



# Annual Report 2019-20

## Southampton Safeguarding Children Partnership



SOUTHAMPTON SAFEGUARDING  
CHILDREN PARTNERSHIP

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## Foreword

It is my pleasure to introduce the Southampton Safeguarding Children Partnership's Annual Report for 2019/2020, which provides information and assessment of the activity that has taken place, the progress that was made in delivering the Partnership's objectives, how learning was identified and applied in practice and some of the challenges we face going forward.

Although the report covers the performance year that ended in March 2020 it would be wrong not to consider where we found ourselves in light of the unprecedented situation caused by the coronavirus (COVID-19).

Like every individual, organisation and indeed society as a whole, the Southampton Safeguarding Children Partnership (SSCP) had to adjust how we communicate, operate and think, with established processes and practices coming under intense pressure. The Partners from both the statutory and voluntary sectors responded together, quickly and effectively adjusting how they maintained line of sight to those children and young people with whom we work.

Safeguarding is critically important and is best approached through agencies working together with shared ambition, shared information and co-ordinated programmes of action. The unique circumstances of recent months have reaffirmed that, and I would want to record my appreciation for the efforts, commitment and professionalism of all those who safeguard the city's children and young people.

The report provides updates on key areas of the SSCP's work including; Safer Sleep, the ICON programme, tackling Neglect and developing a Family Approach. These initiatives reflect regional and national developments, and help to keep the children and young people in Southampton safe and well.

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

Derek Benson



Independent Chair of the Southampton Safeguarding Children Partnership

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## CONTENTS

<b>Foreword</b> .....	<b>2</b>
<b>What is the Southampton Safeguarding Children Partnership (SSCP)?</b> .....	<b>4</b>
<b>Southampton Context and Demographics</b> .....	<b>5</b>
<b>Indicators of Children’s Outcomes</b> .....	<b>6</b>
<i>Rate and number of Children in Need</i> .....	6
.....	7
<i>Child Protection</i> .....	9
<i>Looked After Children</i> .....	12
<i>Rate (per 10,000 children) and Number of Looked After Children</i> .....	12
<i>Children with Special Educational Needs or Disability</i> .....	12
<i>Youth Offending &amp; Criminal Activities</i> .....	13
<i>Children not in education, employment or training</i> .....	14
<i>School Absence</i> .....	14
<i>Children at risk of going missing</i> .....	17
<b>Priorities, Projects &amp; Activities</b> .....	<b>18</b>
<i>Family Approach</i> .....	18
<i>Safer Sleep</i> .....	18
<i>Neglect</i> .....	19
<i>Communication</i> .....	19
<i>Child Exploitation</i> .....	19
<b>Impact of safeguarding partners working together</b> .....	<b>20</b>
<i>Multi-Agency Audits</i> .....	20
<i>Case Reviews &amp; Learning</i> .....	20
<i>Child Death Overview Panel (CDOP)</i> .....	24
<b>Engagement, Training and Awareness Raising</b> .....	<b>25</b>
<b>Next Steps and Priorities for 2020-21</b> .....	<b>27</b>
<b>Appendix 2 LSCB/SSCP Membership</b> .....	<b>30</b>
<b>Appendix 3 Glossary</b> .....	<b>31</b>
<b>Appendix 4 – Structure of the LSCB/SSCP in 2019-20</b> .....	<b>32</b>
<b>Appendix 5 – Functions of the SSCP and its sub groups</b> .....	<b>33</b>
<b>Appendix 6 2020/2021 Southampton Safeguarding Children Partnership Outline Business Plan</b> .....	<b>34</b>

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## What is the Southampton Safeguarding Children Partnership (SSCP)?

Children in Southampton can only be kept safe if all professionals and services work together. Southampton Safeguarding Children Partnership (SSCP) provides the partnership forum and structure to achieve this. This year was one of transition as the partnership moved from the Local Children's Safeguarding Board arrangement to the new Southampton Safeguarding Children Partnership arrangement (SSCP). This was in line with statutory changes under Working Together to Safeguard Children 2018 and the three safeguarding partners (the Local Authority, Police and Clinical Commissioning Group) came together and published their new safeguarding arrangements in September 2019. The new arrangements can be found [here](#).

To complement the local Safeguarding Children Partnership arrangements, the safeguarding partners in Southampton collaborate with neighbouring authorities. This collaboration is formalised in a Hampshire and Isle of Wight, Portsmouth and Southampton safeguarding children partnership arrangement known as 'HIPS'. HIPS enables larger scale strategic development of partnership working across our geographical boundaries and improves our ability to influence practice and positive outcomes for children across local borders.

During 2019-20, the LSCB and latterly the SSCP operated according to statutory guidance and best practice with a broad partnership of senior representatives of the local services that work to safeguard and protect children from social care to health, voluntary sector to the Police. The SSCP is also fortunate to have Lay Members that offer their time as volunteers to bring a valuable and independent perspective to our meetings and work. For ease of reading this report will refer to the SSCP.

The last quarter of 2019/2020 was impacted on by the COVID -19 pandemic and this is reflected in this annual report. The pandemic created an unprecedented context for the safeguarding system. While "lockdown" restrictions began formally on the 23<sup>rd</sup> March, the preceding weeks were impacted by preparing in great uncertainty. An early decision was made by SSCP partners to continue SSCP business as usual as far as possible with regular biweekly meetings with statutory safeguarding partners to promote effective information sharing, co-operation and keep the situation under review. The 2020/21 annual report of the SSCP will demonstrate the operation of the partnership during the pandemic.

During this year the SSCP continued to check that what is done in Southampton to safeguard children works. For example, ensuring that services are working safely, 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 issue focussed 'task and finish' groups of the main SSCP. A structure chart and explanation of the sub groups can be found in Appendix 4.

## Southampton Context and Demographics

The population of Southampton is 252,800<sup>1</sup>, with:

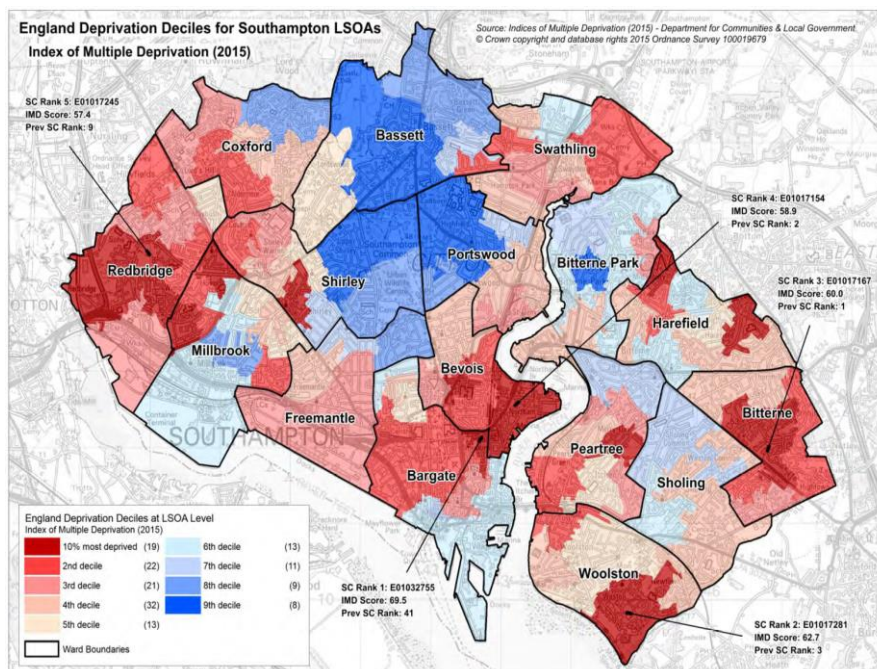
- 57,600 children and young people aged (0-19 years)<sup>2</sup>
- 53,000 residents who are not white British (22.3%)
- 43,000 students.

The city has a young demographic, with 20% of the population aged between 15 and 24 years, compared to just 12.4% nationally. 33% of school pupils in Southampton from an Ethnic Group other than White British<sup>3</sup> (compared to 26.3% in 2010) and for 25.7% of pupils their first language is other than English.

Overall when compared with England averages within the Child Health Profile the health and wellbeing of children in Southampton is worse than England. The infant mortality rate is similar to England with an average of 15 infants dying before age 1 each year. Recently there have been 6 child deaths (1-17 year olds) each year on average. The teenage pregnancy rate in Southampton is worse than England with 110 girls becoming pregnant in a year. Levels of child obesity are worse than England with 11% of children in reception year and 21.9% of children in Year being classed as obese. The rates of child inpatient admission for mental health are higher than the England average as are the rate for self-harm<sup>4</sup>.

20.1% of children in Southampton live in poverty compared to 17% average for England. In 2015 Southampton was ranked 67<sup>th</sup> out of 326 Local Authorities in England for deprivation, 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<sup>5</sup>:



<sup>1</sup> Source: LG Inform, 2019

<sup>2</sup> Source: Southampton City Council website ([www.southampton.gov.uk](http://www.southampton.gov.uk))

<sup>3</sup> Based on those with an ethnicity recorded

<sup>4</sup> Child Health Profile – March 2019, [www.gov.uk/phe](http://www.gov.uk/phe)

<sup>5</sup> Please note some data collection for 2019/20 has been impacted on by the COVID-19 pandemic and so may be less current than usual.

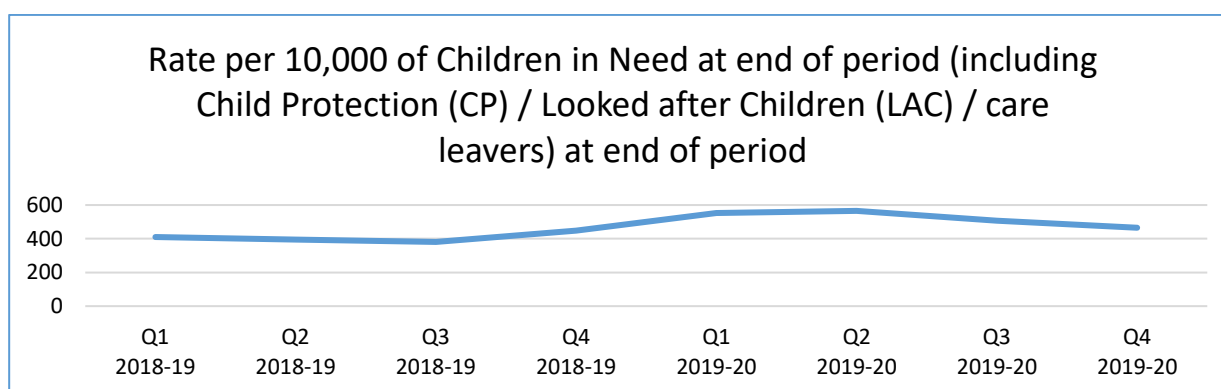
## Indicators of Children’s Outcomes

The SSCP considers a multi-agency dataset containing some key performance indicators for outcomes for children as well as the quality of local provision. It enables the SSCP to understand the impact of its work, and that of services, including changes for example where transformation projects take place. Tracking and analysing local data also allows the SSCP to understand the impact of changes or demand on one part of the safeguarding and child protection system to another. Data is analysed by the Safeguarding Practice Improvement (SPI) Group) through two deep dive thematic audits. In 2019/20 thematic audits took place in relation to Child and Adolescent Mental Health and Neglect. This allows key data to be brought together with other sources of information including the experience and views of children and young people and practitioner views. This provides a focused analysis of key issues to be highlighted to the SSCP and identifies activity to improve.

Below is a summary of annual data for some of these key measures.

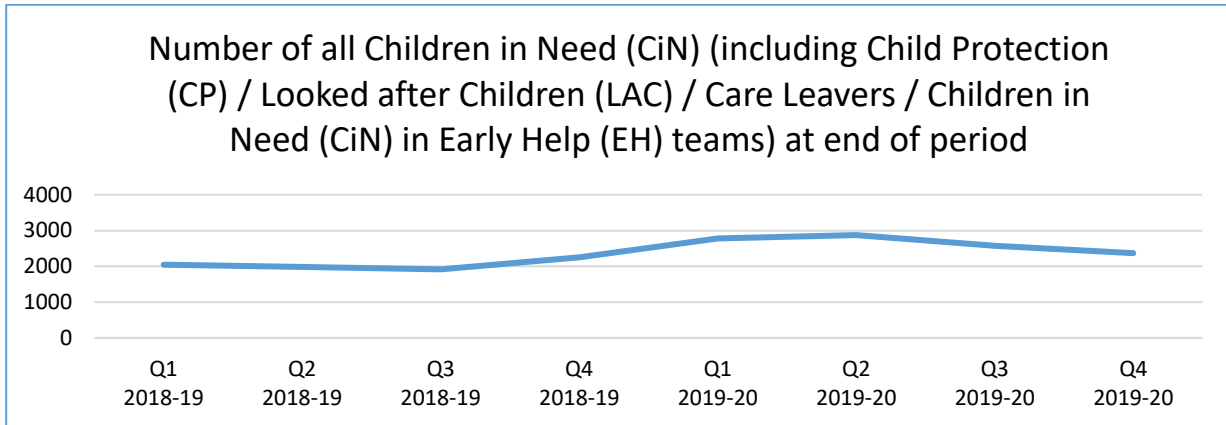
### Rate and number of Children in Need

Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018- 19	Q4 2018- 19	Q1 2019- 20	Q2 2019- 20	Q3 2019- 20	Q4 2019- 20
Rate per 10,000 of Children in Need at end of period (including Child Protection (CP) / Looked after Children (LAC) / care leavers) at end of period	410	395	381	448	552	565	507	466
Number of all Children in Need (CiN) ( <b>including</b> Child Protection (CP) / Looked after Children (LAC) / Care Leavers / Children in Need (CiN) in Early Help (EH) teams) at end of period	2046	1989	1917	2252	2778	2874	2577	2367



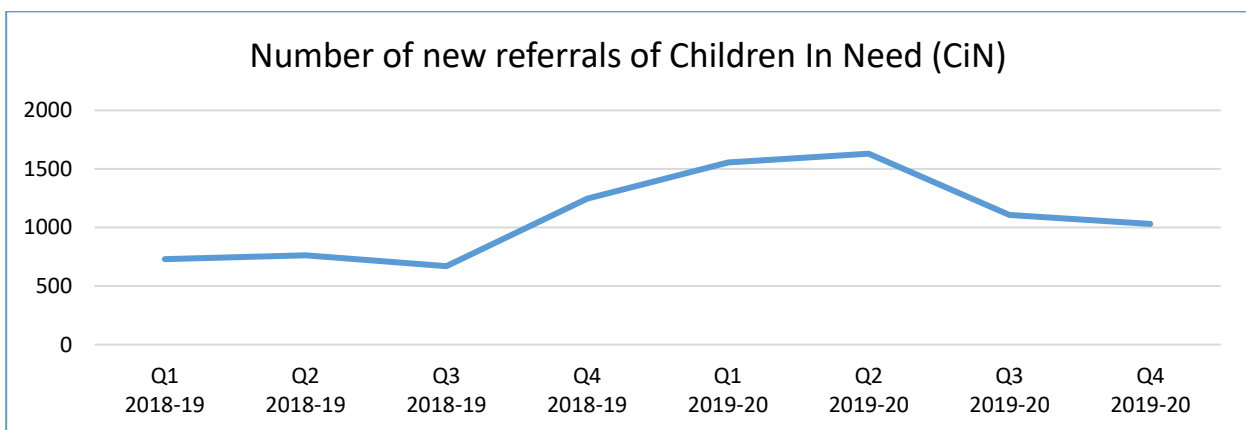
The rate of children in need based on 10,000 population of children under 18 is a key measure of the needs of children’s needs in Southampton and the services and support required.

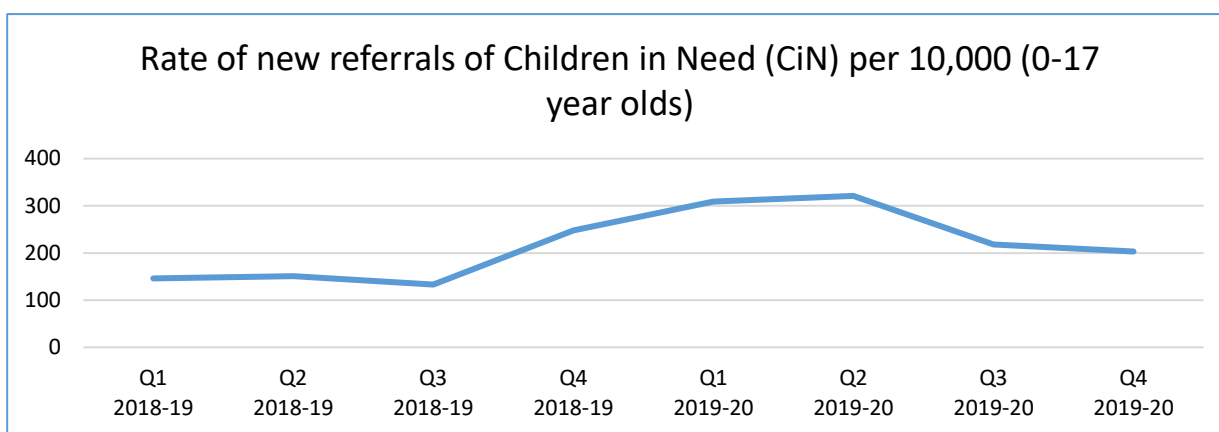
Simply, it can be used as a broad indication of whether children and their families are receiving the right help at the right time and indicative of the success or otherwise of early help intervention and support locally. Q1 and Q2 in 2019 saw an increase where the rate rose significantly. The rate began a downward trajectory in Q3 which continued in Q4 towards more usual levels. As the significant impact of the pandemic came in late March 2020 the impact on these figures is not hugely apparent. This is also replicated in the number of all children in need as can be seen below.



Rate of Children in Need referrals received per 10,000 population

Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018 -19	Q4 2018 -19	Q1 2019- 20	Q2 2019 -20	Q3 2019 -20	Q4 2019 -20
Number of new referrals of Children In Need (CiN)	731	762	670	1247	1556	1630	1106	1030
Rate of new referrals of Children in Need (CiN) per 10,000 (0-17 year olds)	146	151	133	248	309	321	218	203





From Q4 2018/19 there has been a significant increase in new referrals of children in need as can be seen by the rate per 10,000 of children and the numbers. This trajectory changed in Q2 2019/20 with the rate a number declining and then plateauing. Considerable work has been undertaken in Multi Agency Safeguarding Hub (MASH), both through independent review in 2019/20 and with the continuation of auditing processes to confirm the appropriateness of decision making within MASH. This work continues. The OFSTED inspection in November 2019<sup>6</sup> noted issues in the quality and appropriateness of some referrals going into the MASH and that decision making was generally appropriate.

#### Number and percentage of Single Assessments (SA) completed within 45 day

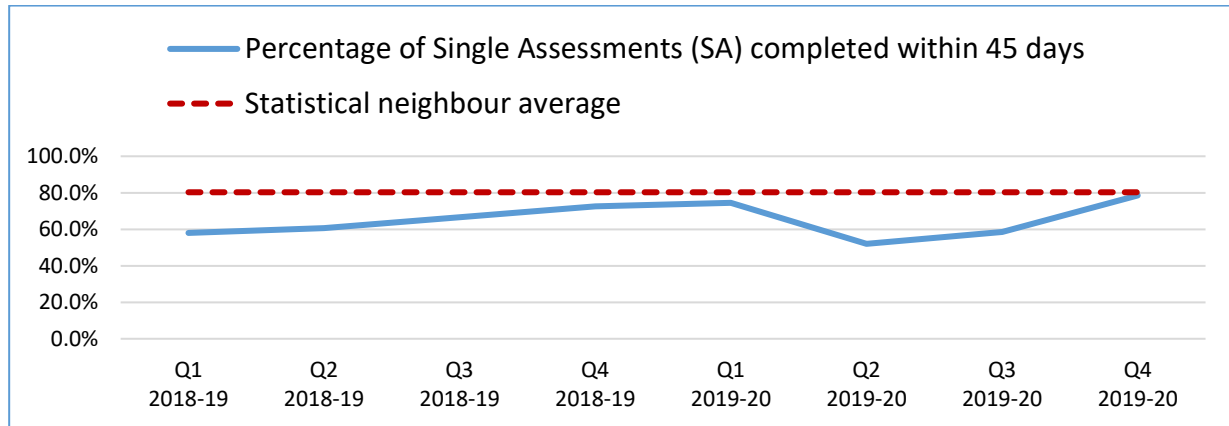
Indicator	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	SN	England	South East
Number of Single Assessments (SA) completed within 45 days	354	320	344	482	616	641	834	849	787	882	1105
Percentage of Single Assessments (SA) completed within 45 days	58.0 %	60.6 %	66.7 %	72.6 %	74.6 %	52.0 %	58.5 %	78.5 %	80.3 %	83.1 %	82.4 %

One of the measures used to monitor the quality of local provision is the timeliness of assessments completed by Children's Social Care within the statutory timescales of 45 days.

<sup>6</sup> The OFSTED Inspection can be found [here](#)



This is a reflection of the need to identify risk and support children and families swiftly when they are considered to be in need of support or services. This above data shows early indications of an improving picture in terms of timeliness with Southampton moving to a position of equal comparison with our statistical neighbour. This is visually highlighted in the graph below.



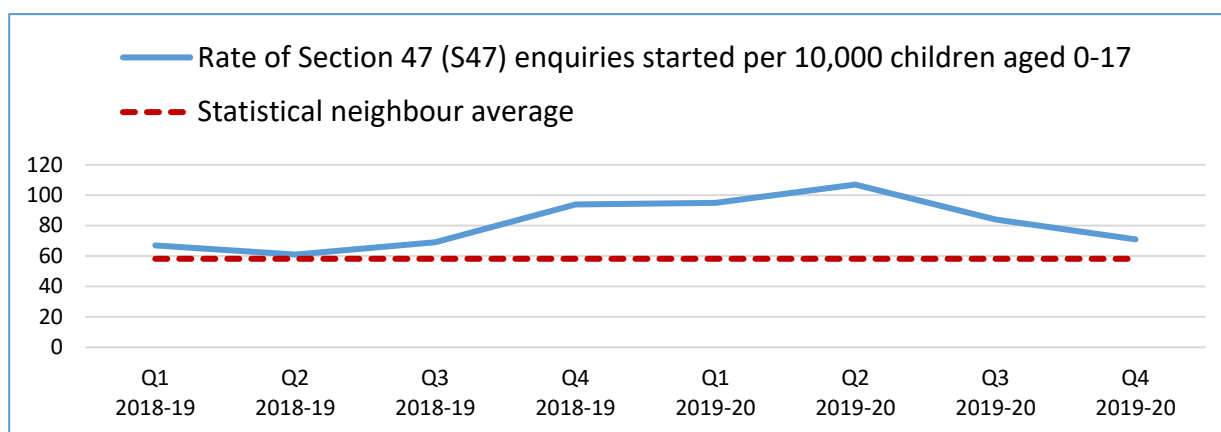
This area of performance is monitored and progressed through the Children’s Services Improvement plan and reported to the SSCP.

### Child Protection

The number of children taken into police protection this year totals 38, Portsmouth city is a comparable authority and a statistical neighbour, given their proximity and coverage by the same police force as Southampton it can be useful to track comparisons. Portsmouth had 49 children subject to police protection during this time. This data is impacted by size of family so should be analysed with that in mind.

#### Rate of Section 47 (S47) enquiries started per 10,000

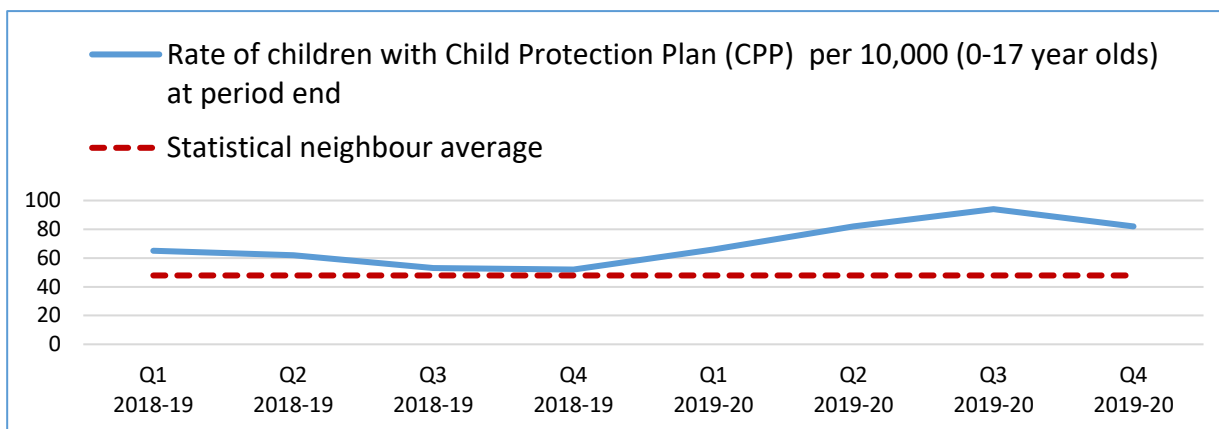
Indicator	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	SN	England	South East
Number of Section 47 (S47) enquiries started	332	309	348	472	476	545	426	362	362	331	443
Rate of Section 47 (S47) enquiries started per 10,000 children aged 0-17	67	61	69	94	95	107	84	71	58	42	43



Where there are child protection concerns (reasonable cause to suspect a child is suffering or is likely to suffer significant harm) the local authority social care services must make enquiries to decide if any action must be taken under Section 47 of the Children Act 1989. This is an essential area of the child protection system. For the first three quarters of 2019/20 Southampton has continued to have a higher rate per 10,000 children. This can be seen to be diminishing from Q 3 2019/20. This performance indicator is being monitored through the Children’s Services Improvement Plan with actions to ensure the right help is provided at the right time to families, early enough where possible, to avoid crises that require more statutory intervention.

#### Number and rate of Children with a Child Protection Plan

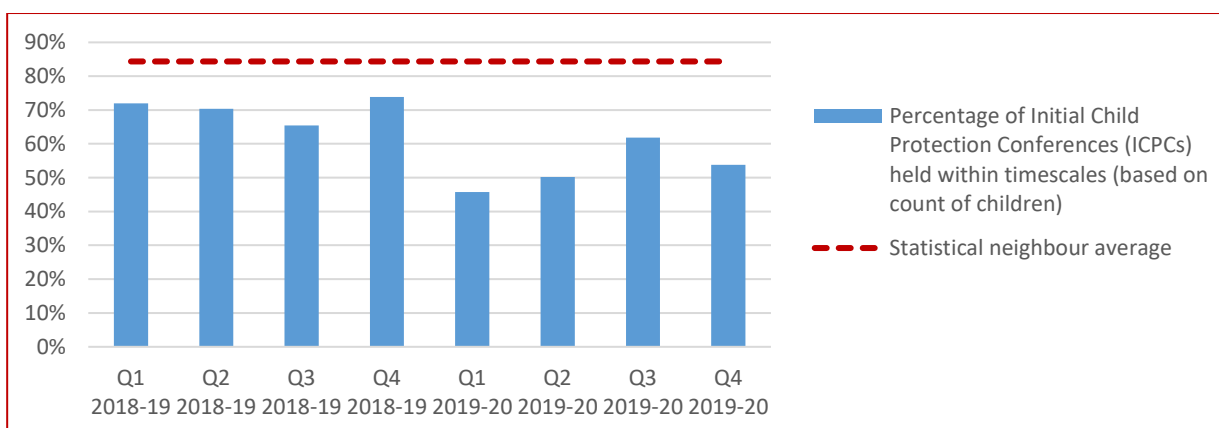
Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018- 19	Q4 2018- 19	Q1 2019- 20	Q2 2019- 20	Q3 2019- 20	Q4 2019- 20	SN	England	South East
Number of children with a Child Protection Plan (CPP) at the end of the month, excluding temporary registrations	324	272	265	262	333	419	479	417	388	439	527
Rate of children with Child Protection Plan (CPP) per 10,000 (0-17 year olds) at period end	65	62	53	52	66	82	94	82	48	44	41



2019/20 has seen an increase in the number and rate of children with a Child Protection Plan which is higher than statistical neighbours. While the rate can be seen to diminishing from Q3 to Q4. This remains an area of focus for the partnership. The SSCP continued to receive assurance reports on the progress of child protection work throughout 2019/20 and this is a focus of the Children’s Services Improvement Plan.

#### Percentage of Initial Child Protection Conferences held within timescale

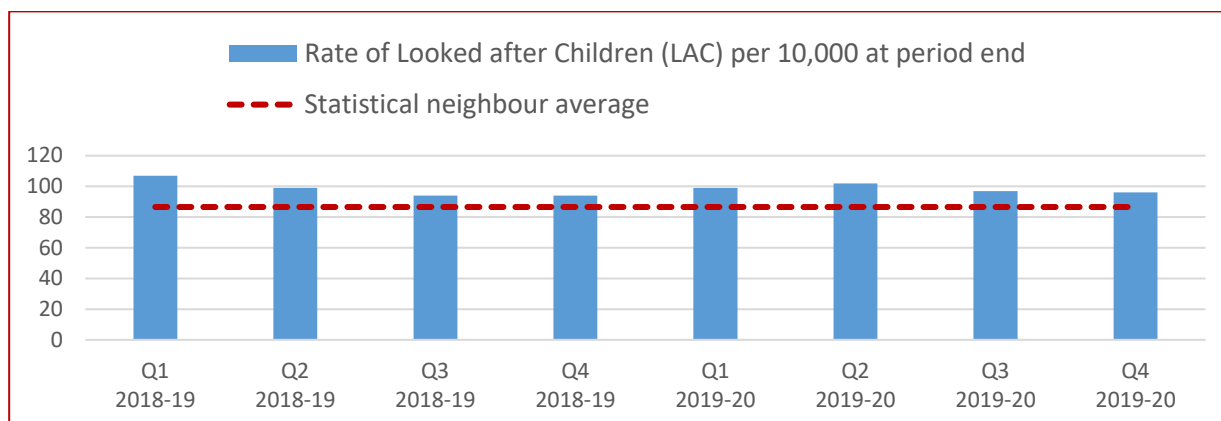
Indicator	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20	Q2 2019-20	Q3 2019-20	Q4 2019-20	SN	England	South East
Percentage of Initial Child Protection Conferences (ICPCs) held within timescales (based on count of children)	72.0 %	70.3 %	65.4 %	73.8 %	45.7 %	50.3 %	61.8 %	53.8 %	84.4 %	78.7 %	77.2 %



The percentage of Initial Child Protection Conferences held within agreed timescales has dropped during 2019/20. Impacted on Q4 2019/20 by the early stages of the pandemic and the introduction of guidance and then regulation.

## Looked After Children

### Rate (per 10,000 children) and Number of Looked After Children



Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018- 19	Q4 2018- 19	Q1 2019- 20	Q2 2019- 20	Q3 2019- 20	Q4 2019- 20	SN	England	South East
Number of Looked after Children at end of period	534	499	475	475	500	516	493	490	496	514	541
Rate of Looked after Children (LAC) per 10,000 at period end	107	99	94	94	99	102	97	96	87	65	53

While Southampton remained higher than our statistical neighbour in terms of the rate of Looked after Children per 10,000 the numbers of children in care reduced slightly over the last two quarters in 2019/20. Given the impact of COVID -19 on children, young people and families, it is very uncertain that this downward trajectory will be sustained over 20/21

This is an area for focus for the Corporate Parenting Board and the Children’s Services Improvement Plan. The SSCP receives regular reports from the Children’s Services Improvement Board and retains clear links with the Corporate Parenting Board.

### Children with Special Educational Needs or Disability

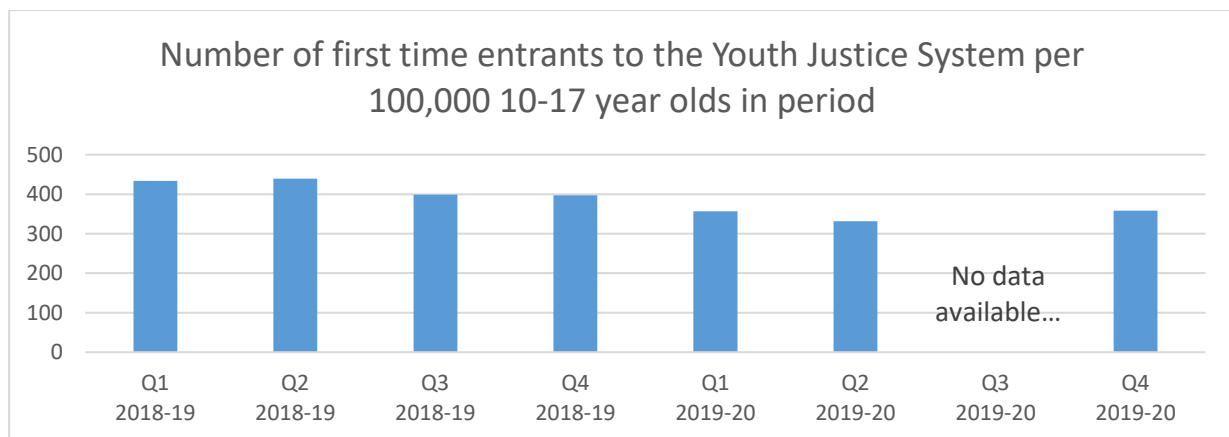
The City has an increasing number of school age children with a learning disability/identified additional needs, which has risen from below the national average in 2013/14 to above the national average since 2017. The demand for specialist SEND provision is increasing year on year and a considerable amount of thought and planning is currently taking place to review how we plan to meet the demand for SEND provision now and in the future. This increasing demand is being experienced from preschool/early years and throughout the 5 Key Stages

across the city and in all SEND provisions. It is predicted that the numbers of children being considered for specialist provision/special school places will continue to increase by up to 50% by 2022. Without additional funding this will put further pressure on the High Needs Block with funding implications across all SEND provisions. Research shows that disabled children are at an increased risk of being abused compared with their non-disabled peers, and that professionals often struggle to identify safeguarding concerns when working with disabled children. The LSCB has previously focussed on SEND assurance and safeguarding children with a disability to seek assurance of local provision and outcomes for children. The SSCP will continue to seek this assurance in partnership with both education and health partners.

### Youth Offending & Criminal Activities

#### Number of first time entrants to the Youth Justice System per 100,000 10-17 year olds in period

Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018- 19	Q4 2018- 19	Q1 2019 -20	Q2 2019 -20	Q3 2019- 20	Q4 2019 -20
Number of first time entrants to the Youth Justice System per 100,000 10-17 year olds in period	434	439	399	397	357	332	No data available for this quarter	358

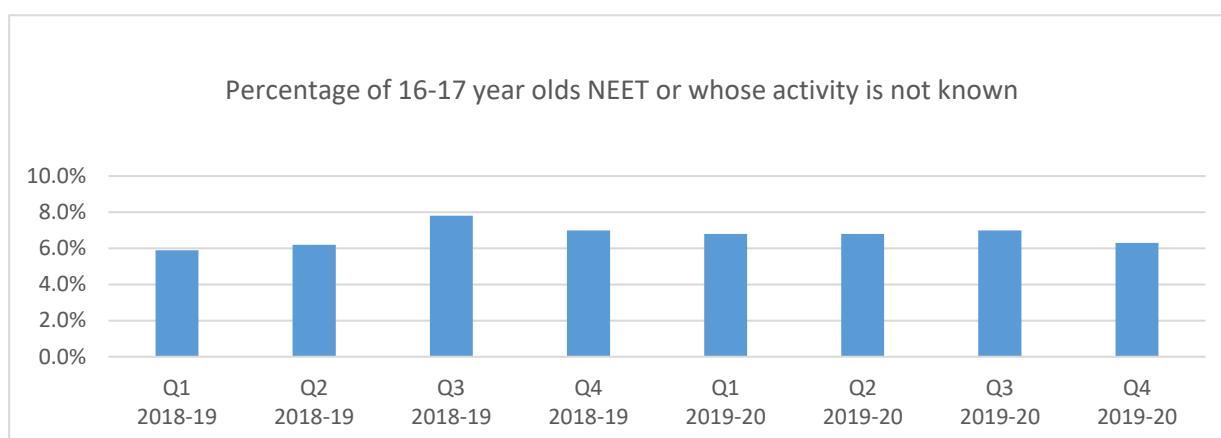


The rate of First Time Entrants to the Criminal Justice System aged 10-17 years old decreased in the first 6 months of this year. A lower level has remained consistent in throughout the year although there is no data available in Q3 due to impact of the Coronavirus pandemic.

## Children not in education, employment or training

### Percentage of 16-17 year olds NEET or whose activity is not known

Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018- 19	Q4 2018- 19	Q1 2019- 20	Q2 2019- 20	Q3 2019- 20	Q4 2019- 20
Percentage of 16-17 year olds NEET or whose activity is not known	5.9%	6.2%	7.8%	7.0%	6.8%	6.8%	7.0%	6.3%



The number of young people (16-18 years) who are not in education, employment or training (NEET) demonstrates a level picture. This will be an area for focus in 2020/21 given the impacts of the pandemic and the additional vulnerabilities of particular priority groups such as care leavers.

### School Absence

The School Attendance and Inclusion Group was formed in June 2015 and has been meeting on a regular basis ever since. It aims to develop a citywide shared purpose and vision to improve school attendance and raise attainment throughout our schools. Furthermore, its purpose is to co-ordinate a consistent, collaborative approach to improve school attendance within the City. It is a vehicle for sharing good practice with others, discussing and exploring current issues that are affecting absence and updating policies, procedures and processes to accommodate the ever changing landscape and reasons for absence from school.

This is a group open to all Southampton schools and is now co-chaired by Head teachers, primary, secondary and special phase, working in partnership with the local authority, developing links with stakeholders to raise the profile and a greater understanding of the benefits of excellent school attendance. The group is identifying ways to address obstacles to

improved attendance and is working collaboratively to produce and ratify guidance for city schools on attendance related matters. This way the message to improve school attendance is high on the agenda throughout the city. Our partnership with Saints Foundation has to support our drive to improve school attendance over the last two years has seen children and young people be rewarded for improved and excellent school attendance. This year will be negotiated in due course but will be very different within these unprecedented times.

## Headlines – Absence Data

### Definitions

**Overall Absence** - The **overall absence rate** is the **total** number of **overall absence** sessions for all pupils as a **percentage** of the **total** number of possible sessions for all pupils, where **overall absence** is the sum of authorised and unauthorised absence and one session is equal to half a day.

**Authorised Absence** - Authorised absence means that the school has either given approval in advance for a pupil of compulsory school age to be away, or has accepted an explanation offered afterwards as justification for absence.

**Unauthorised Absence** - Unauthorised absence is where a school is not satisfied with the reasons given for the absence.

### Primary Phase Autumn Term 2019

Southampton vs. Statistical Neighbours	Southampton %	Statistical Neighbour Average %	Statistical Neighbour Gap %
Overall Absence	4.3	4.3	0.0
Authorised Absence	2.9	3.1	-0.2
Unauthorised Absence	1.4	1.2	0.2
10% Persistent Absence	11.5	11.9	-0.4

- Southampton's Primary Autumn Term 2019 absence rates are below the Statistical Neighbour average for Authorised and Persistent Absence.
- Southampton's Primary Autumn Term Overall Absence rates increased from 3.8% in 2018, to 4.3% in 2019, a 0.5% increase.
- Southampton's Primary Autumn Term Persistent Absence rate increased from 9.8% in 2018, to 11.5% in 2019, a 1.7% increase.

### Secondary Phase Autumn Term 2019

Southampton vs. Statistical Neighbours	Southampton %	Statistical Neighbour Average %	Statistical Neighbour Gap %
Overall Absence	5.8	5.7	0.1
Authorised Absence	2.9	3.7	-0.8
Unauthorised Absence	2.8	2.0	0.8
10% Persistent Absence	15.3	15.6	-0.3

- Southampton's Secondary Authorised Absence (2.9%) and Persistent Absence (15.3%) are lower than Statistical Neighbour averages (Authorised Absence - 3.7%, Persistent Absence - 15.6%), with a gap of 0.8% and 0.3%, respectively.

### Special School Education Autumn Term 2019

Southampton vs. Statistical Neighbours	Southampton %	Statistical Neighbour Average %	Statistical Neighbour Gap %
Overall Absence	9.7	12.2	-2.5
Authorised Absence	7.0	8.7	-1.7
Unauthorised Absence	2.7	3.5	-0.8
10% Persistent Absence	27.6	32.8	-5.2

- Southampton's Special School Absence was lower the Statistical Neighbour average on all measures. Southampton's Special School Overall Absence (9.7%) was 2.5% below the Statistical Neighbour average (12.2%). The Southampton Special Persistent Absence (27.6%) was 5.2% below the Statistical Neighbour average (32.8%).
- Southampton's Special School Overall Absence rate increased by 0.4% from 9.3% in 2018 to 9.7% in 2019. However, remains below the 2017 Southampton Special School Overall Absence rate of 9.8%.
- Southampton's Special School Persistent Absence has also increased, from 26.2% in 2018, to 27.6% in Autumn 2019.

### Pupil Referral Unit (PRU) Education Autumn Term 2019

Southampton vs. Statistical Neighbours	Southampton %	Statistical Neighbour Average %	Statistical Neighbour Gap %
Overall Absence	51.3	35.2	16.1
Authorised Absence	29.4	15.5	13.9
Unauthorised Absence	21.9	19.7	2.2
10% Persistent Absence	82.8	75.2	7.6

- Southampton's PRU Overall Absence increased by 9.9% from 41.4% in Autumn 2018, to 51.3% in Autumn 2019. The Statistical Neighbour average for PRU Overall Absence increased by 0.2% between 2018 and 2019. The gap between Southampton's PRU Overall Absence performance and the Statistical Neighbour average increased to 16.1%.

### 4 Year Old (Nursery) Autumn Term 2019

Southampton vs. Statistical Neighbours	Southampton %	Statistical Neighbour Average %	Statistical Neighbour Gap %
Overall Absence	6.0	5.4	0.6

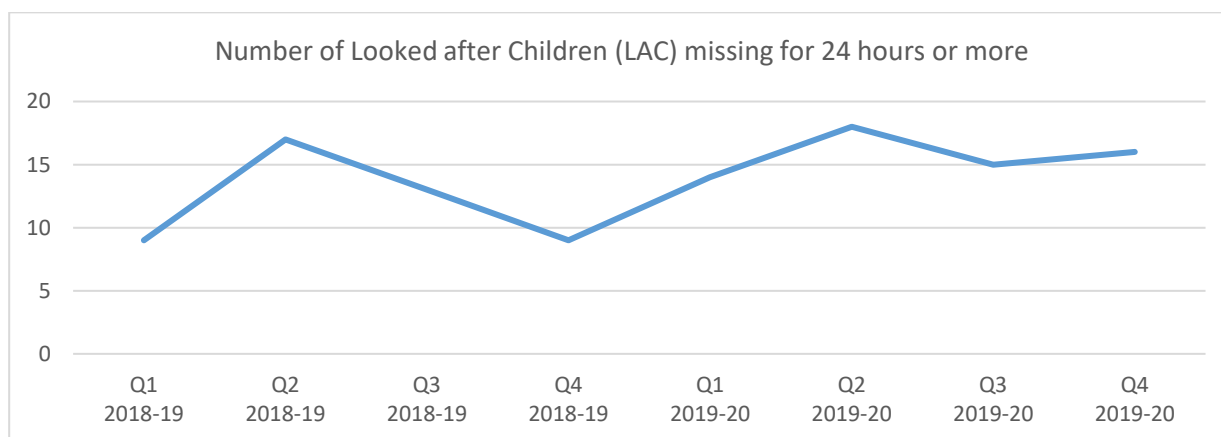
- Southampton's 4 Year Old Absence rate (6.0%) is 0.6% higher, than the Statistical Neighbour average (5.4%) in Autumn 2019.



## Children at risk of going missing.

The OFSTED report in November 2019 noted “children who go missing and are at risk of exploitation, receive effective help.”

Indicator	Q1 2018- 19	Q2 2018- 19	Q3 2018- 19	Q4 2018- 19	Q1 2019- 20	Q2 2019- 20	Q3 2019- 20	Q4 2019- 20
Number of Missing Person Episodes (aged under 18)					394	279	336	360
Number of Missing Persons (age under 18) going missing x3 or more in 90 days					42	35	30	40
Number of Looked after Children missing for 24 hours or more	9	17	13	9	14	18	15	16



The OFSTED Report in November 2019 noted children in care who go missing and may be at risk of sexual and other forms of exploitation, receive responsive services from knowledgeable staff in the Missing, Exploited, Trafficked Team.

The SSCP continues to develop its coordination and assurance activities relating to child going missing particularly with the increased risk of child exploitation associated to this. Partnership arrangements have developed this work even further, with a HIPS Child Exploitation group developing to encompass the wider range of CE issues, across geographical boundaries. Southampton SSCP will seek assurance locally and 20/21 will see clear mechanisms in place to achieve this.

## Priorities, Projects & Activities

For this year the LSCB/SSCP agreed to continue with its previous priority themes for its partnership work. This was to ensure consistency and embedded action across the multi-agency partnership, and review progress in the light of new arrangements to be implemented during 2019-20:

Priority Themes:	
1.	Developing a <b>Family Approach</b> to safeguarding
2.	<b>Child Neglect</b>
3.	Focus on improving safety and outcomes for vulnerable children including; <ul style="list-style-type: none"><li>• <b>Looked after Children</b></li><li>• Those at risk of going <b>missing, being exploited or trafficked (MET)</b></li></ul>
4.	Improve <b>communication</b> between services at senior and practitioner level
Development of <b>new safeguarding partnership arrangements</b>	

Below is a summary of action taken by the LSCB/SSCP during this year including the priority areas:

### Family Approach

1. The Family Approach Toolkit includes:
  - a. Protocol for working together
  - b. Toolkit for professionals
  - c. Launch and training events
2. Development of a joint Southampton training programme with the LSAB, which includes topics such as substance misuse, alcohol use and adult mental health training as a regular feature.
3. The joint audit with the LSAB/LSCB was reported to the LSCB/SSCP this year which has led to an action plan being implemented.
4. The launch of the Family Approach Toolkit in June 2019 was attended by a range of multi-agency professionals and supported by a range of professionals from different agencies. Feedback was very positive with participants identifying impact on their practice moving forward.

### Safer Sleep

1. The agreed approach to Safer Sleep was launched in March 2020. This was a HIPS event which was attended by a range of professionals from across the county.
2. The approach includes agreed “touch points” with families when health colleagues in universal services will share and repeat key Safer Sleep messages.
3. The use of Lullaby Trust materials with parents and carers to share key messages with professionals, parents and carers.
4. Safer Sleep training delivered for Southampton colleagues
5. A HIPS Safer Sleep procedure detailing roles and responsibilities and considering safeguarding risks to children when Safer Sleep advice is not followed and may be linked to other known risk factors such as parent/carer use of alcohol.

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## Neglect

1. Following the publication of the refreshed Neglect Strategy and Guidance, the SSCP Safeguarding Practice Improvement Group undertook a deep dive thematic audit. This identified priority areas to development. This included awareness of the Strategy and Guidance. Promotion has continued through training and awareness.
2. Southampton City Council published Practice Guidance relating to Educational Neglect in response to learning from reviews.

## ICON Programme

ICON was launched in 2019 this was a HIPS wide event which was attended by a range of professionals from across the county.

**ICON** is all about helping people who care for babies to cope with crying. ICON stands for

**I**nfant crying is normal

**C**omforting methods can help

**O**k to walk away

**N**ever, ever shake a baby

The use of ICON materials is in response to concern about abusive head trauma in babies and the need to raise awareness amongst professionals and parents and carers.

This ensures a clear and consistent approach in supporting and educating parents and carers about how to manage stress when babies cry and the harm that can be done by shaking a baby.

## Communication

1. Developed further links for LSCB/SSCP with schools and education settings, including DSL network
2. Delivered a range of multi-agency workshops on key topics to enable networking between services working with families and adults at risk of harm
3. Regular communication with other strategic partnerships including SSAB, Safe City Partnership, Health and Wellbeing Board and Scrutiny Panels regarding issues of concern.
4. The HIPS areas of Southampton, Portsmouth, Isle of Wight and Hampshire regularly refresh HIPS safeguarding policies and procedures and highlight key documents via newsletters and email communication.

## Child Exploitation

The SSCP continues to develop co-ordination and assurance activities relating to all forms of child exploitation. 2019/20 saw transition to the HIPS Child Exploitation Group. Work during 2019/20 has included:

- developing Lurking Trolls, focused on online safety;
- developing links with the Violence Reduction Unit and Modern Slavery Partnership;
- the work of Youth Ambassadors;
- increasing the use by multi-agency partners of intelligence reporting to the Police;
- increasing the use of the Child Sexual Exploitation Risk Assessment Framework tool and;
- sharing of strategic information regarding the operation of County Lines and other forms of child exploitation

2020/2021 sees the publication of a new HIPS CE Exploitation Strategy. This firmly locates assurance of delivery of local actions responding to the strategy with the SSCP.

## **Impact of safeguarding partners working together**

### **Multi-Agency 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 SSCP has aligned its multi-agency audit schedule to undertake a dry run of such an inspection according to national themes. This year the themes were Neglect and Child and Adolescent Mental Health.

The LSCB also undertook an independent multi agency audit, jointly with the LSAB relating to the transition of young people leaving care from child to adult mental health services during this year. The findings from this were reported to the LSCB in June 2019 and the recommendations are being actioned through the Multi Agency Children's Board. Including ongoing training for the workforce regarding Transition to Adult Services

### **Case Reviews & Learning**

In line with the updated of government guidance on reviews in Working Together to Safeguard Children 2018, Southampton Safeguarding Children's Partnership from September 2019 commissions Child Safeguarding Practice Reviews. In line with transitional arrangements Serious Case Reviews commissioned by the LSCB will be completed. The reviews published in 2019-20 during transitional arrangements were Serious Case Reviews.

#### **Serious Case Reviews published 2019-20**

The Safeguarding Partnership published the following Serious Case Reviews in the year 2019-20. Below is summary of those reviews, and a summary of the learning. Full details can be found at <http://southamptonlscb.co.uk/seriouscasereviews/>

**Adam & Anna** (published June 2019) - this SCR focussed on child sexual abuse within the family environment, sometimes known as Intra Familial Sexual Abuse (IFCSA). The SCR examined the barriers to keeping Adam and Anna safe and the correlation between neglect and IFCSA. The review also explored how effectively agencies worked together to identify and

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address the risk posed to the children and what can be learned to improve future professional practice. The recommendations largely focussed around training to ensure that practitioners can confidently recognise the signs of IFSCA and know what action to take.

**Safe Sleep** (published June 2019) - two young babies, Billy and Reece (not their real names) died in Southampton in circumstances that were thought to be linked to co-sleeping. As well as commissioning a SCR into these deaths and in response to a number of cases related to co-sleeping at the Child Death Overview Panel (CDOP) the Safeguarding Partnership undertook a Thematic Review to examine the issue of safe sleep. The learning and improvements for the SCRs regarding Billy and Reece and the Thematic Review were combined. The main areas for learning were the importance of conveying safe sleep messages to parents and tailoring those messages for the parents' needs.

### **Themes identified from this year's case reviews**

The themes identified this year through all of the LSCB/SSCP's case reviews and audit work are summarised below, these are reviewed regularly and influence the 'Learning from Case Reviews' briefings and workshops that the LSCB/SSCP has hosted:

#### **Taking a family approach - including risks from a combination of domestic violence, substance misuse, alcohol and mental health issues**

- Commonality of combination of issues in families, and increased risk of significant harm
- High risks posed to others as well as 'subject' of the casework. This includes wider family members and children where a combination of these issues is present
- Early identification and intervention reduces risk of harm
- Risk escalates quickly particularly where there is a combination of domestic abuse with mental health issue or substance misuse
- There is a need for further understanding of the impact of coercive control on families

#### **Escalation**

- Underpins the principle that 'Safeguarding is everyone's business... until the child /individual is safe'
- A need to constructively challenge if response is inadequate – this is both within own and across agencies
- A need to raise awareness of the HIPS / 4LSAB Escalation procedures
- Key factor in promoting the welfare of our children and adults at risk

#### **Good communication between agencies and with service users**

- Practitioners should work with family members to determine common goals when decision making and care planning
- Practitioners should be clear that safeguarding/child protection concerns override data protection legislation
- Effective communication and healthy working relationships are important part of good multi-agency practice
- Clarity of lead professional role is needed, along with clear roles and responsibilities for each professional working with the family

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## **The voice of the child**

- Professionals must ensure they see the child face to face
- Teenagers should not elicit any less response than a younger child; their voice should be sought & heard
- If it is not possible to see the child alone, this should be recorded as a concern and escalated if necessary.
- The child's voice should not be over-shadowed by the parent or care giver.
- Practitioners should consider the daily lived experience of the child, i.e. the impact of abuse and neglect and the potential long-term significant harm.
- The practitioner should be alive to non-verbal means of communication, e.g. actions, reactions, or silence, or inability to engage with the child due to the parent or care giver.

## **Disguised compliance and hostile families**

- Professional curiosity is key and professionals should be encouraged to triangulate findings in order to test a hypothesis.
- Cases show that intentional deception / control of professionals often exists where parents or care givers are minimising or denying abuse and neglect.
- In cases of disguised compliance and/or hostile families parents or care givers can display various levels of engagement with practitioners from different agencies, e.g. choosing to engage with one particular service to detract from a lack of engagement with another
- Professionals can become over optimistic about progress being achieved, delaying timely interventions for families
- Aggressive / intimidating family members can influence responses in that professionals become hesitate to engage with them, or only 'act on the positives' without challenging a lack of tangible progress for the child.

## **Intra familial Child Sexual Abuse (IFCSA), now known as Child Sexual Abuse within the Family Environment (CSAFE).**

- Awareness of indicators of risk and specialist responses needs to improve
- IFCSA is not always apparent until disclosed and often other presenting factors (such as neglect) are noticed first
- Some children and young people may try and seek help indirectly e.g. unusual or challenging behaviour or in non-verbal ways
- Sexual abuse during childhood may be a risk factor for perpetrating IFCSA.

## **Impact of Neglect**

- Children can spend long periods of time subject to interventions from services with limited impact.
- Early intervention is a key factor in reducing harm. We know that longer term neglect raises the risk of harm to the child.
- The issues of domestic abuse, mental health and substance misuse together often coexist with neglect.

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- Housing issues such as rent arrears and anti-social behaviour also feature in the context of neglect.
  - There is a link between experience of neglect as a child and in adolescence and self-neglect as an adult.

### **Using history to inform current practice**

- The use of quality chronologies with clearly identified risk factors improves outcomes for child and adults. These need to be more than a simple timeline – include qualitative information, analysis and narrative.
- The relevant history of the family should be made available to multi-agency professionals so it can inform all levels of interventions and assessments.
- Need to include patterns or trends noticed for the family / individual. Include patterns of behaviour, crisis times and ‘peaks’ of risk to help predict and prevent future harm.
- Consideration should be given to include previous generational case/family history to form a holistic view.

### **Regular and effective supervision**

- This is an area of repeat concern across agencies in reviews. Each agency should have:
  - A written policy for the supervision of staff working with children, young people and families which reflects SSCP supervision standards
  - A process for handling complaints and disagreements with regards to safeguarding supervision.
  - Safeguarding supervision provided by an appropriately experienced supervisor that is regular, planned with protected time & one-to-one or group basis.
  - A written agreement that explains the purpose, value and importance, the roles of the supervisor and supervisee should be agreed. A record of each supervision should be kept in line with the specific organisation’s own supervision policy and/or agreed processes.
- Decisions relating to children, young people and families should be recorded (or cross-referenced) on the child/young person or family’s case file or record. There is a duty to escalate the following concerns should they arise within safeguarding supervision discussion:
  - Child/family member may be at risk of significant harm.
  - There is unsafe practice placing people at risk.
  - There is illegal activity.

### **Safe Sleep**

- The Safe Sleep Thematic Review showed that sleep messages not heard and acted upon when delivered to some parents, particularly where there are additional needs or vulnerability
- Advice should be scaled according to parent’s needs and targeted for those in ‘high risk’ groups (young parents, Child Protection history, premature babies...etc.)
- Professionals should consider sleeping arrangements in assessments and ask to see these when working with a family with a young baby.

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- Risk of overlay increases when a parent sleeps on a sofa, armchair or airbed with a baby.
  - Increased risk of Sudden Infant Death Syndrome (SIDs) if parents have been drinking alcohol or taking drugs
  - Risk is also increased if a baby is premature (born before 37 weeks), or has a low birth weight (less than 2.5kg or 5.5lb).

### **Recommendations from Reviews**

The implementation of recommendations from reviews are monitored through the SSCP Serious Incident and Learning Group. This provides the SSCP with assurance. Partnership responses to the learning themes identified are as follows.

- Embedding the Family Approach Toolkit – Southampton Family Approach Conference
- Launch of Safer Sleep Guidance, procedure and information for parents/carers and families
- Launch of ICON awareness campaign
- Delivery of Sand Stories training focusing on disguised compliance
- Launch of Educational Neglect Guidance document
- Deep dive thematic audit into Neglect by the SSCP Safeguarding Improvement Group.
- Task and Finish Group developing multi-agency training focusing on intra familial child sexual abuse (now known as Child Sexual Abuse within the Family Environment).
- Developing the HIPS Child Exploitation Strategy and local action plan

### **Future Reviews**

In 2020-21 the SSCP will continue to highlight learning from reviews. This will include awareness, knowledge and intervening where there is concern regarding intra familial sexual abuse (now known as child sexual abuse within the family environment – CSAFE), hostile families and disguised compliance, and issues around child exploitation and contextual safeguarding. Recommendations and learning will feature in the Annual Report for the coming year.

### **Child Death Overview Panel (CDOP)**

In 2019/20 the structure of the CDOP procedure was amended within the statutory guidance of [Working Together to Safeguard Children 2018](#) and requires local areas to establish joint arrangements with their neighbours to enable child deaths to be reviewed across a larger footprint to strengthen the learning to proactively prevent future deaths. Underpinning this strategic work, focused investigations, in consultation with the family, are required to be undertaken by local Child Death Review teams which are then reviewed by the CDOP and submitted to the National Child Mortality Database to inform the national picture and push forward the work to reduce child deaths.



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

Click here for the [2019/20 CDOP Annual Report](#).

### **Engagement, Training and Awareness Raising**

The SSCP works to engage with the public, professionals and families throughout the year in a number of ways. This is to ensure that its work remains focussed on the issues that make a difference to those working with families and the children at the centre of its safeguarding activities.

Public awareness raising takes place through engagement with public facing events and activities, including road shows, as well as direct work via media and social media. This has been impacted during QTR 4 2019 due to the COVID 19 pandemic. Although partner social media channels alongside the SSCP social media presence has been utilised. There have been regular communications to partners.

During the year the SSCP delivered activities and awareness raising work to mark the following events:

- White Ribbon Day
- Maternal Mental Health Month
- Hampshire Police Never Choose Knives campaign
- Safer Internet Day
- FGM Zero Tolerance Day
- Scams Awareness
- Safer Sleep
- ICON

## Safeguarding Partnerships Conference – Adopting a Family Approach

In June 2019 over 150 practitioners working in Southampton attended a conference to launch the Pan Hampshire Family Approach Protocol. Subject Speakers included Ryan Hart from the charity CoCo Awareness talking about his family's experience of coercive control, and Detective Superintendent Rachel Farrell from Hampshire Constabulary presenting on Adverse Childhood Experiences and Trauma Informed Practice. Practitioners had the opportunity to attend workshops on:

- Adult mental health and impact on children
- Domestic abuse- working with perpetrators
- Restorative Practice and Adverse Childhood Experiences
- Impact of substance misuse and alcohol on children and families

The conference brought together practitioners who work with adults, children and families in Southampton and evaluation of the day showed that practitioners who attended would feel more confident to consider a family approach to safeguarding in their everyday practice.



The SSCP offers a **multi-agency training calendar** of events, workshops and core training. This includes 2-hour 'weekly Wednesday workshops', which are learning and networking opportunities for staff and volunteers across sectors and disciplines to attend. These have had good attendance averaging 25 attendees per session. Topics covered include;

- Fabricated and induced illness
- County Lines
- The role of LADO
- Trafficking
- Safe Sleep
- Mental Health

More in-depth training is available for those practitioners who need it and during 2019/20 the SSCP delivered 7 x 1 day training on Identifying needs: Early Intervention and Making a Referral and 7x 1 day training on Child Protection Process. Feedback in relation to the training consistently showed the training was successful in meeting the learning objectives. This was the same for the 6 ½ day refresher training that was offered. The 2 sessions planned for March 2020 were postponed due to COVID-19 restrictions being in place.

Excellent training with very knowledgeable trainer. Experience so evident through case examples which make learning opportunity so engaging

Really useful to hear the views of other professionals in different environments

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In addition regular half-day sessions are held for topics of local and national interest to the multi-agency audience, these included:

- Introduction to Child Neglect
- Learning from Case Reviews
- Child Sexual Exploitation
- Harmful Cultural Practice; Female Genital Mutilation, Forced Marriage and HBV
- Domestic Abuse
- Substance Misuse

The SSCP works closely with the LSAB to provide a coordinated safeguarding training offer. This enables a family approach to be taken via the training, and offers networking opportunities across the disciplines working with children and adults.

### **Next Steps and Priorities for 2020-21**

2020/2021 sees the SSCP operating in challenging and uncertain times due to the impact of the COVID-19 pandemic. There has been considerable evidence of creative and flexible responses by partner agencies to ensure children are safeguarded in “lockdown”, with many children unable to physically attend school and significant pressures arising for families due to the pandemic.

Priorities for 20/21 are therefore identified in this context as follows:

1. Learning from the initial response to safeguarding during the COVID -19 pandemic. This both prepares the partnership for any second wave or spike of COVID-19 and works towards recovery, albeit in a new operating context for the time being.
2. The SSCP continues with the partnership contribution to the improvement journey for SCC Children’s Services and delivering required multi agency improvements as outlined in the OFSTED Inspection 2019
3. Neglect – continuing to raise awareness of Neglect Practitioner Guidance and Educational neglect Guidance, launched in March 2019, review of thematic deep dive by SPI-G
4. Child sexual abuse within the family environment – thematic audit
5. Child exploitation – Roll out of HIPS Child Exploitation strategy and implementation of local delivery plan
6. Continued work on embedding work in relation to ICON/Safer Sleep/ Family Approach
7. Embedding and reviewing the effectiveness of the SSCP and HIPs partnership arrangements
8. Embedding learning from Child Safeguarding Practice Reviews and case reviews, nationally and locally. The SSCP continues to focus on ‘learning into practice’ as a key focus in all its activities during 2019/20. Latterly impacted by lockdown restrictions in quarter 4 of 2020.

Where priorities are shared with other SSCPs in the Hampshire and Isle of Wight area, collectively known as the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Partnership, there will continue to be a joint focus and activities. This can be seen through:

- 
- The Family Approach
  - Safer Sleep
  - ICON
  - HIPS Child Exploitation Strategy
  - A continued focus on Neglect
  - Continued joint review and development of HIPS wide safeguarding procedures

[Appendix 6 Outline SSCP Business Plan](#)

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## Appendix 1: LSCB/SSCP Finance

LSCB/SSCP partners agreed to the following contributions to cover 2019 – 20:

<b>Board Partner Agency</b>	<b>Contribution 2019-20</b>
Southampton City Council	<b>99,516</b>
Southampton City CCG	<b>40,174</b>
Hampshire Constabulary	<b>15,865</b>
Other Contributions (Hampshire & IOW Community Rehabilitation Company, CAFCASS)	<b>3,557</b>
<b>Total:</b>	<b>159,115</b>

## Appendix 2 LSCB/SSCP Membership

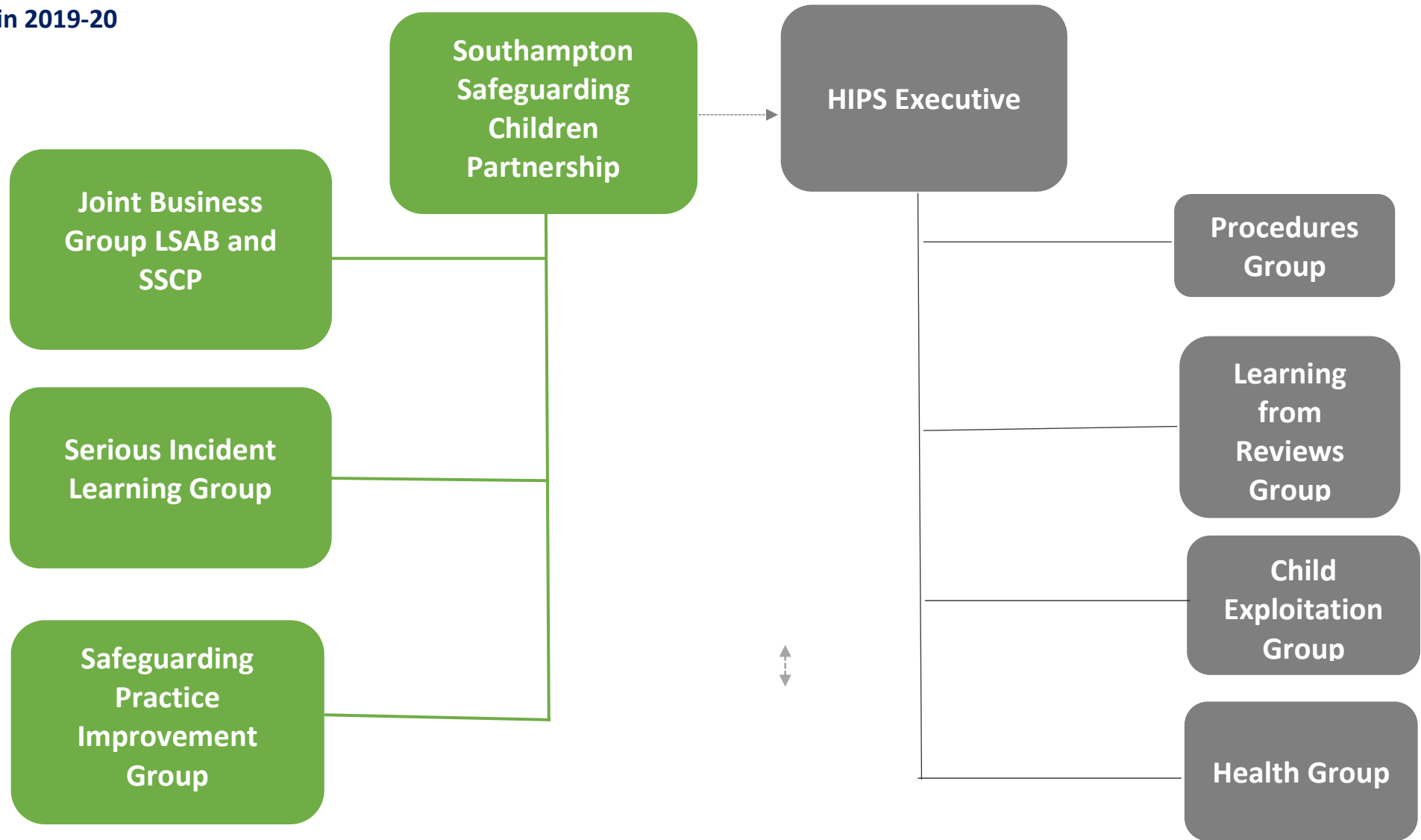
Agency	Position
Independent Chair	Independent Chair
Southampton City Council	Director of Children's Services Director of Housing, Adults & Communities Lead Member for Children's Services
Hampshire Constabulary	Chief Superintendent
Hampshire Probation	Director of Portsmouth/Southampton LDU
Community Rehabilitation 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
Education	Cross Phase Advisor
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
Safeguarding Partnerships Team	Partnership Manager
SSCP Lay Member	Lay Member

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## Appendix 3 Glossary

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

**Appendix 4 – Structure of the LSCB/SSCP in 2019-20**





## Appendix 5 – Functions of the SSCP and its sub groups

The **Main Partnership** 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 **Business Group** 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 incident Learning Group** receives referrals for reviews and determines whether they meet criteria for a Serious Case Review. The Group initiates and monitors delivery for Reviews. It ensures that learning is shared with partners to help prevent the circumstances occurring again and links with Child Death Overview Panel. Meetings run quarterly.

The **Safeguarding Practice Improvement 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.

The **HIPS Co-ordinated work** includes HIPS Procedures Group, HIPS Health Group, HIPS Child Exploitation Group and the HIPS Executive for future collaboration and coordination.

## Appendix 6 2020/2021 Southampton Safeguarding Children Partnership Outline Business Plan

Priority	Outcome	Actions	Time frame and Lead Responsibility
<p>1. Learning from the initial response to safeguarding during the COVID -19 pandemic</p>	<p>The safeguarding system is prepared for the impact of a second wave of COVID-19. This is in terms of hidden harms that may become apparent, the need to be vigilant to this and supporting services to continue to maximise the more virtual ways of working where this is shown to be helpful and/or needed.</p>	<p>Continue to maximise collaboration across partnership arrangements across the SSCP and HIPS to ensure safeguarding is effective</p> <p>Safeguarding partners continue with assurance arrangements both informal and formal (s11 Audit)</p> <p>Continue with arrangements between safeguarding partners for the timely sharing of information/risks as required during this time</p> <p>Maintain and review issues and risks identified during this time including the mitigating actions put in place.</p>	<p>Ongoing Statutory Safeguarding Partners/Independent Chair</p>
<p>2. The SSCP continues with the partnership contribution to the improvement journey for SCC Children's Services</p>	<p>SCC Children Services are supported in the improvement journey and that partners are engaged in this, recognising the contribution of multi-agency partners in this endeavour.</p>	<p>Partner representation as part of the improvement board and governance arrangements</p> <p>SSCP to continue to receive improvement plan updates/ assurance at each partnership meeting</p>	<p>Partner representatives – Improvement Board – Complete QTR 3 2020/21 Head of Service CSC/Independent Chair. Ongoing BAU</p>

		For multi-agency partners to engage in multi-agency improvement activity as required. For example, quality of referrals to the multi-agency safeguarding hub	SSCP members as required
3. Neglect	Neglect continues to be a theme arising in case reviews. The SSCP will continue to deliver the Neglect Strategy, raising awareness with practitioners. The actions required from the thematic audit will also be delivered	<p>Work in collaboration with HIPS colleagues to harmonise and collate resources and tools in relation to Neglect.</p> <p>Continue to deliver training and awareness in this area</p> <p>Review and update actions in relation to the thematic audit</p>	<p>QTR 4 2020/21 SSCP manager</p> <p>Ongoing - SSCP Manager QTR 4 2020/21 Safeguarding Practice Improvement Group Chair</p>
4. Child sexual abuse within the family environment – thematic audit (Safeguarding Practice Improvement Group)	CSAFE continues to be a theme arising from case reviews. The SSCP will co-ordinate delivery of an agreed multi-agency training package in terms of identifying and responding where there are concerns a child may be experiencing sexual abuse	<p>Design, develop and deliver a multi-agency training package that is peer reviewed and dovetails with a CSAFE Practice Framework for Children’s Social Care</p> <p>Undertake a deep dive thematic audit in relation to local practice and identify actions to improve identification and response</p>	<p>Task and Finish Group SSCP QTR 4 2020/21</p> <p>Safeguarding Practice Improvement Group QTR 3 2020/21</p>
5. Joint Targeted Area Inspection preparation	The safeguarding partners will be assured relevant agencies are able to effectively engage in a JTAI. This dry run will be used to support practice improvement and so Child Exploitation is under consideration	<p>JTAI dry run project plan to be developed</p> <p>JTAI dry run will confirm actions partners may wish to consider</p> <p>SSCP will confirm role of the SSCP team in relation to JTAI.</p>	<p>SSCP Manager/Service Manager SCC Quality and Assurance QTR 3 2020/21</p>

<p>6. Child Exploitation</p>	<p>Partner agencies will be kept updated in terms of knowledge and response to Child Exploitation.</p> <p>Delivery of the HIPS Child Exploitation Strategy and action plan will work to ensure children and safeguarded and protected from exploitation</p> <p>The SSCP will be assured of the delivery of the action plan</p> <p>The SSCP will be assured the action plan supports priority areas for action within Southampton</p>	<p>The SSCP to agree the MET Operational Group forms part of the SSCP arrangements to ensure local accountability and assurance</p> <p>The MET Operational Group will maintain oversight of the CE Action Plan</p> <p>The SSCP will collaborate with HIPS partners to revise the Sexual Exploitation Risk Assessment Framework to become a Child Assessment Risk Assessment Framework.</p> <p>The SSCP will work with HIPS, the Safe City Partnership, Violence Reduction Unit and Modern Slavery Partnership to maximise collaboration in terms of safeguarding children from being exploited</p>	<p>QTR 2 2020/21 Complete</p> <p>MET Operational Group Chair/SSCP Manager QTR 1 2020/21 – Action complete</p> <p>Ongoing. SSCP Manager/Independent Chair/Stronger Communities Manager</p>
<p>7. Embedding projects to business as usual (ICON, Safer Sleep, Family Approach)</p>	<p>The SSCP will be assured that time and resource engaged in HIPS campaigns meeting local priorities is maximised.</p>	<p>Continued promotion, training and awareness of these areas.</p> <p>Identification and purchase of an email newsletter platform to support swift and easy communication maximising the SSCP networks</p>	<p>SSCP Team</p> <p>SSCP Manager/SCC Comms</p>
<p>8. Embedding and reviewing the effectiveness of the SSCP and HIPS partnership arrangements</p>	<p>The safeguarding partners can be assured of the effectiveness of the partnership arrangements both at the LSCP and HIPS level with any areas for improvement identified</p>	<p>Review will be supported by the national work being undertaken in autumn 2020.</p> <p>Areas in development for HIPS include a workforce development. There is emerging learning that collaboration at a county level</p>	<p>Complete – Annual Report published and engagement with national review of Safeguarding</p>

		does not negate the need for local arrangements	arrangements complete
9. Delivery of Child Safeguarding Practice Reviews ( see Working Together 2018) within timescales ensuring a focus on learning delivered swiftly	<p>The Serious Incident Learning Group will be operating within Statutory Guidance ensuring through use of Rapid Reviews immediate learning can be delivered and actioned swiftly.</p> <p>The SSCP can be assured that these significant reviews are maximised in terms of learning and improvement for the safeguarding system</p>	<p>Child Safeguarding Practice Review Procedures to be developed and approved</p> <p>The SSCP to receive regular updates on progress in relation to reviews and associated action plans in order to effectively hold partners to account</p>	<p>QTR 3 2020/21 – SSCP Manager</p> <p>Ongoing</p>
10. Embedding learning from Child Safeguarding Practice Reviews and case reviews, nationally and locally. The SSCP continues to focus on ‘learning into practice’ as a key focus in all its activities during 2019/20.	<p>The safeguarding partners will be assured that learning is impacting positively on practice and so outcomes for children. This is an area of concern for the SSCP given the repeated themes in serious case reviews also reflected in part in the OFSTED Inspection in 2019.</p> <p>The SSCP will consider the capacity of the Serious Incident Learning Group and Safeguarding Practice Improvement Group to provide the required focus on ensuring learning is reflected in practice.</p>	<p>Training will continue to be offered and if capacity allows will continue to work in partnership with HIPs colleagues, designated safeguarding professionals and workforce development colleagues to ensure practice messages are shared and understood by practitioners. This can include a range of communication, briefing and practice tools including, training, briefings, webinars, all of which are dependent on capacity.</p>	<p>Ongoing – SSCP team</p>