Annual Report on Safeguarding Arrangements 2019-20

Foreword

Although the report covers the year 2019/20 it would be wrong not to take stock of where we find ourselves in light of the unprecedented situation caused by the coronavirus (COVID-19).

Like every individual, agency and indeed society as a whole, the Portsmouth Safeguarding Children Partnership had to adjust how we work, operate and think.

Safeguarding is critically important and is best approached through agencies coming together with shared ambition, shared information and joint programmes of action. More detail will be provided in the annual report for 2020/21 but the strength of the Partnership in Portsmouth has been evident during the crisis, and I would like to place on record my appreciation of the efforts, commitment and professionalism of all those agencies and individuals who come together to safeguard the city's children and young people.

This report provides timely and relevant information about the activity that has taken place, how learning is identified and applied in practice and some of the challenges we continue to address as a partnership.

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

Derek Benson
Independent Chair of Portsmouth Safeguarding Children Partnership

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Introduction

This report presents the work that the Portsmouth Safeguarding Children's Partnership (formerly known until September 2019 as the Portsmouth Safeguarding Children's Board), and the organisations that make up the PSCP have done to keep children and young people safe. The report covers the period 1st April 2019 to 31st March 2020.

> **Working Together to Safeguarding Children 2018** - This statutory guidance says we must publish a report at least once in every 12-month period. It must set out what we have done as a result of the arrangements, including on child safeguarding practice reviews. The report should also include evidence of the impact of the work of the safeguarding partners and relevant agencies.

During 2019-20 we have been finalising and implementing the arrangements required by Government to transition from a Safeguarding Children Board to the Safeguarding Children Partnership. This is in line with the Children & Social Work Act 2017 and the statutory guidance in Working Together to Safeguard Children 2018 (WT 2018). The new arrangements were implemented on 1 September 2019; so we are pleased to present this report on behalf of the safeguarding

partners; Portsmouth City Council, Hampshire Constabulary and Portsmouth Clinical Commissioning Group (CCG), on the activity of the final 5 months of the PSCB and the first 7 months of the PSCP. Details of these new arrangements are set out in the Portsmouth Safeguarding Children Partnership Arrangements[1] that were published on 27th June 2019

About Portsmouth

The total population of Portsmouth is 212,658

The population of Portsmouth as a whole, is younger than the national average.

41,639 (19.6%) are aged between 0-18 years

Age	Number	Percentage
0-4	12,087	5.6%
5-9	12,528	5.9%
10-14	11,189	5.3%
15-17	5,835	2.7%

75% of Yr. R to Yr. 11 children are White British.
25% of children are from a wide ranging number of ethnic backgrounds, including Black African, Chinese, White and Asian, Indian, Bangladeshi and Pakistani.

18% of Yr. R to Yr. 11 children do not have English as a first language. First languages spoken include Bengali, Arabic, Kurdish, Police, Romanian and French.

Education[2]

81% of children achieve a good level of development at 2-2 ½ years. 69.4% of children achieved a good level of development at the end of reception year

40.8% of children achieved an average GCSE score of 8, compared to a national average of 47.6% and a regional average of 48%

63 state-funded schools, 2 state-funded FE colleges and 5 independent schools

1 all through school
48 primary schools
10 secondary schools
4 special schools

4.8% of 16 & 17 year olds are NEET (not in education, employment or training) compared to a national and regional average of 5.5%

Absence and Exclusions 2018/19 (most recently published figures)

Overall Absence rate for Portsmouth State funded schools:	5.41% of enrolments
Overall Persistent Absentee rate Portsmouth State funded schools:	13.35% of enrolments
Overall Fixed Period Exclusion rate for Portsmouth State funded schools:	10% of pupils
Overall Permanent Exclusion rate for Portsmouth State funded schools:	0.06% of pupils

[1] https://www.portsmouthscp.org.uk/about-us/new-portsmouth-safeguarding-children-partnership-arrangements-27-june-2019/
[2] https://www.gov.uk/government/statistics/key-stage-4-performance-2019-revised

Money[3]

36% of children live in poverty, meaning that their household income is no more than 60% of the country median income. This level varies significantly across the various wards in the city.

21.7% of children receive a free school meal

5.6% of adults are claiming benefits, compared to a national average of 5.1% and a regional average of 3.9%

Portsmouth has a family homelessness rate of 3.8 per 1,000 compared to a national rate of 1.7

Ward	% of in poverty children before housing costs	% of children in poverty after housing costs
Drayton & Farlington	9.4%	18%
Hilsea	16.3%	27%
Eastney & Craneswater	15.6%	29%
Baffins	15.9%	29%
Milton	16.6%	29%
Central Southsea	19.5%	29%
Cosham	20.0%	30%
Copnor	17.4%	32%
St Jude	13.8%	33%
Nelson	24.1%	38%
Paulsgrove	26.2%	41%
Fratton	26.7%	44%
St Thomas	29.6%	52%
Charles Dickens	40.7%	57%

Health[4]

Prevalence of underweight children in Yr. R is 0.7%, compared to a national rate of 1%

In Yr. 6 the prevalence is 0.7%, compared to a national rate of 1.4%

Prevalence of obesity children in Yr. R is 12.5%, compared to a national rate of 14.2%

In Yr. 6 the prevalence is 21.6%, compared to a national rate of 20.2%

21.2 per 100,000 of 0-5 year olds in Portsmouth have a hospital admission for dental caries, compared to a national rate of 307.5

Under 18s conception rate per 1,000 is 18.9, compared to a national average of 16.7%.
55.4% of these conceptions lead to an abortion.
Portsmouth has a rate of 0.7% teenage mothers compared to a national average of 0.6%.

The rate for hospital admission episodes for alcohol specific conditions is 34 per 100,000 compared to a national rate of 31.6

For substance misuse the hospital admission rate for 15-24 year old is 77.2 per 100,000 compared to a national average of 83.1

Hospital admissions as a result of self-harm in 15-19 year olds is 833 per 100,000 compared to a national rate of 659.5

For 10-14 year olds this rate is 251.6, and nationally is 226.3 per 100,000

[3] http://www.endchildpoverty.org.uk/poverty-in-your-area-2019/
[4] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133228/pat/6/par/E12000008/ati/102/are/E06000044/cid/4

11 child death notifications during this reporting period of which 7 were reviewed. Fewer than 5 of the 11 deaths were unexpected. All 7 cases (both expected and unexpected) discussed at panel were due to medical causes, perinatal/neonatal events or known life limiting conditions

Safeguarding

The Multi-Agency Safeguarding Hub (MASH) received 22,020 contacts in relation to 11,999 individual children. This is in comparison to last year's total of 23,933 contacts for 7676 individual children.

204 children have a Child Protection Plan

180 children per 10,000 have a CIN plan. This is in comparison to 208 in 2018/19.

463 children are Looked After in comparison to 483 during the same period in 2018/19.

254 children were considered to be at risk of exploitation. 117 were at risk of sexual exploitation (CSE) and 137 were at risk of criminal exploitation (CCE) and 6 were considered to be at risk of both.

There were a total of 1,060 episodes of children being reported missing. 97 children were reported missing more than 3 times in 90 days. The reasons for having gone missing that children state during their return interviews are often a combination of familial breakdown and the desire to see friends:

Push factors

- *Problems at home.*
- *Needing space. Not able to have their own space at home.*
- *Relationship difficulties/arguments with siblings/parents.*

Pull factors

- *Running away to see friends.*
- *To have fun/go to town/shops/park. To drink/take drugs & hang out*

Workforce development

A key part of making sure we have an effective safeguarding response is by making sure we have effective training. During 2019-20 the PSCP ran 71 multi-agency training courses as part of its core programme, with a total attendance of 986 delegates. In addition to this, the PSCP also ran a number of multi-agency briefings, workshops and conferences, as well as being commissioned by services to provide bespoke single agency training to their workforce.

Course	Attendance	Type
Adopting a Family Approach	85	Workshop
Basic Safeguarding	141	Multi-agency training
Basic Safeguarding	830	Single agency training
Bruising Protocol	56	Workshop
Child Criminal Exploitation	99	Workshop
Child Exploitation	43	Multi-agency training
Child Protection	125	Multi-agency training
Contextual Safeguarding	46	Conference
Designated Safeguarding Lead - MA	94	Multi-agency training
Early Help	56	Single agency training
Early Help	113	Multi-agency training

Female Genital Mutilation	24	Multi-agency training
Introduction to Adverse Childhood Experiences	77	Workshop
Introduction to the Youth Justice System	35	Multi-agency training
Learning from Case Reviews	237	Workshop
Local Authority Designated Officer	38	Multi-agency training
Managers	64	Multi-agency training
Principles of Restorative Practice	145	Multi-agency training
Restorative Practice	188	Conference
Restorative Practice Development Session	17	Multi-agency training
Restorative Practice Development Session	179	Single agency training
Safeguarding Children with Disabilities	9	Multi-agency training
Safer Sleep	35	Workshop
Supervision	36	Multi-agency training
Supervision	10	Single agency training
Understanding Adverse Childhood Experiences	20	Single agency training
Understanding Adverse Childhood Experiences	50	Multi-agency training
Understanding Childhood Neglect	52	Multi-agency training

1. What we've learnt

As set out in our Partnership arrangements, the PSCP is committed to a model of front-line practice evaluation to inform practice, policy and strategy developments. There are 4 main ways in which the Partnership seeks to learn about the quality and effectiveness of the multi-agency safeguarding arrangements in order to promote good and effective practice, as well as to be able to identify and challenge areas that require improvement. These 4 areas are:

1. Use of data and intelligence to monitor performance;
2. Multi-agency and single agency case audits;
3. Learning from Case reviews; and
4. Inspection reports.

1. **Use of Data and Intelligence to Monitor Performance**
   The Partnerships Dataset Framework provides performance information to the Partnership in order to inform the assessment of the effectiveness of the help being provided to children and families (including early help). Data relating to key safeguarding processes and particularly vulnerable groups of children is provided each quarter with an analysis that provides an explanation of any trends and issues for attention of the group. This will be supplemented by specific reports on topics that have been identified by the 3 Safeguarding Partners as requiring assurance monitoring.

What we learnt

Early Help and Mash

- The total number of contacts (individual children) in to MASH as of Q4 was 11,999. This indicates an increase from the previous year as the total number for 2018-19 was 7676.
- The number of Early Help Assessments completed in Q3 was 41; a significant drop from 112 in Q4 (2018-19).
- The percentage of referrals that lead to an initial assessment remains high, at 98.2% in Q3. This figure has sat consistently above 95% since 2016-17
- The percentage of re-referrals in to Social Care is 22.2% in Q4. This is an increase from the end of 2018-19 figure (19.8%)

What next?

- The PSCP Monitoring, Evaluation and Scrutiny Committee requested that the MASH manager fed in to the group regarding the increase in contacts to MASH. A thorough review was completed and it was not believed that this increase in numbers represented a significant theme. No further action was necessary.
- Workshops are due to take place to understand why agencies are not doing these assessments and are just making a referral to MASH. There is a requirement to ensure this is being monitored and in 6 months if no improvement then this needs to be flagged up to the Early Help Board.

Child in Need, Child Protection and Looked After Children

- The rate per 10,000 children of children in need was at 180 in Q4. This rate was 208 during the same period last year.
- The rate per 10,000 of children on a child protection plan in Q3 was 46. This compares with 44 during the same period in the year before.
- The number of looked after children in Q4 was 463, in comparison to 483 during Q4 2018/19.
- The percentage of Children in Need with an allocated social worker has increased to 96% in Q4. The 2018/19 Q4 snapshot was 84%
- The percentage of repeat child protection conferences that are inquorate dropped from 10% in Q2 to 3% in Q3. This is the lowest rate recorded since PSCP records began.
- The percentage of looked after children participating in their reviews remains at a good rate – 99%. This is the highest rate since 2015/16.
- The percentage of looked after children statutory visits completed on time remains high at 95%.
- 100% of looked after children placements are good or outstanding.
- The percentage of children becoming subject to a Child Protection plan for second or subsequent time (within 2 years) is 8% in Q4. This figure has decreased from 14% in 2018/19.
- The number of looked after children reported missing from care for over 24 hours was 18 in Q4 2019/20. This is the same figure as Q4 in 2018/29.
- The percentage of new looked after children placed over 20 miles from home has fluctuated from 12% in Q2 to 4% in Q3.

What next?

- In relation to the increased number of children on a child protection plan for a second or subsequent time, the PSCP agreed to monitor the outcome of quarterly Children's Social Care audits to better understand if the right decisions are being made. This will be monitored going forward.
- The number of looked after children being placed over 20 miles away has fluctuated. The Monitoring Evaluation and Scrutiny Committee discussed this further and agreed that this is primarily due to unaccompanied minors in the city. Although this total number had grown in Q2, it was less that the national average.
- The Chair of the Monitoring, Evaluation and Scrutiny Panel agreed to take the issue of looked after children going missing for over 24 hours, to Corporate Parenting Board for further discussion. This will be monitored by the Committee.

2. Multi-Agency and Single Agency Case Audits

At the heart of the PSCP scrutiny programme is a rolling plan of 'deep dives' into specific areas of safeguarding practice. The topics for the 'deep dives' are agreed at the Partnership Board on the recommendation of the Executive Committee. 'Deep dives' include multi-agency audit of cases, evaluation of key relevant data, and engagement with practitioners across the system and activities designed to hear the views of children and families.

The first deep dive audit carried out by the PSCP was on Child Criminal Exploitation. In order to gain a full understanding of the issue in Portsmouth, the PSCP undertook the following activities:

- Multi-agency case audit
- Single agency audits
- Review of relevant multi-agency data
- Child and family experience and feedback
- Workshops and conferences
- Practitioner views
- Case review findings

What we learnt

Learning from each of the above strands helped to formulate a set of 27 recommendations, which were presented to the PSCP in November 2019. These included recommendations for single agencies and for the Partnership as a whole. This work identified the following key themes:

Across the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) area there a number of different Groups, Boards and Services, all with a varying focus on Exploitation. It was felt that this can cause some confusion for professionals and may be acting as a barrier. A recommendation was for clear mapping of groups and services to be carried out, ensuring that roles and responsibilities are agreed and widely understood and any duplication is removed.

There have been discrepancies in the way that Hampshire Constabulary and Portsmouth City Council assess exploitation risk and it was therefore agreed that the method for making an assessment or risk needs to be agreed and uniform across all agencies. This helps to inform risk planning and mitigation tactics, as well as monitoring when a child has remained medium or high

risk for a longer period of time. In such cases, a management review may need to take place alongside an assessment of the current plan's effectiveness.

It was recommended that Hampshire Constabulary ensure that the difference in data between number of victims and number of arrests was appropriate. The PSCP will also seek assurance of this. The use of CAWNS (Child Abduction Warning Notices) was also an area for review, to ensure that they are being utilised effectively.

Information sharing was a key theme throughout the findings of this deep dive activity. It was recommended that the Clinical Commissioning Group consider the feasibility, appropriateness and impact of a list of children with a high risk of exploitation being shared with safeguarding teams in acute, primary and community health services. The MASH Board have also been asked to review how they can collate exploitation intelligence received through the CPI (Community Partnership Information) process.

It has been recommended that the Partnership reviews its communication strategies around Exploitation, both for professionals and for the public. This would include information on recognising signs of exploitation, completing toolkits such as the National Referral Mechanism (NRM) for children who may have been trafficked, and for further detail around specific issues such as the impact of drug and alcohol use.

What Next?

The PSCP accepted the recommendations that were presented in November 2019 and it was agreed that a multi-agency steering group would lead on the implementation of the 27 recommendations. Included in this work would be a refresh of the Portsmouth Missing Exploited and Trafficked (MET) Strategy, in addition to writing a bid for Department for Education (DfE) sponsored work on 'Tackling Child Exploitation'. Portsmouth have since learnt that this bid was successful and work is underway alongside Research in Practice and The University of Bedfordshire. Key areas of focus for this project are:

(i) Our approach to identifying risk for individual and groups of young people and responding at the earliest opportunity.

(ii) Our joint working arrangements at the local, operational level, in particular between the Police and Children's Services, as part of a contextual safeguarding approach.

(iii) Our tool kit for front line staff.

Outcomes and both the Project and the Steering Group's specific work will be represented in the 2020-21 annual report.

3. Learning from Case Reviews

Outcomes and findings from all our reviews are used to promote a culture of continuous learning and improvement across the partner agencies. The aim of all types of learning review is to enable professionals and organisations protecting children to reflect on the quality of their services, learn from their own practice and that of others and to ensure that services can be improved to reduce the risk of future harm to children. All safeguarding partners and relevant agencies are expected to refer cases to the Learning from Cases Committee. The Committee considers these cases in line with Working Together 2018 to judge whether they meet the threshold for a Child Safeguarding Practice Review (CSPR), previously known as Serious Case Reviews (SCR), and to consider the appropriate proportionate response to these. If a case does not meet the criteria for

a CSPR but it is felt that there is some learning that can be identified from it in order to improve practice, then an alternative multi-agency learning review can be held.

During 2019-20 the PSCP did not publish any Serious Case Reviews. There are two ongoing SCRs for Child H and Child I that are awaiting outcomes of police investigations before they can be concluded and published. However, during this year the PSCP published a Learning Review in relation to Child G[5].

Child G - What we learnt

Child G was diagnosed with a degenerative and life limiting condition when he was 7 years old, and as a result he had contact with around 24 agencies/organisations and numerous professionals across these. The combination of Child G having complex needs, being over 16 years of age and experiencing neglect, alongside the complexity of working arrangements increased the level of risk, and contributed to problematic situations being created. Despite a perception that there were individual agencies and professionals taking a lead, there was no one single identified lead agency taking a holistic and strategic view about Child G's circumstances.

Although there was considerable ongoing support and packages of care from health professionals and children's services, there were concerns about neglect and the mother's ability to meet the care needs of Child G. The threshold for escalating concerns and intervening became confused, in part due to there being an enduring belief about Child G's mental capacity, and right, to make informed choices.

There was a lack of 'Professional Curiosity' to look beyond the presenting issues other than to refer on to another agency. There was a failure to consider the whole family, and recognise that the parents may well have had care and support needs of their own.

What we did

As this Learning Review shared a number of themes with a Safeguarding Adults Review[6] of Mr D completed by Portsmouth Safeguarding Adult Board (PSAB), we worked with them to publish both reports at the same time. In conjunction with the PSAB we held a series of workshops that were attended by 237 practitioners from across both the children's and adults workforce. These workshops focused on the experiences of both Child G and Mr D and explored the support given to both them and their families. The attendees then spent time considering the implication of this learning for their own practice and each had to develop an action plan to inform how they would utilise this to improve their future practice and their team's systems and processes. The attendees were contacted 6 months later to provide evidence of the impact this learning had upon their practice.

The PSCP and PSAB worked with the other LSCPs and LSABs in Hampshire, Isle of Wight and Southampton to develop a Family Approach to Safeguarding Toolkit[7]. The aim of this is to secure better outcomes for children and adults with care and support needs by working with families to understand their needs and co-ordinating the support they receive Adults Social Care and Children's Social Care.

[5] https://www.portsmouthscp.org.uk/learning-from-practice/serious-case-review/child-g-learning-review/
[6] http://www.portsmouthsab.uk/wp-content/uploads/2019/05/PSAB-Mr-D-2019-Executive-Summary-vFINAL.pdf
[7] https://www.hampshirescp.org.uk/toolkits/adopting-a-family-approach-joint-toolkit/adopting-a-family-approach-joint-toolkit-landing-page/

The PSCP also led on a multi-agency review of the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Escalation Policy for the Resolution of Professional Disagreement. We worked with partner agencies to review the learning from Child G, and also to seek examples of where the previous policy had been used well. As a result of this consultation it was re-drafted to emphasise the shared responsibility of all agencies; to ensure that it reflected the thresholds document, to make clear the timescales and stages of the escalation process, and a restorative approach was taken to the policy to recognised that open and honest dialogue between colleagues is the key to successful resolution of professional differences.

In addition to this the Committee facilitated 4 Reflective Practice Meetings[8] which allow practitioners to come together in either a single or multi-agency environment to review their engagement and activity with a case, to consider if there is any learning for their practice Inspections

4. Inspection Reports

The Partnership also considers the outcomes from any multi-agency safeguarding inspections. These joint inspections look closely at the experiences of children and provide a rigorous assessment of the quality and impact of work in a local area.

Mental Health Joint Targeted Area Inspection (JTAI)

In December 2019, Ofsted, the Care Quality Commission, HMI Constabulary and Fire & Rescue Services and HMI Probation carried out a joint inspection of the multi-agency response to abuse and neglect in Portsmouth. The JTAI inspection focussed on agencies' responses to all forms of abuse, neglect and exploitation, and it also evaluated responses to children living with mental ill health. This inspection included a 'deep dive' focus on the response to children subject to child in need and child protection plans, and children in care who are living with mental ill health.

The inspectors acknowledged that "Children in Portsmouth benefit from a wide range of services to support their emotional well-being and mental health. Professionals work effectively, as part of a multi-agency network, to support children". [9] They also noted a strong Child and Adolescent Mental Health Service (CAMHS) which offers children good support and intervention. Innovative practice was recognised and was stated to have been due to strong integrated working both strategically and organisationally.

Although decision making within the MASH was deemed effective, it was noted that strategy meetings did not always include the relevant agencies. This can have a negative impact on the quality of assessment and planning. Key areas for development across the Partnership and within individual agencies were noted such as management oversight, quality of referrals, the use of the escalation protocol, early use of early help assessments and information sharing. Please see the full published letter for further details.

The inspection found 56 areas of good practice and 26 areas for improvement.

The Partnership has developed an action plan to address the key issues raised within the inspection. The Monitoring, Evaluation and Scrutiny Committee will oversee this plan and review progress on a quarterly basis.

[8] https://www.portsmouthscp.org.uk/learning-from-practice/reflective-practice-meetings/

[9] https://files.ofsted.gov.uk/v1/file/50144233

2. Further actions we've taken to improve safeguarding

Cyber Ambassadors - PSCB has co-funded a Coordinator post alongside the Office of the Police and Crime Commissioner (OPCC) to offer this peer led online safety initiative to all 11 secondary schools in Portsmouth during 2019-20

[10] ICON Babies Cry, You Can Cope!

ICON - this programme was introduced in Portsmouth and the PSCP held a series of train-the-trainer workshops to embed this across the children's workforces. ICON is an evidence based intervention programme aimed at helping parents and carers cope with a crying baby and help reduce the incidence of Abusive Head Trauma in babies.

Contextual Safeguarding Conference - This event offered a chance to update the City's workforce on recent national and local learning activity, in addition to providing an opportunity to gather ideas for action from our frontline professionals. The key note speaker was Dr Carleen Firmin who leads the national Contextual Safeguarding Network.

CIS'ters Surviving Rape & Sexual Abuse

Adverse Childhood Experiences *(ACEs)* - CIS'ters were funded by the OPCC to deliver a screening of the documentary film Resilience. This film explains the concept of ACEs and the impact that these can have into adulthood. The screening was run in conjunction with the PSAB. The PSCP followed this up with 4 workshops to help the children's workforce explore what they can do to recognise ACEs and support children to build greater resilience to these.

Safer Sleep for Babies - following the deaths of several babies across the HIPS area, the 4 LSCPs worked together with colleagues across health to develop guidance for the whole workforce on what are the risk factors associated with a baby's sleep environment and produced a protocol to make clear when, how and who should be having these conversations with families. The guidance was launched in March 2020 at an event supported by the Lullaby Trust

[11]

University of Bedfordshire | research in practice | The Children's Society

Tackling Child Exploitation (TCE) Support Programme - the PSCP were successful in its bid to the TCE Programme, A joint initiative between the University of Bedfordshire, Research in Practice and The Children's Society funded by the Department for Education. This programme is designed to provide time-limited support to help local areas review and develop their strategic approach to safeguarding children and young people.

[10] https://iconcope.org/about-icon/

[11] https://hipsprocedures.org.uk/qkypxo/children-in-specific-circumstances/safe-sleep-for-babies-and-infants/#s4915

3. What children and families have told us

Many of the learning activities described in section 2 above have included seeking views from children and families.

Children and Families in PCC: Feedback February

Feedback February is an annual survey by Children and Families Services to gather the views of Children, Parents, Young People, Care Leavers and Foster carers on the care and support they receive from the local authority.

This year parents have said:

Is there any way we can improve the support provided by Social Workers?

Listen more and sticking to timed appointments
Stop changing social workers
Listen to parents' concerns better
Give them access to more funds to provide more help for families
Some of the processes could be quicker
Give them less cases so that they have more time
Having more social workers out in the community so people are not so scared of them
Relay the same information to both sides of the family
More support for families after court and care proceedings

Is there any way we can improve the support provided by other agencies?

More funding for respite, better support for enable ability"
Better inter agency communication
It would be better if social services were more open to what's available
I think more mum and baby groups
More funding for school facilities and travel
Teenage project not coping well with my child's needs
Not knowing who to contact, this could be made easier with a directory of key number on cards, fridge magnets and so on

Could you describe any areas of Portsmouth Children's Social Care that you think we do really well?

Help family to change their lives around
Multi agency involvement knowing about other services available
I feel you support me extremely well and are available to support my family in urgent situations
Give great information on situations and have regular contact
I think you engage with the child in a way that they can understand and you don't talk down to the parents
When we have asked for services or particular requirement's this is always done effortlessly and promptly by our social worker
Helping mums that struggle with their mental health
Work with children and let them input how they feel
Very understanding, listen and take in everything you say and are always making sure the kids are happy
You keep us up to date and provide excellent support

What children, young people and families have told us about child exploitation and the impact of services in Portsmouth?

There has been a calendar of community events across the city supported by a wide range of professionals. Aimed at children, family and community members, they're not limited to those who've experienced exploitation as they also have a preventative focus. At each, everyone is

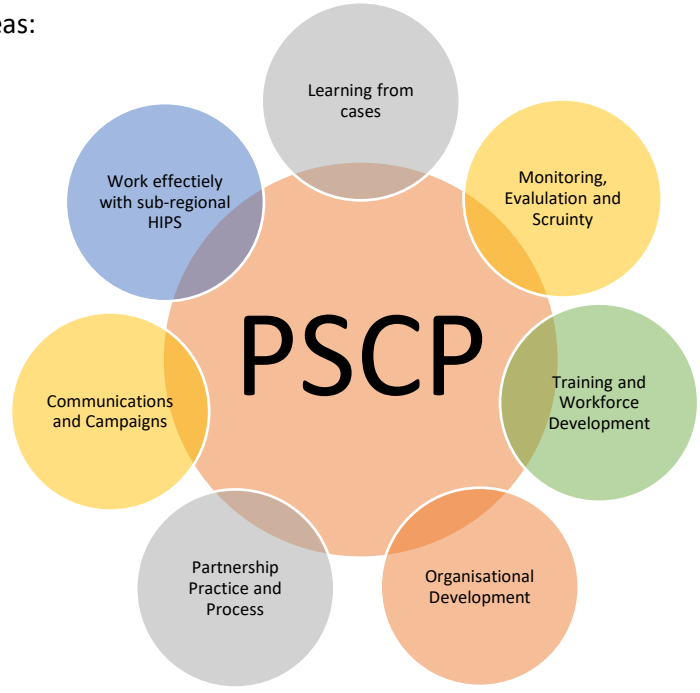
encouraged to share what they're concerned about in terms of risks and services available. Some of the issues raised by parents have been:

Children who've experienced exploitation have said the following:

- having a consistent worker that I can build a trusting relationship is key to being able to talk about what's happened and being able to move away from the exploiters
- I like the balance of support and challenge (without ever feeling judged) and feel this has been important in helping learn how to keep myself safe
- the help to repair the relationship with my parents has been great, as I now feel able to spend more time at homes and get support from my family
- there needs to be an out of hours service, as agencies often aren't available to offer support at times when it's most needed.

4. Our headline plans for next year

During 2020-21, the work of the PSCP can be split in to the below areas:



1. **Learning from Cases**
    - Publication of formal reviews - Child I, Child H and Child J
    - Ensure our training and communications work is fully informed by the Learning From Cases
    - Formalise and carry forward learning from non-statutory learning reviews

2. **Monitoring, Evaluation and Scrutiny**
    - Ensure recommendation tracking process is fully up and running, and that it fully informed the PSCP training programme
    - Carry out annual compact audit self-assessments, to include primary care.
    - Continue with programme of deep dive audits, to focus on neglect and transition in 2020/21

3. **Training and Workforce Development**
    - Develop more learning for socially distanced training
    - Develop exploitation offer including the launch of the new CERAF tool
    - Strengthen DSL induction, support and certification
    - Support agencies to improve on certain issues coming out of PSCP quality assurance work e.g. use of sociograms; voice of the child and the family in assessment and planning; communicate outcomes of assessments and plans clearly and innovatively with professionals from other agencies who are working with the child and their family

4. **Organisational Development**
    - Create an effective Organisational Development model and support - Compact, culture, leadership development
    - Develop Leadership Coaching skills and Action Learning Set facilitation in the PSCP Team and wider
    - Provide capacity into the Team Around the School model
    - Review the Partnership's understanding and proactivity around diversity and inclusion

5. **Partnership and Process**
    - Develop and promote clear guidance for 'stuck cases', using reflective practice and escalation
    - Clarity on all assessment toolkits for practitioners, ensuring linkage to HIPS. Clarity on use of toolkits to access services and support for families

6. **Communications and Campaigns**
    - Relaunch of Trolls Campaign
    - One Minute Guides - clarity and branding for all agencies
    - All appropriate campaigning follow case reviews e.g. ICON

7. **Work Effectively with Sub-Regional Hips**
    - HIPS Neglect
    - HIPS Exploitation
    - HIPS Executive Committee
    - HIPS Procedures