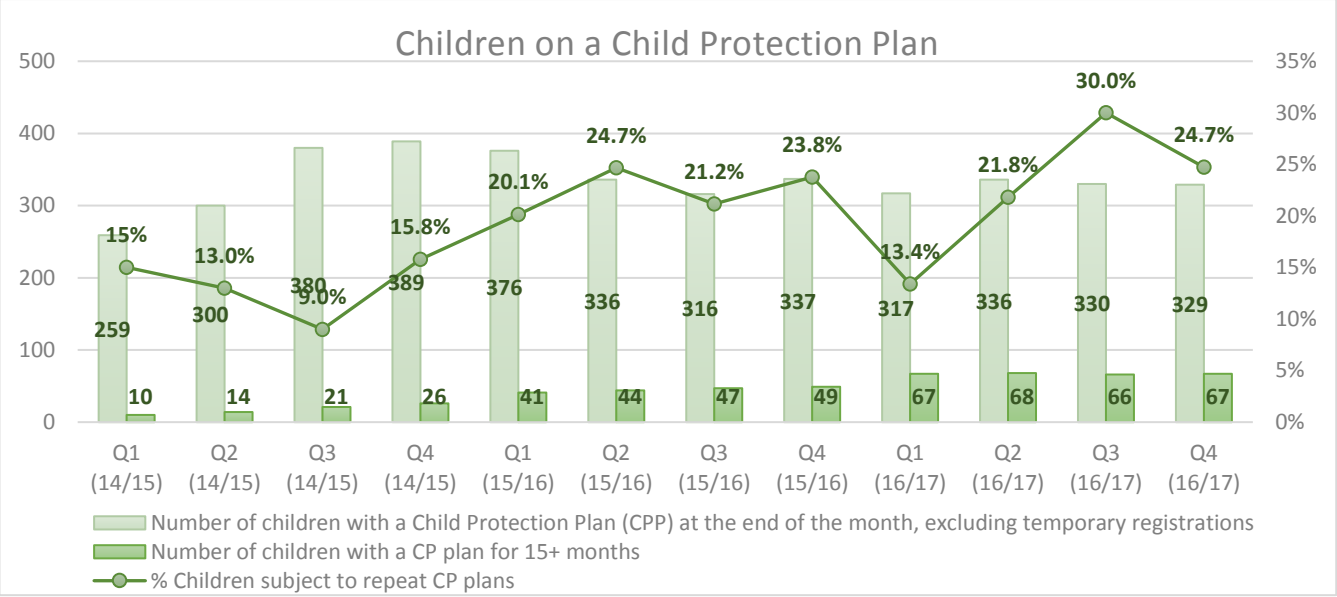
Children's and Families' Services have reflected that National NEET reporting has now changed to only include 16-17 year olds (as opposed to 16-18) and to also incorporate 'unknowns'. Whilst Southampton continues to perform well in relation to the NEET element alone against core cities and stat neighbours, our ranking has reduced (i) because we were previously relatively outperforming on 18 year olds that are now not in scope and (ii) we have a slightly higher level of 'unknowns'. Both of these factors are being addressed through (i) re-focussing on younger age group and (ii) new approaches to tracking.



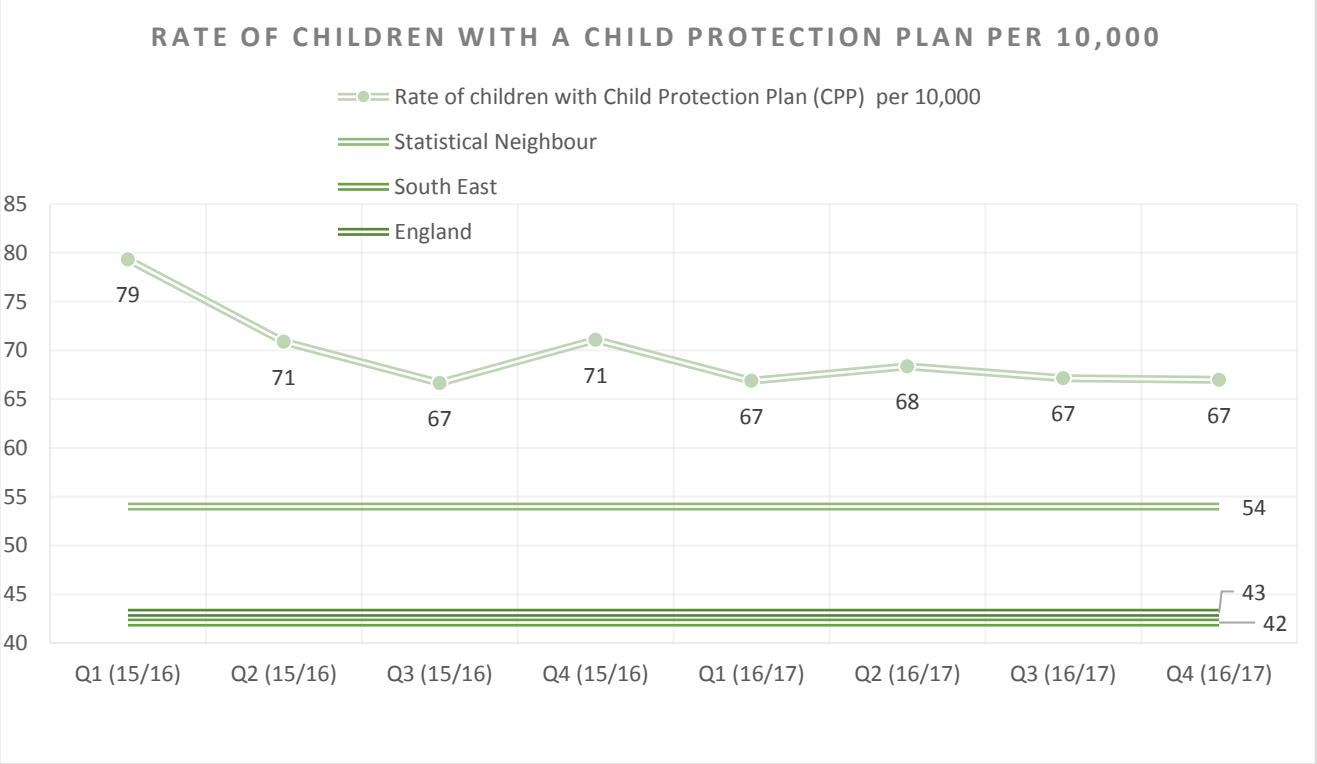
This year has seen an increase in the number of contacts coming to MASH. There was a 65.0% increase in contacts form April 2016 to March 2017. Commentary from the team reflects that an increase in referrals is anticipated given the new front door process. Throughout the year, 1361 referrals became Section 47 enquiries.



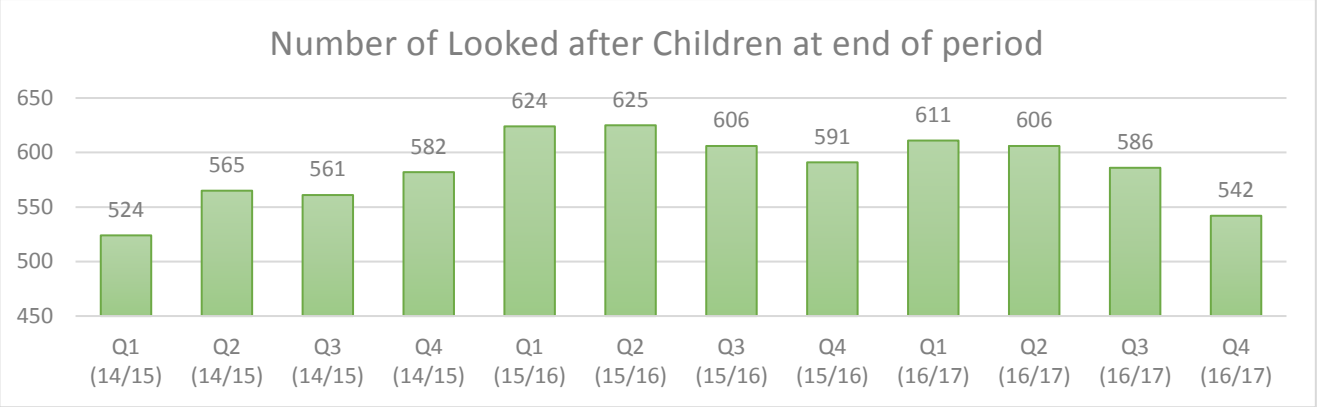
In 2016/17 there were 3595 Child In Need Referrals. There has been a decrease in the number of Child In Need Referrals as in 2015/16 and 2014/15 there were 4091 and 4594 contacts respectively. A 10.9% decrease from 2014/15 to 2015/16 and a 12.1% decrease in Child In Need Referrals from 2015/16 to 2016/17. Over the last 7 quarters, form quarter 2 (15/16) to quarter 4 (16/17) there have been significant fluctuations in the number of referrals from quarter to quarter. Over this same period the number of referrals within a 12 month period has oscillated between 19% and 23%.



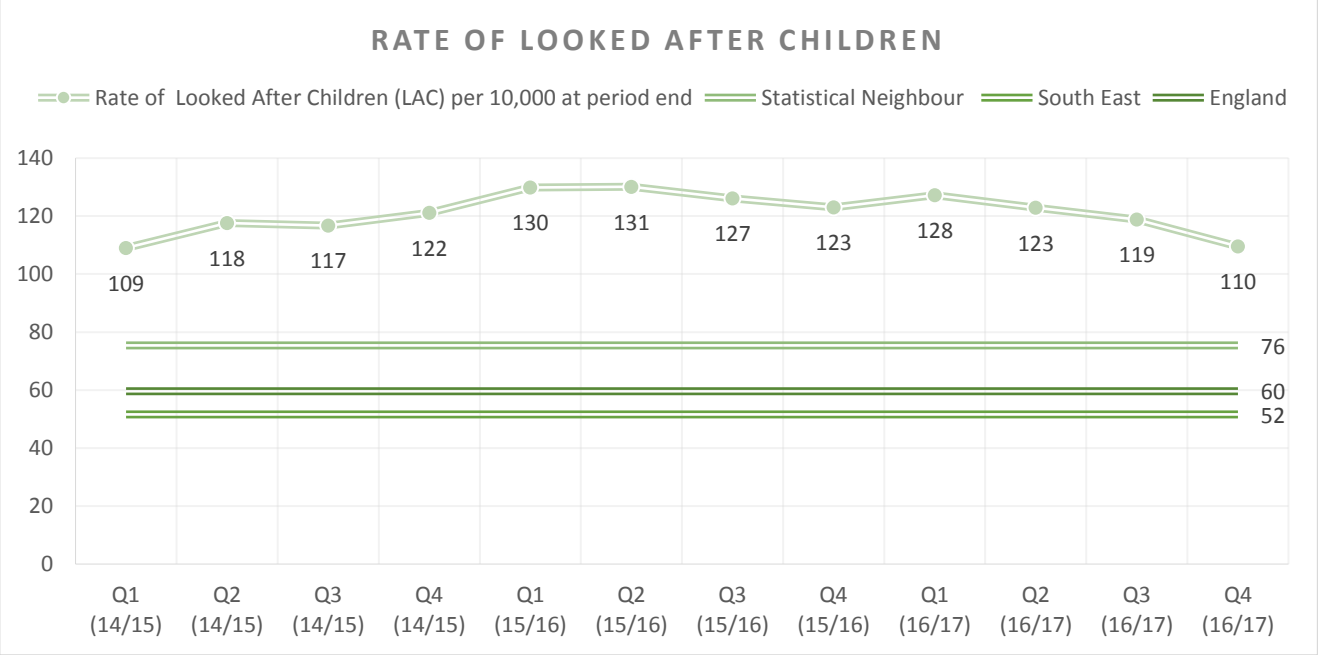
The number of children on a Child Protection Plan has fluctuated steadily between 337 and 316 between quarter 2 (15/16) and quarter 4 (16/17). However, over this same period the number of children on a Child Protection Plan for 15+ months has increased from 44 to 68. In addition the percentage of children that are on a repeat Child Protection Plan is increasing overall.



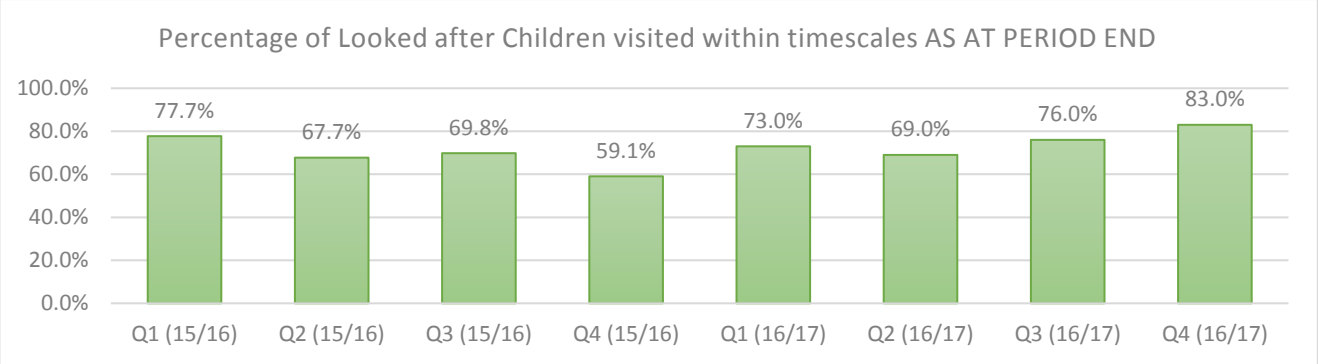
The rate of Children on a Child Protection Plan has not changed significantly across 2016/17. Southampton's rate (67) is significantly higher than the statistical neighbour rate (54) and is significantly higher than the South East (42) and national (43) rates.



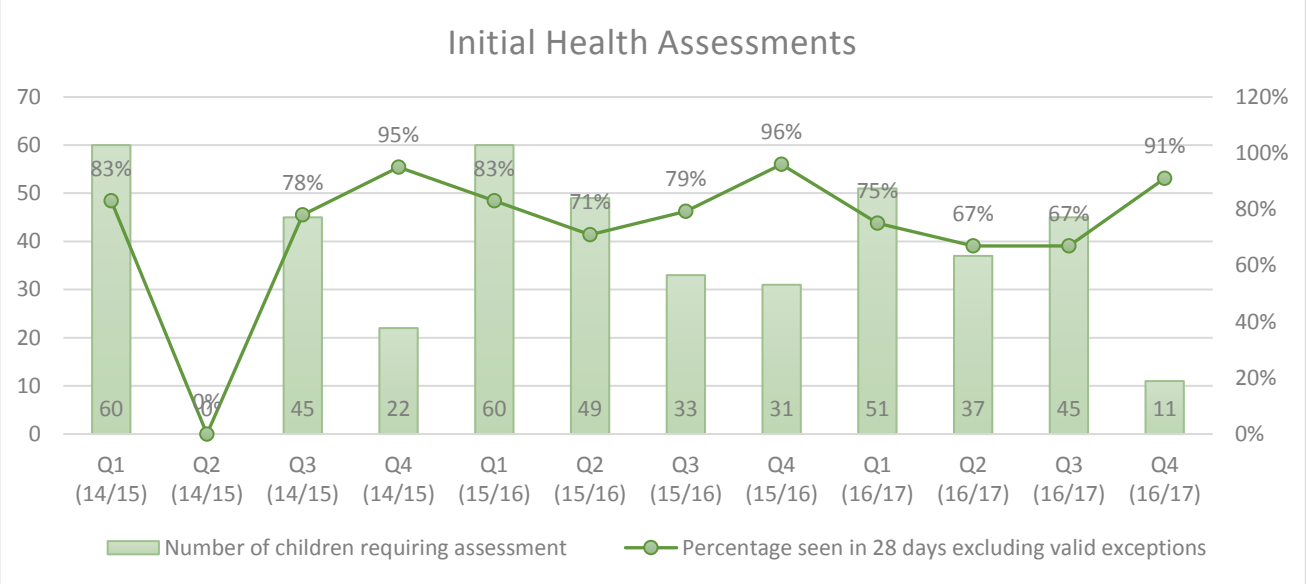
In 2016/17 the number of Looked after Children has decreased significantly by 11.3%. The figure is now at its lowest since quarter 1 2014/15. Children and Families' Services reflect: significant decrease in looked after numbers which is linked to the work of our dedicated LAC reduction plan, focussed work around looked after children in the service and close monitoring of all LAC arrangements. This is a combination of reunification planning for those in care where appropriate, permanence planning for those who need to remain in care and ensuring all possible options have been explored prior to considering a child being accommodated. It is expected that the number will fluctuate as the service needs to prioritise the safety of children at risk of harm in the care of their parents and this can be unpredictable at times.



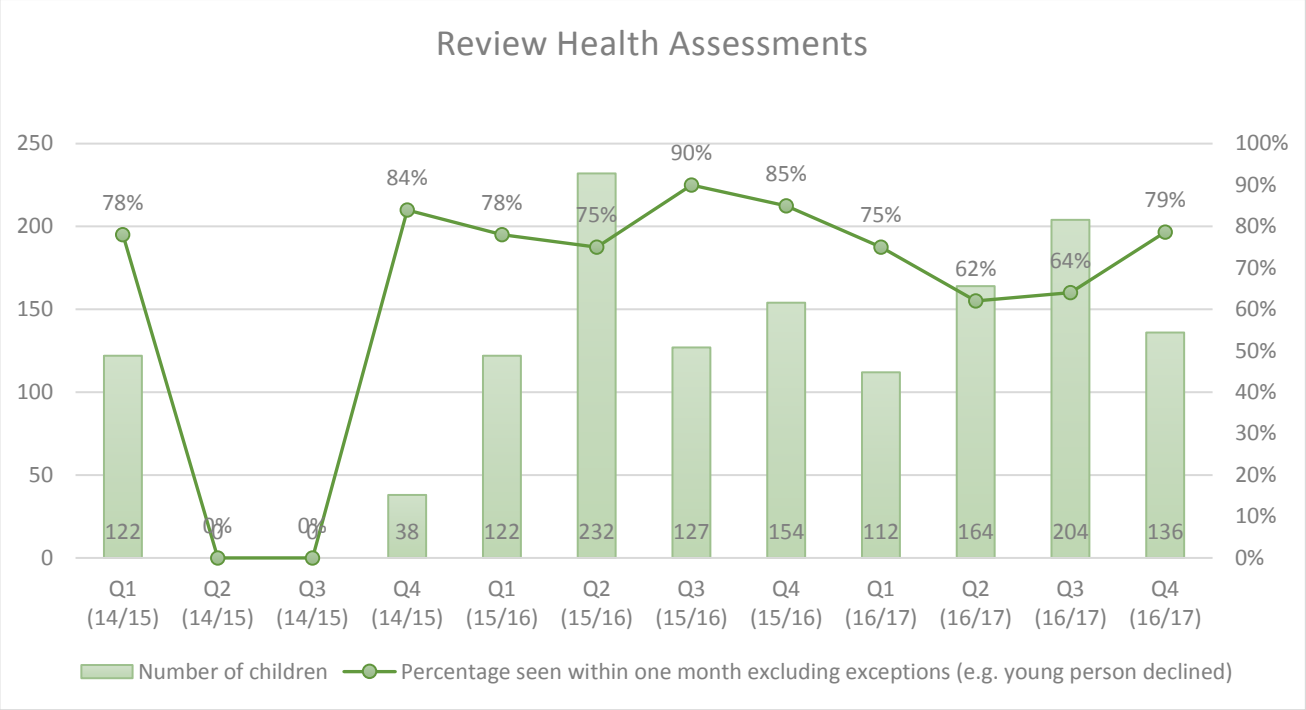
The rate of Looked after Children has shown a reducing trend across 2016/17. Southampton's rate (110) is significantly higher than the statistical neighbour rate (76) and is significantly higher than the South East (52) and national (60) rates



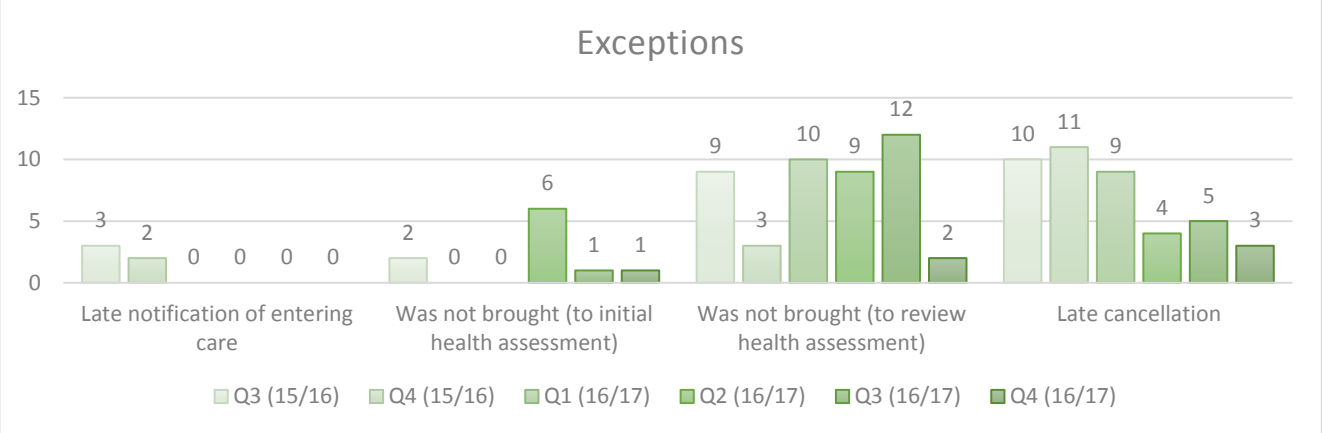
2016/17 has seen an improvement in the number of Looked after Children that have been visited within timescales. Quarter 4 (16/17) has seen the highest percentage over the last two years.



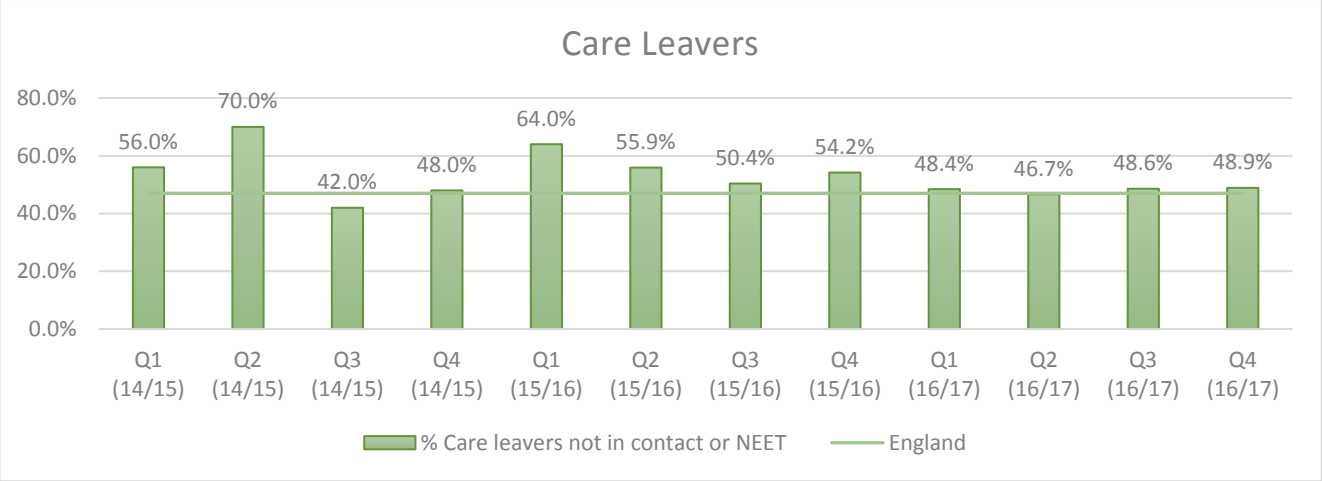
The percentage of children having their initial health assessments within timescale decreased to 67% over Quarters 2 and 3 but increased in Q4.



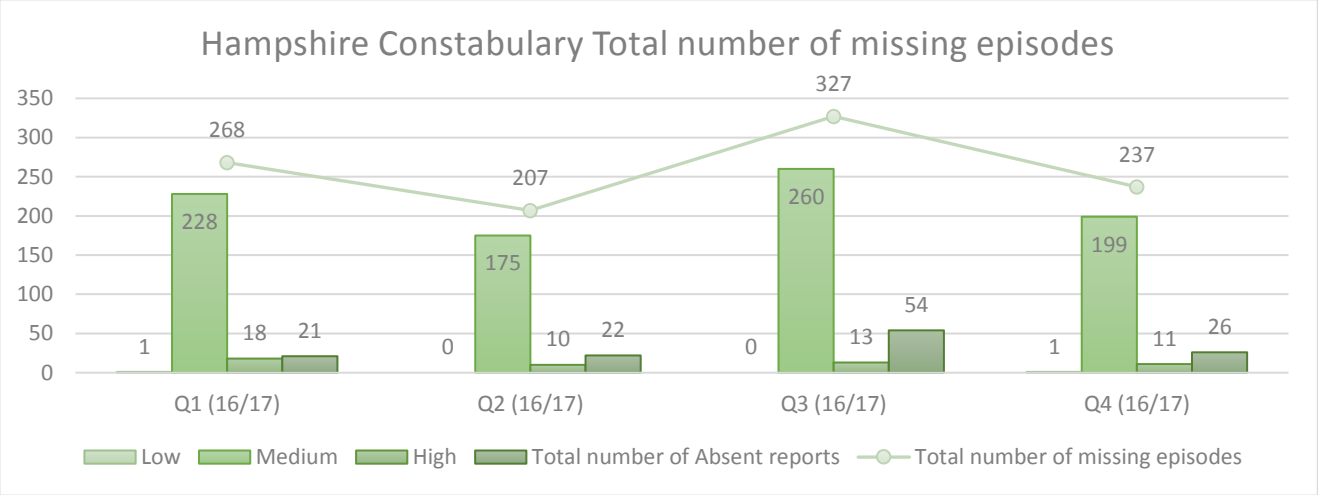
As with the initial health assessments, there was a dip in the number of Looked after Children having their review health assessments within timescales. However, at the end of 2016/17 the percentage having assessments within timescales was at its highest for the year.



The figure above shows the exceptions for Looked after Children's health assessments. There were no late notifications of entering care and the number of late cancellations has decreased compared to last year. The number of 'Was Not Brought' to initial health assessments has decreased over the year however, the number of 'Was Not Brought' for review health assessments remained high through the year. It is worth noting that the 'Was Not Brought' figure also includes children who refuse to attend.



The number of Care Leavers not in contact or not in employment, education or training has decreased in 2016/17 as compared to previous years. This year the percentage has not changed significantly.



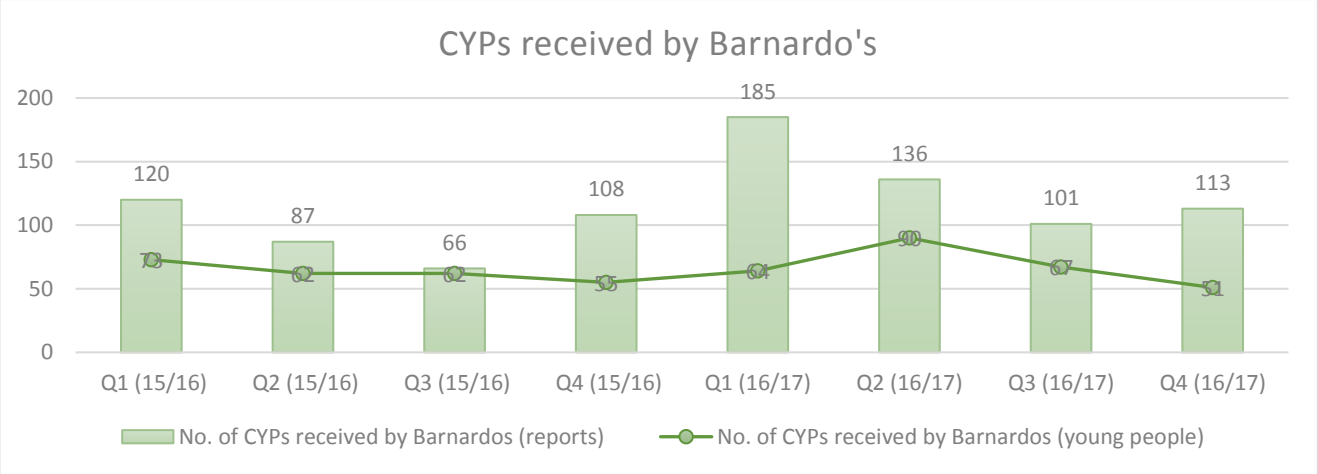
During the course of 2016/17 the Hampshire Constabulary have reported a total of 1039 missing episodes. The risk category of these missing episodes can be broken down as follows:

High risk: 52 (5.0%)

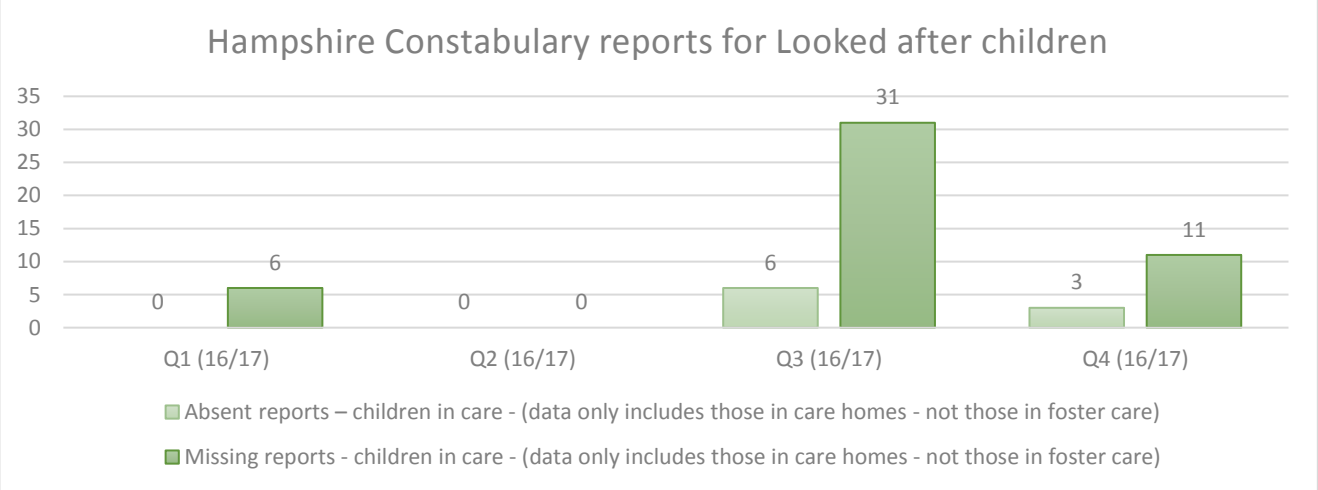
Medium risk: 862 (83.0%)

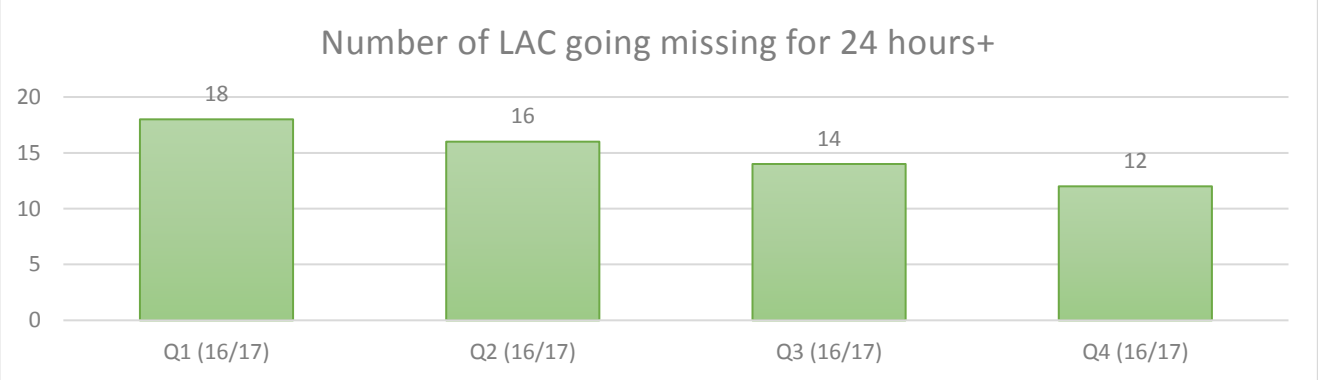
Low risk: 2 (0.2%)

Absent reports: 123 (11.8%)



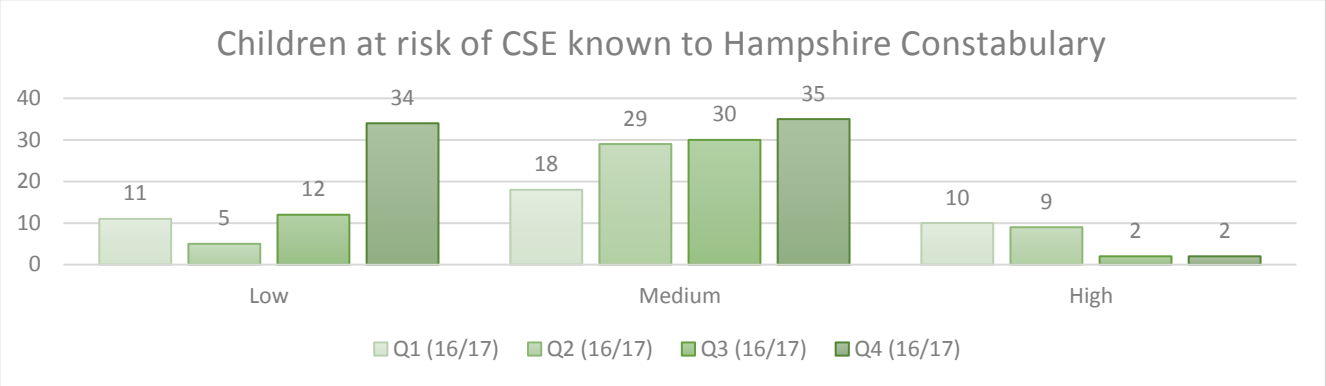
The number of missing reports received by Barnardo's amounted to 535 for 2016/17. From the graph above one can see that in some cases multiple missing episodes can correspond to one young person. The number of missing episodes and missing reports fluctuates significantly on a quarterly basis and no particular trend can be observed.





Hampshire Constabulary has seen a significant decrease in the number of missing reports for Looked After Children in care homes. The number of absent reports has also decreased since last quarter. Quarter 3 does have an unusually large number of missing and absent reports as compared to quarters 1, 2 and 4.

Children and Families' Services have reflected that there is a steady decline in our missing LAC. Managers receive a daily missing report and monitor the young people closely.



The number of children and young people known to be at risk of CSE by Hampshire Constabulary has gradually increased across the year. For each quarter, the figure is as follows:

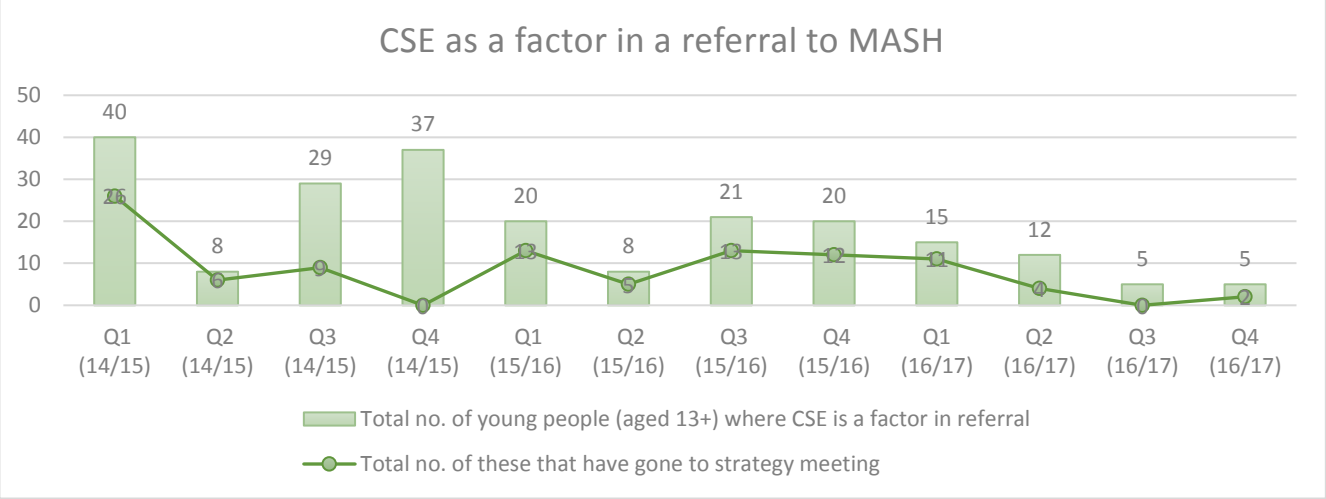
Quarter 1: 39

Quarter 2: 43

Quarter 3: 44

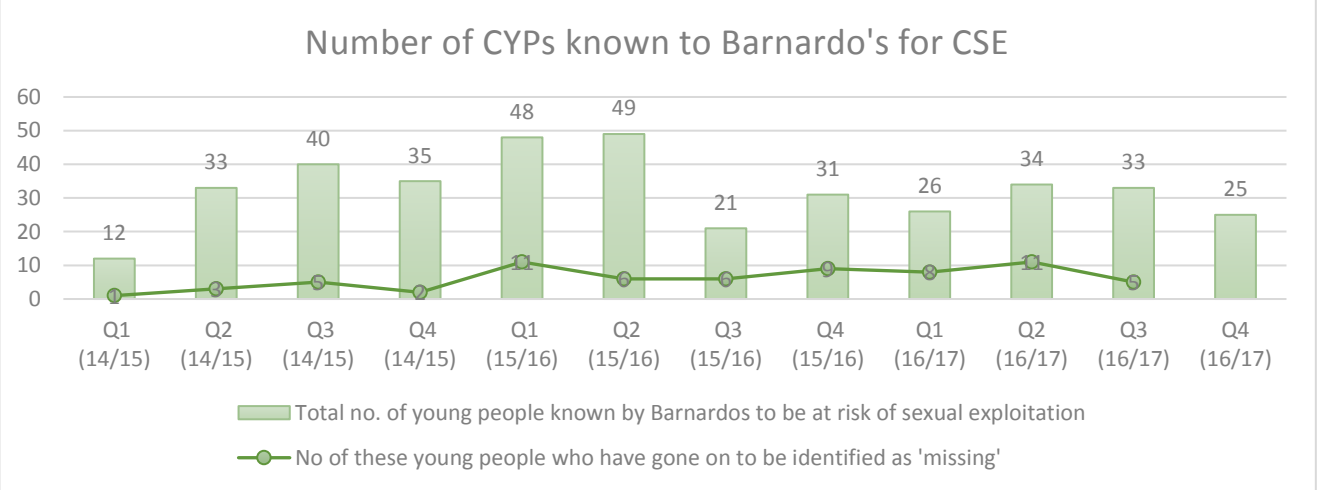
Quarter 4: 71

The majority of these children and young people are of medium risk of CSE.



Children and Families' Services have reflected that "This is a figure that can fluctuate month on month, though there was a recording issue in Dec/Jan. This has now been rectified. There has been work undertaken over the past 18 months to deliver CSE awareness raising workshops across the city to a range of organisations, resulting in a more accurate understanding of CSE in the city.

Alongside this, the MET Operational Group has identified that the majority of young people where CSE is a factor and where a strategy discussion has been recorded are already open cases to Children's Social Care so would not be measured for this scorecard.



The number of young people open to Barnardo's U-Turn service has fluctuated steadily between 21 and 34 since Quarter 3 (2015/16).

Between January 2015 and Q4 2016/17, no new referrals were sent in to Barnardo's for Trafficking. Over that period of time Barnardo's worked with two young people. However, two new referrals were sent in in Q4, one to the new Independent Child Trafficking Advocacy Service and the other in to the existing service.

We continue to offer training on MET issues to ensure that frontline staff are kept fully aware of the signs and indicators. Clear referral processes are also in place.

The Board closely monitors the above actions quarterly to ensure that we are aware of any trends and gaps that may need addressing by a multi agency forum.

In addition to quality assurance, the Board works to engage the community and young people. We also offer a range of training to professionals. Details of this activity is below.

Other Board Activity -

Community Engagement

Throughout the year, the Board has organised or been a part of a number of community engagement activities. This is to try and raise awareness and the importance of safeguarding with the general public and to share resources. Examples of activities undertaken are below:

Safeguarding Week – June 2016

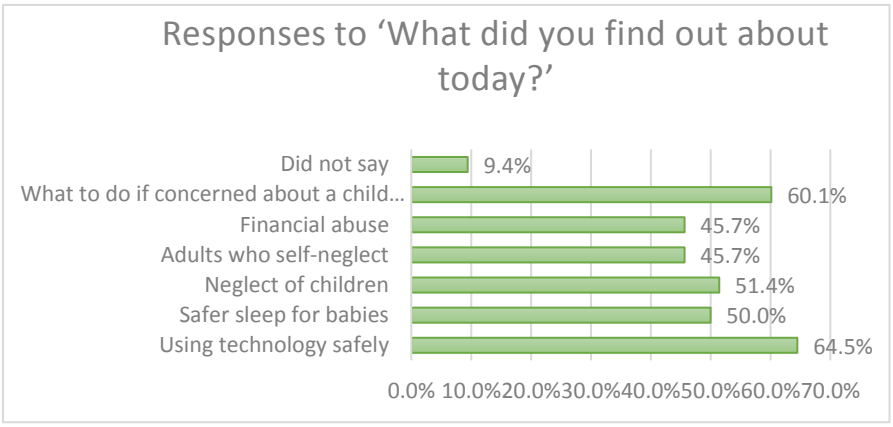
The Week coincided with the Child Accident Prevention Trust's (CAPT) Child Safety Week, the theme for 2016 was - 'Turn off technology for safety'. This event was joined with the LSAB to ensure a 'think family' approach and to make it relevant for all.

Local themes were:

- **Monday** –Child Safety Week 'Turn of technology for safety' launch
- **Tuesday** – Safe sleep for babies
- **Wednesday** – Recognising and responding to self-neglect in adults and neglect in children
- **Thursday** – Financial abuse (adults focussed)
- **Friday** –Raising awareness of what to do if you think somebody is at risk of harm or abuse

On three of the days within the week we went out with the Local Authority trailer at different locations and worked with partner agencies to engage with over 400 families and individuals to promote the key messages.

Evaluations received from 138 members of the public told us the following:



Imagine the Future – July 2016

On 12 July 2016 the second 'Imagine the Future' event took place, supported by the LSCB. This event is the only one of its kind which takes place on a ferry and is designed and led by young people, for young people. Three workshops took place and these were designed and run by students from local colleges. 250 school children attended and took part in workshops which were 'My Life Online' (looking at online safety and issues),'Looking after Yourself' (looking at self-care and wellbeing for young people) and 'Burst the Stigma!' which looked at destigmatising mental health issues and peer support.

The event took place on a red funnel ferry cruising from Southampton to the Isle of Wight and back and gave many young people their first opportunity to get out on the water. The other organisations supporting it were Red Funnel Ferries, Southampton Connect, Southampton Clinical Commissioning Group, Southampton Education Forum, and Hearing Dogs for the Deaf. It was a great opportunity to find out more about what mattered to young people in Southampton and enable the Board to incorporate

this into its work. The issue of online safety in particular has been an ongoing theme in the Board's work and will be the theme of the Safeguarding Boards Annual Conference in 2017.

Online Safety Day – February 2017

This year the Local Safeguarding Children Board promoted Safer Internet Day which took place on Tuesday 7th February 2017 with the theme 'Be the change: unite for a better internet'.

Online safety is a worrying issue that seems to be increasingly apparent locally, as well as nationally. Not only does it cover topics such as online bullying and grooming, it can also be used to glamourize and promote self-harm and other dangerous/ illegal activities.

As part of our push to raise awareness of key internet safety issues, we promoted the use of the 'Safer Internet Day' education packs within schools/settings in Southampton. These are national resources and have been tailored for ages 5-7, 7-11, 11-14, 14-18 and parents and carers. Packs included:

- Lesson plan
- Assembly presentation and script
- Play script
- Quick activities
- Whole school or community activities
- Poster

The LSCB also promoted the day via the following methods:

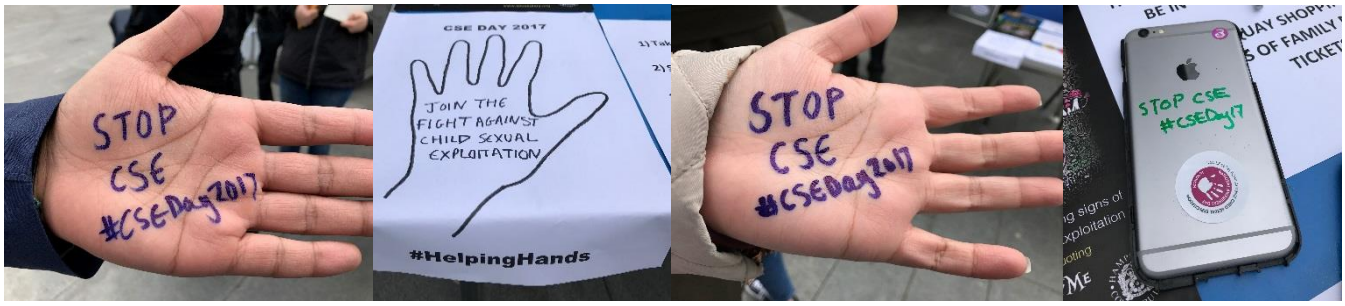
- Displaying a range of useful resources in the Southampton Civic Centre reception between 6th – 10th February 17
- Sharing important messages via social media throughout the week

CSE Awareness Day – March 2017

Southampton LSCB worked with Children and Families Service, The Police and Barnardos to deliver an awareness raising session on National CSE Awareness Day.

We had a trailer filled with resources parked in Southampton's Guildhall Square from 9am – 1.30pm on the day and we had a constant stream of professionals from each of the aforementioned agencies speaking to members of the public.

We engaged with community members and asked them to have a picture with their pledge for CSE Awareness Day
We also shared key messages via our Social Media pages.



Voice of the child

As the LSCB's Communication Strategy states, we want to ensure that the views of children and young people, their parents and carers and adults at risk themselves and the wider community are heard and their feedback used to improve safeguarding of Southampton's children and adults at risk.

Our aim is to ensure that those we communicate with understand how to keep children, young people and adults at risk safe and are able to recognise and know what to do where they suspect individuals or groups may be at risk of harm.

The Children Act 1989 and 2004 recognises children as citizens with the right to be heard and requires that when working with children in need, their wishes and feelings should be ascertained and used to inform making decisions. The Children and Families Act 2014 section 19 requires that children, young people and families should be involved in decision making at every level of the system. Working Together 2015 states that one of the key principles for effective safeguarding arrangements in a local area is to

take a child centred approach: 'for services to be effective they should be based on a clear understanding of the needs and views of children'.

Throughout the year, the LSCB has been keen to hear young people's views in a variety of ways. Examples of this activity is below:

a. Looked after Child Case Study at LSCB meeting

A young person attended the meeting to share his experience as a Looked after Child. As a 14 year old he went missing from home. Mum had abusive boyfriends and his lifestyle was very chaotic. He got into bad ways, went missing and got arrested. He was eventually placed into care and moved around a lot. He feels he had a messed up view as to what was right and wrong. His social worker became inspirational to him and told him things could get better. At 16 he moved into supported living, he was then rushed into the adult homeless unit quickly and he described it as horrific, he had felt safe in children's homes but felt very vulnerable in adult hostels. He was exposed to the wrong influences and became addicted to heroin, he was involved with the wrong people at the wrong time.

He wanted the LSCB to know that it is dangerous to rush young people into that adult situation. Drug use is a major concern. He came out the other side, his support worker used a unique approach, and took him to favourite places where he felt comfortable, shops, open spaces. He has been clean from drugs for 3 1/2 years and it has been almost 3 years from when he was last arrested.

When the Board asked if there was anything that he felt could have helped him earlier in his youth, he stated that he thought Police could be 'more human' when responding to young, troubled people. He said that he needed someone to talk to and someone to help him understand the way he was expressing himself. The Children and Families representative pledged to take the learning from this back to the service and speak to Social Workers such as workers taking young people to shops and open spaces. We are very grateful to this young person for giving up his time and telling his story!

b. Case Studies at Neglect Annual Conference

At the Safeguarding Boards Annual Conference in December 2016 on neglect, delegates heard three case studies from service users and professionals. One case study, which was read out by the Youth Participation Officer (SCC) was about '*Freddy*', a young boy who had suffered emotional and physical neglect since birth.

In the afternoon, attendees heard directly from a parent who told her story of self-neglect, the impact of this on the children and how she is now overcoming these issues.

These thought provoking case study were used to set the scene for the morning and afternoon sessions and helped participants to understand the far reaching impact of neglect on children and young people.

c. Youth led workshop at Neglect Annual Conference - *'Neglect: A day in the life'*

The NSPCC participation group led a workshop which offered a chance to think and talk about how children and young people experience neglect throughout the day through the eyes of a child/young person. The workshop focussed on what that child/young person sees, thinks and feels, as well as the impacts of neglect at different times of the day.

The session was delivered by four members of Southampton's NSPCC Participation Group. This is a group of young people that regularly meet to discuss issues relevant to the NSPCC's work with children and families. They are able to give views and opinions that as adults and professionals we often don't think of, or overlook, and give us relevance to what is going on in the lives of young people.

This was one of the most successful aspects of the conference and was seen to be extremely thought provoking and interactive.

d. Youth 'Safeguarding' Survey

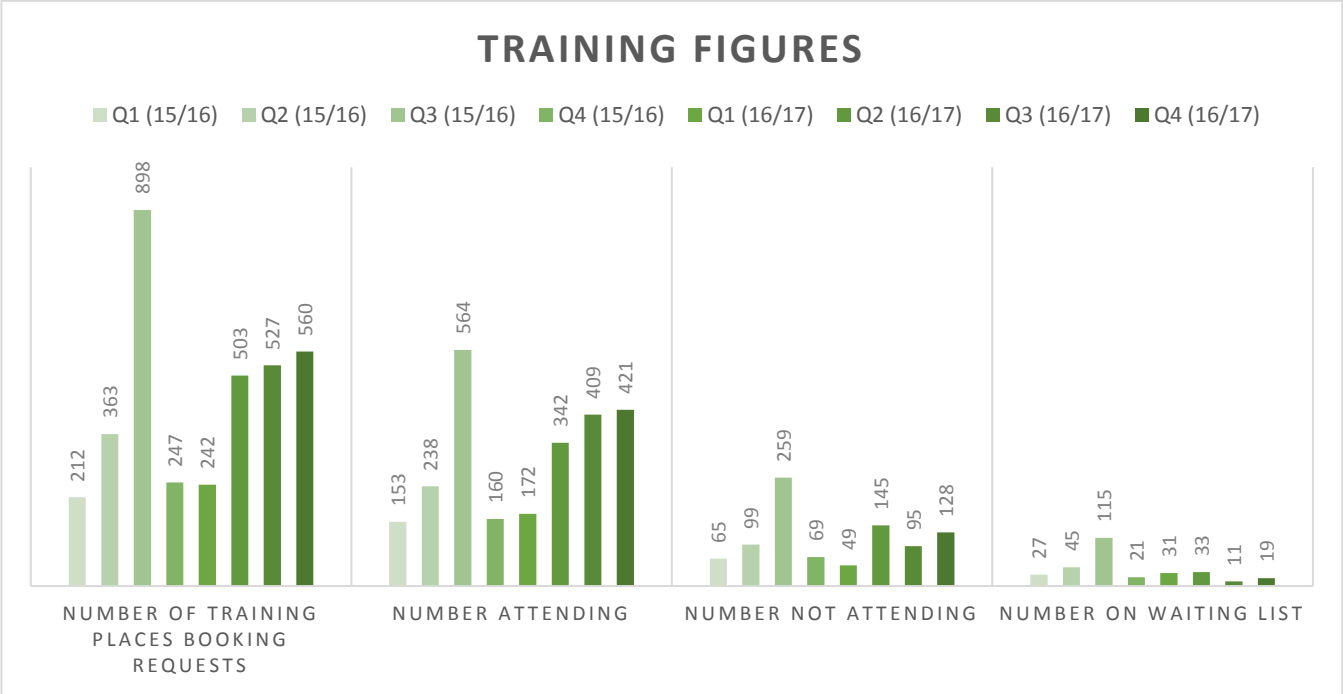
We asked a range of young people in Southampton 'what does Safeguarding mean to you?' Below is an example of feedback that was received:

This was fed back to the LSCB at the Business Planning Day in March 2017 by the Youth Participation Worker (SCC). They also shared a video made by the Children in Care Council about their experiences of being in care and about how it has impacted them within their life, since becoming care leavers. This had a great impact and served as an effective reminder of what the Board exists to do and how we all work together to improve the welfare and quality of life for our City's young people. This video directly drove a number of new additions to the Business Plan for 2017 – 18, including a more detailed assurance of Foster Carer procedures in the City.

Training

The Safeguarding Board has been delivering an agreed programme of Weekly Wednesday Workshops, Level 3 Safeguarding Training and other 'ad hoc' half day workshops for the last year.

Below is a summary of all attendance at LSCB training, broken down by quarter.



Wednesday Workshops:

Total number of Weekly Wednesday Workshops: **33**
Total number of attendees: **424**

Examples of workshops offered:

- Working with interpreters
- Youth Justice
- Universal Credit
- Fabricated and induced illness
- CSE and BAME communities
- Recognising physical injuries
- Child Abuse Investigation Team
- Working with families affected by suicide

Our most attended workshops were:

- Working with interpreters
- Recognising physical injuries
- Child abuse investigation team
- Working with GPs

Working Together to Safeguard Children and Young People Level 3 Training:

Total number of Working Together to Safeguard Children and Young People 2 day courses: **6**
2 day course total number of attendees: **137**

Total number of Working Together to Safeguard Children and Young People Refresher Courses: **6**
Refresher course total number of attendees: **77**

Half Day Workshops:

Total number of half day workshops: **13**
Total number of attendees: **329**

Half Day Workshop Topics:

- Substance and Alcohol Misuse
- An Introduction to Child Sexual Exploitation
- An Introduction to Neglect
- Adult Mental Health

Below is an example of feedback received in all types of LSCB training:

LSCB Membership

Agency	Position
Independent Chair	Independent Chair
Southampton City Council	Director of C&F Director of Housing, Adults & Communities
Hampshire Constabulary	Detective 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 Headteacher Compass School
Secondary School Rep	Secondary Schools Conference Representative

Agency	Position
Special Schools Rep	Special Schools Conference Representative
Further Education Rep	Further Education Representative
Voluntary & Community Sector	SVS
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

Contact Information

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