



# **Southampton Children and Adult's Safeguarding Partnership**

**Yearly Report April 2024 – March 2025**

# Independent Scrutineer Foreword

It is a pleasure to present the first combined Southampton Children and Adults Safeguarding Partnership Yearly report for 2024/2025. There has been significant change in the Multi Agency Safeguarding Arrangements during this reporting year with the amalgamation of the Children and Adults partnerships. This has been a process that I have been involved in shaping and providing scrutiny to, both during the review period, implementation and post implementation phases.

This has been an important transition, but also a one that has seen partnership support and connectivity from a senior level from our statutory partners.

I will continue to provide scrutiny of the arrangements in the coming year to confirm they are both meeting the statutory duties required but also to ensure that the multi agency safeguarding response to children, young people, families and adults at risk is not only effective, but has the voice of those people at the heart of what we do.

My role is one that provides support to, but also one that requires me to seek clarification or challenge from members of the partnership. This is an important function, and a role that I take very seriously, as we must scrutinise our arrangements thoroughly. During this year I have also taken dual responsibility as the safeguarding scrutineer for the Children and Adults, which has extended the scope of my role.

Southampton is a partnership with good relationships at a strategic and operational level, being supportive, but also a forum where constructive challenge takes place. There is scrutiny of, and assurance provided in terms of progress of the business plan linked to our strategic priorities and multi agency audits, alongside the statutory duty linked to the child and adult review processes.

I plan to encourage the partnership to be more thorough and proactive in handling and monitoring multi-agency data, to support the development of mechanisms for measuring impact.

Monitoring of data and the effectiveness linked to our front door arrangements, or the MASH, is key to the safeguarding system. As part of my role, I conducted a review of the systems and processes linked to the multi agency response, as well how effective the relationships, auditing processes and training are. I shared my findings and recommendations with the MASH strategic group. The introduction of the conversational model within the Children's Resource Service of the local authority was a significant change in the operating model and following implementation in January 2025 I am in the early stages of conducting a further review, which I will provide an update on in next years report, as it will be extended to include and review of the Adults front door.

This report has seen the launch of the Family Safeguarding Model, with governance around the implementation provided by the partnership. It takes a multi-disciplinary approach to working with children, young people and families, so the integrated team has partnership at the heart of it. The strengths-based framework being delivered by staff with differing professional backgrounds and skills, sharing knowledge across the team will strengthen engagement with Children and Families, and I am sure improve outcomes for them.

You will also find references to the comprehensive review processes and ongoing learning initiatives established within the partnership. The 'Let Our Voice Be Heard' conference and the 'Hear My Voice' initiative exemplify proactive efforts to enhance our safeguarding expertise and strengthen the professional response within our multi-agency workforce.













Scott MacKechnie  
Independent Chair and Scrutineer

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# Southampton's population



	In 2023, the resident population of Southampton was estimated to be 264,957, an increase since 2022 from 263,769
	Children between the ages of 0 – 5 make up 6.3% of the population = 16,808, which is a decrease from 17,032 in 2022
	Young people between the ages of 16 – 24 make up 18.6% of the population = 49,155, which is an increase from 40,884 in 2022
	Southampton has a young population, with 14.3% over 65, lower than the national average of 18.5%
	Southampton remains ranked as the 55 <sup>th</sup> most deprived out of 317 local authorities
	There are 75 schools in Southampton; 55 primary, 12 secondary and 8 special / pupil referral units
	34% of all pupils in state funded Southampton schools are eligible for free school meals (nat. average is 23.8%), which is an increase from 30.4% in 2022
	In the 2021 census, 68.1% of the population identified as White British, 12.6% as White other and 10.6% as Asian / British Asian
	Between 2018 – 2020, Southampton had the 5 <sup>th</sup> lowest life expectancy with 78.3 for males (79.6 nat.) and 82.5 for females (83.1 nat.)
	There are nearly 160 different languages spoken in Southampton

# Southampton Children and Adult Safeguarding Partnership Arrangements (SCASP)

The Safeguarding Children's Partnership and Safeguarding Adults Board operated as separate boards until January 2025, when they merged to form the Southampton Children and Adults Safeguarding Partnership (SCASP).

The aim of the amalgamation was to strengthen multi-agency collaboration, identify system issues across both children and adults, the transition between the two and the experiences across the whole life pathway to improve outcomes for our residents.

Early feedback is positive, and partners are optimistic about the effectiveness of the arrangements. The amalgamation has enhanced oversight, fostered stronger joint working, and sharpened the partnership's focus on transitional safeguarding. Notable improvements include stronger decision-making supported by a broader range of professionals. The partnership arrangements can be found [here](#) [Southampton Children and Adults Safeguarding Partnership – Local Multi-Agency Safeguarding Arrangements](#)

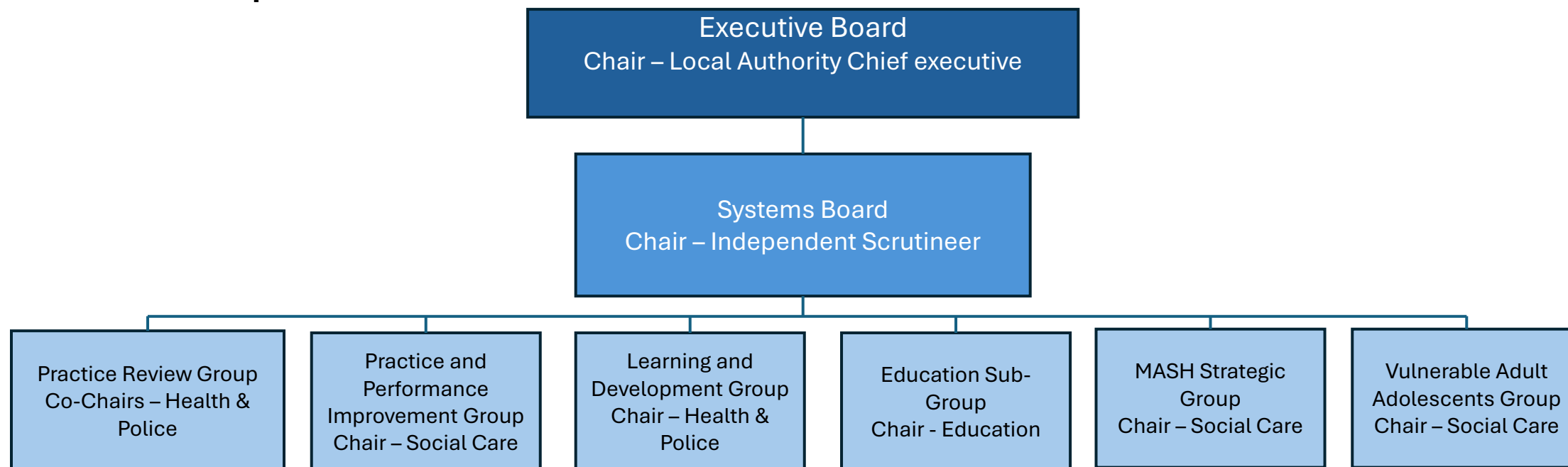
The governance of the partnership arrangements is led by the executive board, with the ongoing review of the impact and effectiveness of the new arrangements to ensure that the voices of children, young people, families and adults at risk are heard equally. The arrangements have been welcomed by partner agencies who have been involved and contributed to the developments throughout.

There is closer alignment with the Community Safety Partnership, Domestic Abuse and Violence Against Women and Girls Board. The Homelessness Prevention Board, the Health and Wellbeing Board, Health and Care Partnership and the Drug Harm Reduction Board. This ensures connectivity across the issues that impact residents of the city, with ambitions to promote a healthy, safe and vibrant city that understands the diversity and intersectionality across communities and safeguarding within Southampton that is required to have an impact for children, the adults who care for them and adults who remain in and move to the city.

The amalgamation has resulted in collaborative approaches to learning from all reviews to impact system changes and safeguarding practice strengths that have an impact.



# Partnership Structure



The practice review group considers referrals to the partnership for Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Rapid Reviews and Domestic Abuse Related Death Reviews. This group oversees the recommendations and action plans following reviews, including local learning and national reviews, with 6 monthly assurance activity.

The learning and development group works closely with all sub-groups to ensure learning is disseminated through a variety of methods.

Audit and analysis of the impact of learning and related training, campaigns and toolkits is provided through the practice and performance improvement group, including the analysis of data across the partnership.

Scrutiny and oversight is provided through the systems board, with strategic plan progress, updates and escalations raised to the executive as agreed through the systems board. The scrutineer provides independent scrutiny and challenge to the partnership.

# Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) arrangements

The SCASP works collaboratively with Hampshire, Isle of Wight and Portsmouth Safeguarding Children Partnerships and this collective is known as HIPS. The HIPS arrangement provides opportunities for alignment across borders on strategic issues and common themes. This arrangement supports each Safeguarding Children Partnership area to retain a focus on local priorities. The HIPS Executive Group consists of the delegated safeguarding partners from each Local Safeguarding Children Partnership (LSCP) area and is chaired by Scott MacKechnie, as Independent Chair and Scrutineer.

The Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Safeguarding Children Procedures Group ensures consistent safeguarding and child protection policies across the HIPS area. The group maintains the website with up-to-date documents, reviews policies in line with legislative changes and learning from case reviews, as well as overseeing assurance processes.

Areas of focus for this group have included;

- Safeguarding children as victims of domestic abuse
- Working together to resolve professional differences procedures
- Pathway for haematological investigation of bruising and bleeding

- Subconjunctival haemorrhage guidance
- Self harm pathway
- CSA strategy and toolkit
- Medical assessments in siblings
- Centre for expertise child sexual abuse pathway update
- Protecting children moving across LA borders

The HIPS Health Group co-ordinates safeguarding business across the HIPS wide integrated care system. The group leads on the promotion and implementation of effective practice and learning, including revision to protocols and procedures from the perspective of the HIPS health economy.

The HIPS Strategic Child Exploitation Group leads on the development and shared implementation of the HIPS Child Exploitation and Extra-Familial Harm Strategy 2023-26, working to develop a shared understanding of the exploitation risks and responses to children, which may include organised exploitation.



## 4 Local Safeguarding Adult Boards (4LSAB Southampton, IoW, Portsmouth and Hampshire)

The SCASP also work collaboratively with the 4 local safeguarding adult boards (4LSAB) to share learning from reviews, plan and deliver activity around adult safeguarding week, share training provision and develop and review policies, guidance and toolkits.

There are 3 sub-groups across the 4 areas;

1. 4LSAB health group
2. 4LSAB housing group
3. 4LSAB policy group

The policy group work to a programme of reviewing policies and procedures and work together to produce toolkits and spotlights on practice to support practitioners with common learning themes and reports of areas for development from the self assessment schedule.

Areas of focus in the reporting year have included;

- Domestic abuse policy
- Allegations management framework
- Responding to self neglect

- Mental capacity assessments
- Multi-agency risk management framework
- Escalation policy
- Family approach (8 board document)
- Falls protocol
- Pressure ulcers protocol
- Safeguarding in prisons and approved premises
- The MARM framework and tools
- Adults who disclose non recent childhood sexual abuse
- Large scale safeguarding enquiries

A series of short guides are available on the LSAB websites, with links to the host areas where appropriate and can be found here;

[Southampton Safeguarding Adults Board](#)

# Safeguarding Data

## Adult safeguarding

- Adult social care data is developing to ensure that analysis can be provided of patterns and trends for residents in the city. This is part of the adult social care improvement plan which is monitored through the Systems Board.
- The data provided by the constabulary on a quarterly basis is currently under review; discussions are underway to assess whether this reporting can include further detail.
- Health partners are making changes to the Ulysses incident reporting system with changes planned from July 2025.
- The partnership have facilitated workshops to ensure that partners are aware of the need to progress the provision of data for analysis to identify new safeguarding risks, issues, emerging threats and joined up responses across relevant agencies.
- Improvements have been seen in the Practice and Performance Improvement Group and will be reported upon in next year's annual report. This is identified as a risk and an area for scrutiny through the Systems Board and an area for focus of the independent scrutineer.

## Children's safeguarding

- Children social care data is provided on a quarterly basis to the Practice and Performance Improvement Group for analysis and scrutiny.
- The constabulary provide quarterly data to the partnership and in July 2024 made significant changes to reporting to provide greater detail for analysis. Further work is underway to provide a descriptive narrative to support the data provided.
- Health partners provide data for audit activity around key themes in the Practice and Performance Improvement Group. One example related to the low numbers of medical assessments taking place following sexual abuse. This led to specific health led training to emphasise the importance of medical assessments for a child's social, emotional and physical wellbeing and myth busting perceptions or assumptions of the assessment process. The audit activity resulted in targeted dissemination of learning across children's social care to ensure that children and young people receive assessments when required. The Practice and Performance Improvement Group will analyse the impact of this in the coming year.

# ASC data (Safeguarding Adults Collection - SAC returns)

	2023 / 2024	2024 / 2025
Individuals involved in safeguarding concerns	1,186	887
Individuals involved in s42 enquiries	659	281

- Southampton identified as having a low number of Safeguarding concerns relative to peer comparator local authorities.
- 2023/24 figures show Southampton close to England average for Safeguarding Adults (SGA) Enquiries, but Southampton's figures fell 58.8% from 2023/24 to 2024/25.
- England average for both SGA Concerns and SGA Enquiries is increasing, and Southampton's number is decreasing.
- For SGA Concerns, the number that has decreased in our 2024/25 submission was already half of the increasing England average figure

## Actions taking place in response to the above

- Practice changes taking place to ensure all SGA concerns are recorded as such on CareDirector and that the risk management work is recorded on the concern form rather than the contact as this won't account for the work taking place.
- Data for the SAC return will be examined quarterly and discussed to determine if pattern has changed
- SGA Induction and Level 1 Training is now mandatory for all Service Centre staff to understand the thresholds for SGA.
- Due to the decrease in numbers, data analysis and audit activity will be undertaken to understand the causation and actions that are needed moving forwards.

## Concluded section 42 enquiries and source of risk

Type of risk	2023 / 2024	2024 / 2025
Physical abuse	99	61
Sexual abuse	20	22
Psychological abuse	77	44
Financial or material abuse	104	70
Discriminatory abuse	4	1
Organisational abuse	19	18
Neglect or acts of omission	474	245
Domestic abuse	45	34
Sexual exploitation	7	6
Modern slavery	0	0
Self neglect	0	40

### **Mental capacity for concluded s42 enquiries**

	2023 / 2024	2024 / 2025
Yes, they lacked capacity	111	101
No, they did not lack capacity	271	187
Don't know	169	145
Not recorded	23	3

### **Making safeguarding personal for concluded s42 enquiries**

	2023 / 2024	2024 / 2025
Yes, they expressed their desired outcomes	276	246
Yes asked, but no outcomes expressed	172	65
The individual was not asked their desired outcomes	128	55
Don't know	115	62
Not recorded	23	8

## **Safeguarding Audits**

Two new pilots for Safeguarding audits are under design.

The first will analyse contacts progressing to concerns but not to enquiry.

The second will review the enquiries taking place.

This is due to the identification of the changes to data and an absence of audit activity.

Our Principal Social Worker will be analysing the results. The learning will be used to develop our monthly “Learning Space” sessions which will be presented to the whole department. The form itself has been reviewed by the principal Social Worker and others completing it and the result was positive.

# Children Social Care data

CONTACTS/REFERRALS/ASSESSMENTS	2022/23	2023/24	2024/25
Total number of contacts to the Children's Resource Service	21146	20942	21518
% contacts progressed to referrals	18.1%	14.7%	12%
Number of child in need referrals	4294	3420	2934
% of re-referrals to CRS MASH	24.1%	25%	20.3%
Child & family assessments completed within timescales	82%	88%	86%
Total number of children open to Children's Social Care during the year	5467	5044	4329
CHILD PROTECTION (CP) PLANS	2022/23	2023/24	2024/25
Number of children with a CP Plan	315	276	292
Number of unborn babies with a CP plan	12	5	8
MAIN CATEGORY OF RISK/HARM: (CHILD PROTECTION PLANS)	2022/23	2023/24	2024/25
Neglect	155	154	172
Emotional abuse	109	75	74
Sexual abuse	19	25	16
Physical	32	22	30

LOOKED AFTER CHILDREN	2022/23	2023/24	2024/25
Total number of looked after children	538	488	460
Number of children in care per 10,000 during the year	103.8	97.9	91.3
% of looked after children reviews completed in time frames	94.0%	93.1%	84.8%
% of health reviews completed in time frames	89.8	86.1	87.8
% of care leavers 18+ in suitable accommodation at year end	80	79	80
% of care leavers 18+ in employment, education, or training at year end	45.3	44.5	54.6

## Education attendance data

	2023 - 2024	2024 - 2025
Total overall absence – primary, secondary and special schools	7.9% (of total school population)	7.3% (of total school population)
Total persistent absence (over 10%) – primary, secondary and special school	23.2% (of total school population)	20.3% (of total school population)
Overall absence Primary	6.3% (of total school population)	5.5% (of total school population)
Persistent absence primary	18.3% (of total school population)	15.9% (of total school population)
Overall absence secondary	10.2% (of total school population)	9.3% (of total school population)
Persistent absence secondary	28.8% (of total school population)	24.6% (of total school population)
Overall absence special schools	11.4% (of total school population)	12% (of total school population)
Persistent absence special schools	38.4% (of total school population)	37.5% (of total school population)

The school attendance action group oversees and monitors the attendance data, working closely with education settings. The education sub-group is a multi-agency forum to address issues and areas of focus across the partnership.



# Areas of focus for the safeguarding children's partnership pre amalgamation Jan 2025

## **Priority 1: We will address the impact of neglect and gain assurance around the embedding of the neglect strategy for all practitioners working with children and their families**

Significant progress has been made through the identification of learning and actions from sub-group activity. The impact for children and their families has resulted in earlier intervention and the multi-agency network utilising available tools for working with children, young people and their families to support sustainable change.

The provision of data for analysis across the partnership requires improvement to ensure intelligence of understanding. This is a common theme across the children and adult partnership.

## **Priority 2: We will work as a partnership to support the reduction of serious youth violence and child exploitation**

There is a reduction in rates of serious youth violence and evidence of progress through the sub-group activity, however rates in Southampton remain higher than local and national averages. The number of proven serious violence offences as a proportion of the 10 – 17-year-old population.

Youth Justice Service	2023/24 Q3	2023 / 24 Q4	2024 / 25 Q1	2024 / 25 Q2
Southampton	27 per 100K (6)	5 per 100K (1)	31 per 100K (7)	18 per 100K (4)

The work around the Child Exploitation Risk Assessment Framework (CERAF) use and Risk Outside The Home (ROTH) developments in line with the HIPS exploitation strategy is moving forwards.

## **Priority 3: We will promote the Child Sexual Abuse Strategy and the roll out of the CSA toolkit**

The learning from reviews and audit activity has influenced the development of an impactful training programme to upskill the partnership, including practice month focused on child sexual abuse with a number of experts delivering workshops across the network, developed from a series of reviews, audits and the national safeguarding practice review “I wanted them all to notice”.

Data provision has improved from a policing perspective.

Further scrutiny and assurance is overseen by the HIPS procedures group with collaborative work across the 4 areas.

#### **Priority 4: We will focus on children's participation in education**

The education sub-group is well-established and has progressed multiple projects. The impact of this work has been a greater collaboration with schools and early years settings in the city to support children throughout their education.

Whilst improvements have been seen and the DfE are satisfied with the plans in place, absenteeism remains at a higher rate than national averages. Severe persistent absence remains a significant issue for Southampton children.

#### **Priority 5: We will support the partnership with a focus on the appropriate application of the pathways document across partner agencies to ensure the right service is provided to the right children at the right time**

The development of the CRS, MASH and conversational model has involved the partnership, and significant progress has been made in this area.

#### **Priority 6: We will gain assurance and review the arrangements**

Extensive progress has been made in assurance from learning across all agencies.

Further improvements are required in the data provision from the multi-agency network for analysis and identification of patterns and trends.

The partnership arrangements have been reviewed and the amalgamation of the children and adults safeguarding partnerships is underway. Greater alignment across all partnerships in the city will further improve the impact for residents.

- Progress against the priorities is detailed below in the sub-group activity. The amalgamated partnership considered the themes from reviews, and audit activity to agree areas of focus for the amalgamated partnership for the best impact and outcomes for the residents of the city.

# Areas of focus for the safeguarding adult's partnership pre amalgamation Jan 2025

## **Ambition 1: Prevention and Engagement**

The learning from reviews and audit activity has resulted in significant changes to the structure and inter-connectivity of the safeguarding adults partnership and sub-groups, leading to toolkits and guidance for practitioners across the network to utilise.

The voices of adults and families are central to the work of the partnership team when undertaking reviews.

An area for development is the involvement and participation of the community to work towards meaningful co-production.

## **Ambition 2: Quality and Learning**

There has been good progress in the audit activity and resulting action planning and assurance with close tracking, monitoring and challenge.

The provision of data is an area for improvement to identify and respond to patterns and trends.

Themes have been identified from reviews and learning which will form recommendations for future priorities.

### **Ambition 3: Working in Partnership**

There are higher levels of demand for services in Southampton across adult and children safeguarding, health inequalities, education and crime and disorder than comparators.

Multiple partnerships are in place with a variety of governance structures which can be confusing and duplicitous. The amalgamation of the children and adults safeguarding partnership, with closer alignment with the Community Safety Partnership and governance by the Executive Committee brings together the key stakeholders to plan and implement the strategic priorities to focus on prevention to make an impact on achieving better outcomes for the residents of the city.

The identification of the strategic priorities for the partnership to drive forward will have the greatest impact with more efficient and effective partnership arrangements.

The involvement of the community in the planning for the implementation of change is a gap in the arrangements currently and a focus is required across all agencies to promote participation and co-production.

- Progress against the priorities is detailed below in the sub-group activity. The amalgamated partnership considered the themes from reviews, and audit activity to agree areas of focus for the amalgamated partnership for the best impact and outcomes for the residents of the city.

# Southampton Children and Adults Safeguarding Partnership

## Strategic Priorities 2025 - 2028

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### **Neglect and Self Neglect**

We will gain a deeper understanding of the experiences of neglect and self-neglect across the whole life pathway for residents of the city to develop plans to prevent the impact on people's lived experiences through system wide partnership working

### **Transitional Safeguarding**

We will gain a deeper understanding of the systems in place to provide appropriate interventions and support for children and young people as they transition into adulthood to prevent the need for crisis intervention through planning at an earlier stage across the partnership

**The voices of children, young people, adults and communities are at the heart of all we do**



### **Severe and Multiple Disadvantage and Multiple Exclusion Homelessness**

We will gain a deeper understanding of the systems in place for people experiencing severe and multiple disadvantage and multiple exclusion homelessness to impact and influence change to prevent further harm and deaths due to system barriers

### **Child Sexual Abuse and exploitation**

We will continue to develop a deeper understanding of the responses to and identification of child sexual abuse through preparing a highly skilled workforce across the partnership with a mature data analysis and qualitative audit programme to impact practice

# Actions and impact through sub-group activity

## Practice Review Group

The PRG receives referrals for Safeguarding Adult Reviews (SARs), Domestic Abuse Related Death Reviews (DARDRs), Rapid Reviews and Children's Safeguarding Practice Reviews (CSPRs) and monitors the progress of reviews, as well as conducting assurance activity 6 months after publication to ensure learning has been embedded into practice. Its broad membership includes partners from across a wide range of services to support robust decision making and professional challenge.

	Adults	Childrens
Referrals - total	14	9
SARs or CSPRs	6	0
Rapid Reviews	-	4
Southampton Local Learning Reviews	2	2
Publications	3	0
Additional work forming part of thematic review	2	4

Adult themes: Neglect and self-neglect, substance use, mental health, culturally inclusive practice, transitional safeguarding, Multi-Agency Risk Management (MARMs), escalation protocol

The published reviews can be found here;

[Reviews and learning](#)

Children's themes: Child exploitation, child sexual abuse, physical abuse, neglect, parental alcohol and substance use.

Following two similar referrals around child exploitation, though not meeting the threshold for a Child Safeguarding Practice Review, the PRG recommended a deep dive audit of the Child Exploitation Risk Assessment Framework (CERAF). Key areas such as referral timeliness, risk assessment quality, and management oversight were explored by the Practice and Performance and Improvement Group (PPIG), leading to multiagency training on effective CERAF completion.



The amalgamated adults and children's group provided valuable insight into a care leavers referral, sharing a wide view of the services they used throughout their life. A multi-agency workshop explored the complex and multiple disadvantages they faced, with impactful contributions from all partners. This work has since developed into a thematic review focused on homelessness due to be published next year. This work highlighted the vulnerabilities of some of our care leavers and led to actions around reviewing care leavers who are in what is classed as 'unsuitable' accommodation.

A Southampton Learning Review explored babies born in traumatic circumstances where there was significant parental trauma, alcohol and substance use and neglect. Agencies highlighted the benefit of coming together to review how they could have been informed of the mother's pregnancy earlier. Learning was shared across the network with a focus on the unborn baby protocol. The review strengthened the safeguarding systems, procedures and responses of a local outreach service and pharmacies delivering substance use services across the city. Targeted work was delivered by the Integrated Care Board (ICB), the partnership team and midwifery service where learning and improvements were identified and implemented to support risk assessments and collaboration for vulnerable pregnant women and unborn babies.

Following the Stephen Review in 2023 which identified issues around engagement and professional curiosity, the partnership developed and published the 'When engagement is difficult' guidance which Stephens family were consulted on and contributed to. This guidance supports practitioners to further understand engagement, recognise barriers to engagement and identifies the benefits of partnership working, providing strategies, tools and resources. In addition, the neglect toolkit was promoted across the partnership and agency action plans reflected improvements made to supervision provision. Both resources have received positive feedback from practitioners, who praise its accessibility and usefulness in offering practical support for front-line staff.



PRG members regularly share resources such as out of area reviews, updates to policies and guidance, as well as local and national safeguarding reports. This year, PRG shared and discussed:

Learning and recommendations from two domestic homicide reviews, as they were similar to the findings in a recently published SAR. Discussions took place about the recurring themes and how they could be addressed on both a national and local level

The progress of two single agency investigations that did not meet the criteria for a SAR were monitored through the PRG. Assurance was gained that learning was being actioned, and professional challenge was offered

4LSAB Guidance on Modern Slavery and Human Trafficking. This guidance was circulated amongst staff in partner agencies as a learning tool to use as part of their practice

PRG continued to get assurance that learning from previously published reviews were embedded into practice and discussed deep dive assurance activity from PPIG.

Lily's family were able to offer insight into her caring nature right from the start of the review.

Following the publication of the Lily review, Social Care has implemented a multi-agency transitions pathway, overseen by a Transitions Team Manager.

Transitional Safeguarding has been made one of the SCASP priority areas of focus, and audit activity is planned in the PPIG to gain assurance and identify further areas for improvement. This level of focus will ensure that the transition of support from childhood into adulthood is appropriate, and consistent.

The 4LSAB Escalation Protocol has been re-circulated and highlighted across the Partnership, partners have stated that this has improved staff awareness of, and confidence using, the protocol.

An internal investigation was undertaken which recommended medicine management refresher training for hospital staff and resulted in a change in policy. This has improved staff understanding and confidence in this area.

"Lily was the youngest of our two daughters. She was vibrant, strong willed, intelligent and a pleasure to have as a daughter. She had a great sense of humour. She was selfless and always so helpful and caring for those around her. We were very proud of her."

In response to the Gianbir and Anna reviews, the partnership has made contact with a wide range of community and faith groups in the City to improve safeguarding practice by gaining the voice and views of the community and to gain a better cultural understanding. A multi-agency cultural inclusion strategy is being co-produced utilising a relational approach for use across all partnerships. This will be shared in the Autumn.

The Learning and Development Group launched the 'Hear My Voice' Animation for staff, which was focused on making sure that the 'voice' of adults is heard – and included a section on translators and interpreters. This was widely praised as a helpful tool (see feedback in subsequent slide), resulting in a more robust training offer and increased confidence from practitioners and can be found [here](#);

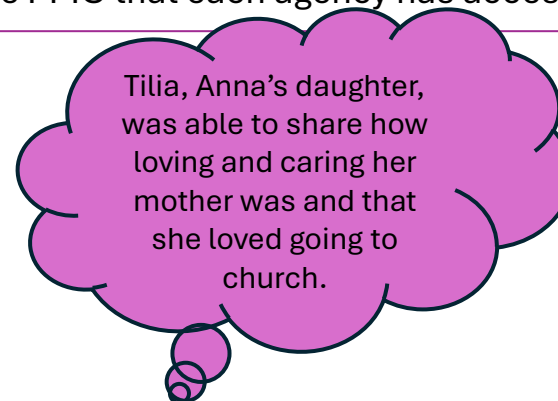
#### [No decision about me without me - making safeguarding personal](#)

A deep dive audit was undertaken around Making Safeguarding Personal to gain assurance around how effectively services in the city were listening the 'voice' of the people they are working with. The safeguarding partnership audit activity now includes the impact of protected characteristics as a golden thread throughout.

Work is underway to develop a co-production strategy across the partnership and will be reported upon in the next reporting year.

The importance of using interpreters instead of family members was promoted across the partnership to ensure that the individuals voice is gained. Assurance was sought in the PPIG that each agency has access to a reliable interpreter/translator service.

Anna's daughter was supported by her social worker to enable her to share her thoughts and views.



## Learning and Development Group (LDG)

The group's purpose is to work alongside the sub-groups to identify and encourage learning and training opportunities that may come from Child and Adult Safeguarding Reviews and findings from audits. The group makes sure these opportunities support the partnerships strategic goals. The LDG were pleased to include voluntary, charity and faith sectors, as well as foster carers as part of its membership which has provided learning and training opportunities to reach a wider audience.

LDG members identified that practitioners would benefit from information around private fostering to improve both knowledge and awareness in this area. A 7-minute briefing was developed through LDG group and is now accessible for all professionals to access through the SCCP website.

The training quality assurance audit tool was created to help monitor the multiagency training provided. It enables the LDG to check that the training is current and reflects local, national policy and legislation.

The LDG saw a greater demand for training in particular sessions such as 'Claire's law' and 'Sarah's law'.

Following last years Mental Capacity Act Guidance, the partnership sought feedback from frontline practitioners. The overwhelmingly positive feedback across the partnership highlighted that 98% found it useful in practice, highlighting its effectiveness in clarifying the Act's application and supporting practitioners in making informed decisions.

The partnership delivered a rich programme of training, workshops, and seminars, promoting multi-agency learning and collaboration across Southampton and 4LSAB, during National Safeguarding Adult's Week. A broad range of topics including but not limited to transitional safeguarding, mental capacity, self neglect and hoarding and professional curiosity, ensuring practical benefits for frontline professionals. We saw enthusiastic engagement from across the multi-agency workforce improving knowledge, understanding and practice.

In November 2024 we commissioned training delivered by Child Sexual Abuse survivor and founder of The Flying Child, Sophie Olson, and consultant social worker Sarah Pritchard. The session focused on how the safeguarding system can better empower those who have experienced interfamilial sexual trauma to 'speak out' and reclaim their voices, both as a child and later in life as an adult.

The **"Hear My Voice" animation** developed following the Anna and Gainbir SAR's and in collaboration with students from Solent University, has been a pivotal tool which will enable frontline practitioners to prioritise and authentically capture the voices of adults in safeguarding situations. This animation has not only raised awareness but will improve the quality of interactions and interventions by ensuring that adults' perspectives are heard and respected.

No decision about me without me - making safeguarding personal

**"The work of the group has collectively strengthened the safeguarding framework, promoted best practices, and ensured that the voices of adults at risk are at the forefront of safeguarding response."** – Adult Subgroup Chair

**'This video is fabulous! This will embed Making Safeguarding Personal, reinforce the 6 Principles of Safeguarding, increase awareness of Adult Safeguarding Boards'** - UHS

**'It has been sent it to all our neighbourhoods Inspectors force wide as the message is not just for Southampton! Really impressive final product!'** – Hampshire & IoW Constabulary

**'This is brilliant! I can use this in training sessions to help explain adult safeguarding processes. I will send this out to the church networks across the city and to SVS who love to get bits as well, and I can use it when doing training for volunteers there!'** – Voluntary and Charity groups Representative





# Let Our Voices Be Heard Event

The Southampton Safeguarding Children Partnership "Let Our Voices Be Heard" event took place on 14 October 2024 at Southampton Football Club's St Mary's Stadium. The event brought together over 200 individuals from a variety of agencies and organisations, including representatives from children's and adult's social care, health services, the police, education and schools, and the voluntary sector, amongst others, to discuss and consider the voices and views of children, young people and their families in the work they do, in line with the Southampton Safeguarding Children Partnership Strategic Priorities.

The event was co-produced with a group of young people with lived experience of working with partner agencies and included a section delivered by the Youth Commission.

Whilst engaging with the scenarios, attendees were provided with QR codes which linked to various partnership policies, procedures, guidance, and toolkits, as well as published Child Safeguarding Practice Reviews and Thematic Reviews. Attendees were asked to access any QR code they thought relevant to assist with their decision-making and conversation.

*"Professionals in Southampton work tirelessly to support the thousands of children and young people in the city. Events like 'Let Our Voices Be Heard' provide an important opportunity to pause and reflect on how we work together. With colleagues from the Police and NHS sitting alongside teachers and social workers we heard the voices and experiences of young people throughout the day. It was a perfect opportunity to put Family Safeguarding into practice as well as use toolkits in a practical and meaningful way".*

Scott MacKechnie, the Independent Chair and Scrutineer of the Southampton Safeguarding Children Partnership

*"It's so vital that as professionals we take the time to challenge each other and ourselves. Our children and young people are telling us how they feel and what's happening in their lives, but we also need to pick up on what they aren't telling us. As adults, we can often miss the signs when we need help with personal struggles, it means we have to be even more aware of those signs in our children and young people".*

Robert Henderson, Executive Director for Children, Learning and Community Wellbeing



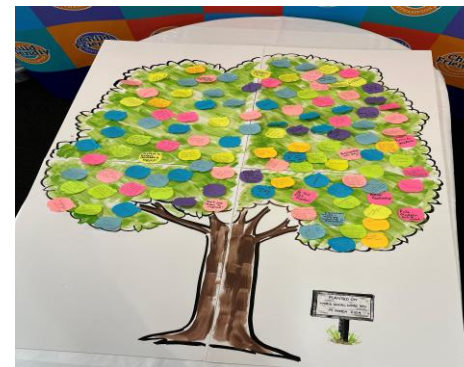
Young people who have accessed and experienced services, mainly through Children's Social Care, were given the opportunity to talk about their experiences which were presented at the event. Young people at Itchen College further education college, along with members of the safeguarding partnership and the children's mayor, planted an apple tree to symbolise the foundations of the new Family Safeguarding approach in Southampton on World Social Work Day. This is an innovative way of multi-agency teams working with the whole family to help keep families together wherever it is safe to do so. Attendees at the event were invited to share their feedback by placing apple post-notes onto a drawing of a tree. The feedback from the day was overwhelmingly positive, with professionals leaving comments such as 'young people at the centre', 'voice of the child', 'the young speakers left me in awe' and 'listen'.

Kezia: "my family, I protect them a lot. Having to share that with strangers is a bit weird". "if she would let me talk to her when I wanted to talk to her". "I don't know what I feel myself, how am I supposed to tell you".



Layla: "social workers changed my life", "I don't think my mum and dad would be here at the moment, they were addicts". "it was pretty scary and hard, but if I didn't say anything my life wouldn't be like this now".

Mylo: "I had to tell the social worker they were talking about stuff that was in the past", "when I had a different social worker, I said we already talked about the past, we already know what happened in the past".



Andrea: "people should be told what it is like knowing that people don't have the same opportunities others do, and some people can be privileged with different things".

The Youth Commission and Youth Independent Advisory Group presented recent work and shared the priorities they are working towards across Hampshire at the event. They shared their views of the event....

Ellie: "It was such an amazing opportunity for me to be able to push myself out my comfort zone and help me grow my confidence! During the whole day I was able to talk to amazing professionals who listened to what I had to say and made sure to input my ideas, with everyone being engaged whilst we were presenting. I hope people were able to walk away from the conference with a new outlook and understand that the young people want to help and will let us share our voices more!"

Leo: "The highlight for me was the opportunity to offer a single piece of advice to our professional partners – a message from young people to those with the power to make change. My message was – and is – simple: let us be a part of your conversations, let us help you to help us. We will do anything to make a change for all young people; we want to be listened to – really listened to. Above all, let us be heard, seen, and empowered."

Corey: "It felt empowering... I could tell by the reactions & the responses from them that everybody in that room were paying attention & listening to what we had to say. I hope our presentation helped inspire them to continue making the steps necessary to improve our systems, especially in regards to how young people are treated across the board."

Scarlett: "It was a great opportunity both to push myself out of my comfort zone but also to talk to some amazing professionals who were all engaged in what we had to say and spoke promisingly about centring youth voice in their practice. It gave me a lot of optimism for the development of public, children and family services despite all the negativity I often see in the news."

# Practice and performance improvement group (PPIG)

The purpose of the PPIG is to analyse safeguarding data to identify patterns and trends in the City, as well as carry out quality assurance deep dives into specific aspects of safeguarding that are priorities for the Partnership and highlighted by PRG activity.

**MAKING SAFEGUARDING PERSONAL audit** June 24, was a focus following the Anna and Gianbir SARs

Findings from the audit identified key areas for improvement around unconscious bias, providing opportunity to hear the voice of the individual away from their family and capturing their thoughts and feelings.

Hampshire Fire and Rescue's Making Safeguarding Personal Campaign was shared across the multi-agency network. This ensured greater awareness and understanding around the principles of MCA, and what is important to capture in records. The Hear My Voice Animation was developed and promoted across the partnership as well as the Mental Capacity Act guidance both developed by the Learning and Development Group.

**CHILD SEXUAL ABUSE audit** June 2024, explored the impact of the Child Sexual Abuse in line with the strategic priorities and following the launch of the CSA Strategy and Toolkit launched in March 2023.

The audit highlighted misunderstandings around the purpose of CP Medicals being to secure evidence for prosecution rather than ensure a child's sexual, physical, emotional and mental health, how not identifying protected characteristics earlier led to missed opportunities to engage the wider community in safeguarding the family, and the limited use of the Child Sexual Abuse Toolkit across agencies.

In response, refreshed training around CP Medicals was delivered as part of a Practice Month into Child Sexual Abuse, health colleagues have highlighted the CSA Toolkit to all staff through internal communications. The CSA Toolkit was also signposted in sessions as part of Practice Month and further activity is planned in the coming months. The Flying Child event was delivered across the partnership in November 2024 to ensure that signs, indicators and responses are recognised across the partnership.

## **CHILD EXPLOITATION RISK ASSESSMENT FRAMEWORK (CERAF)**

**audit** November 24, audit explored the timeliness, quality and risk analysis of the CERAF along with management oversight. The key learning identified was around agencies working in silo and missed opportunities for information sharing and contributions to CERAF planning. In addition, there could have been greater analysis of the risks and more collaboration around the downgrading of the CERAF.

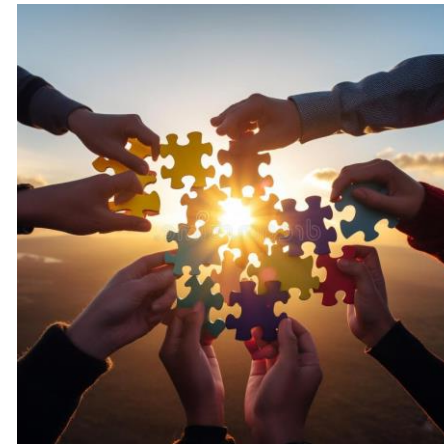
As a result, a 'one-page CERAF deep dive' document was produced for sharing amongst agencies to raise awareness. The 4LSAB CERAF guidance was distributed and promoted.

Additional CERAF training sessions were offered across the multiagency workforce and the training offer for designated safeguarding leads (DSLs) now include information about completion of CERAFs with the aim to improve practitioner confidence.

**GETTING REFERRALS RIGHT audit** December 24, carried out a deep dive audit of 5 cases, looking into getting referrals right following concerns that the quality of initial referrals into adult social care were slowing down the safeguarding process.

Key areas explored were missing information, quality of detail provided/not provided, not stating the level of need of the individual and referrals did not consistently provide the voice of the individual.

As a result, a learning summary was shared with all agencies to highlight the need for better quality referrals. A lunch and learn session to cover Making Safeguarding Personal and Making A Good Referral was offered to all staff in the Hampshire and Isle of Wight NHS trust.



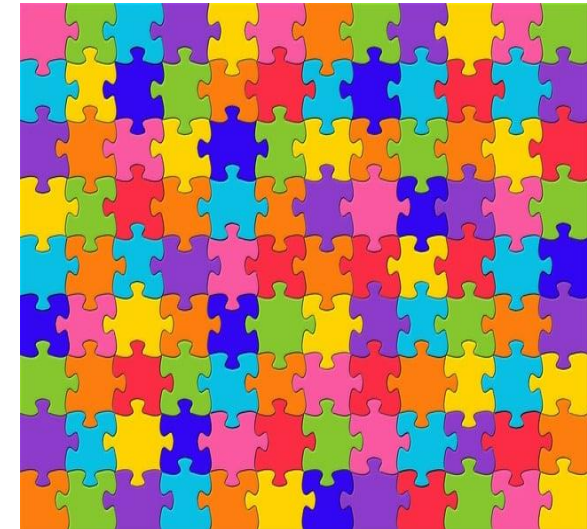
# Neglect, Self Neglect and Hoarding audit 2025

The first amalgamated partnership audit focused on the neglect and self neglect priority. The impact of adult needs in relation to self neglect and hoarding on both them and their children considered the whole family approach and the impact of professional curiosity and relational interventions to understand the whole picture for improving the interventions provided across the partnership.

This audit explored whether professionals worked in a trauma-informed way to look beyond the surface-level reasons for neglect and hoarding behaviour, the effectiveness of multi-agency planning and communication and how well the voices of the people involved were captured.

The audit highlighted the need for agencies to work in a more trauma-informed way, as there were missed opportunities to address the root cause of the neglect/hoarding behaviour at an earlier stage of involvement. Improvement was identified in multi-agency communication and planning to involve the right professionals in decision-making, and it was found that family members with a 'dominant' voice were over-represented in records.

In response, the mental capacity practice lead in Adult Social Care is working with training facilitators to ensure that there is a greater link between mental capacity and trauma-informed practice in their training package. Health colleagues have also promoted the Child Protection Information System to improve multi-agency communication and highlighted the Family Approach toolkit and Hear My Voice animation to make sure that each family member's voice is represented equally.





## Keeping children safe in education – education subgroup

The expansion of group membership to include alternative providers, independent settings and universities has resulted in key messages reaching a wider audience and improved communication and working relationships between sectors.

The group welcomed working alongside the Department for Education (DfE) National Safeguarding Partner Facilitator. This resulted in best practice examples being shared nationally and provided assurance around the way the group operates. It further highlighted clear consideration of the Partnership key priorities whilst also being responsive to emerging needs.

Guidance regarding Children Collected Late or Not Collected from Educational Settings was a hugely successful multi-agency piece of work which enabled professionals to understand the systems and barriers for individual agencies and resulted in the creation of a workable pathway understood and agreed to by all.

A refresh of the Educational Neglect Guidance has provided frontline practitioners with the necessary tools and knowledge to identify and address instances of Educational Neglect.

The creation of Kirpan Guidance has supported educational leaders and governors to be more confident in decision making around internal policies and procedures.

A new version of the section 173 school safeguarding self-evaluation audit was trialled following feedback from group members. Reports from professionals identified that the format was easier to access, had less duplications and questions better reflected Southampton specific priorities.

The implementation of an assurance system regarding alternative providers, including the creation of an 'Assured Providers Network' (incorporating training on local safeguarding processes, local needs and how to monitor and report progress) has offered opportunities for professional development, problem-solving, and building relationships that can support ongoing and future initiatives.



Multi-agency working has resulted in earlier intervention and greater impact for knife crime initiatives. Following analysis from the subgroup, a more targeted offer was created for primary aged children in years 5 and 6.

New guidance regarding Permanent Exclusions has been designed to help frontline practitioners understand the legal requirements whilst focusing on the best interests of the young person.

Promotion of the post 16 'Choices' programme has led to increased uptake and the programme is currently operating at near full capacity.

### **Looking ahead to 2025-2026**

The Education subgroup will focus on workstreams including Contextual Safeguarding, Participation in Education, focused analysis of the School Safeguarding Evaluations and capturing the voice of young people across all ages and stages of development.



# MASH strategic group

This group has oversight of the MASH function within the Children's Resource Service (CRS), and monitors the work of the MASH including workload, decision-making, and timescales, considering solutions to any operational barriers.

The regular audit work has strengthened oversight and promoted consistent decision-making, helping achieve the 'right child, right service, right time' vision and streamlined allocations to teams within Children's services.

The conversation model was successfully launched in January and has been positively received by partner agencies, praised for its accessible support and guidance when concerns arise about a child's well-being.

Data sharing has helped partner agencies understand local needs and children's services activity. The group has tracked trends, compared Southampton's performance with other authorities, and provided both assurance and challenge where needed.

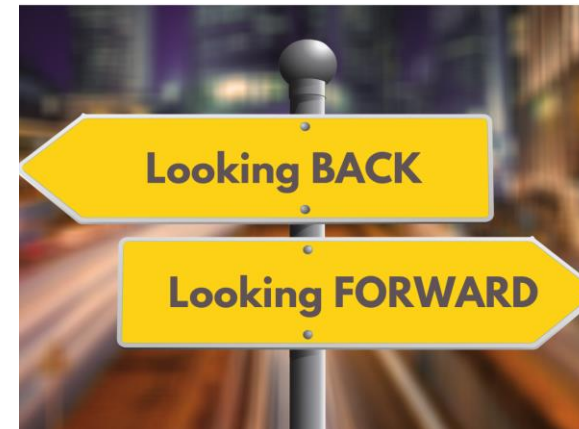
The MASH strategic group have provided governance and oversight of the implementation of actions identified in the scrutineer visit. Activity and progress updates have been monitored through the group.

## Looking ahead to 25/26

This group will continue a regular audit program to ensure that a good and consistent service is being provided.

Partners will be encouraged to provide data to ensure a rounded view of need and activity within the City.

A thematic need assessment focusing on missing episodes and exploitation of teenagers will be undertaken.



# Vulnerable adolescents board (VAB)

The Vulnerable Adolescent Board (VAB) brings together statutory and key non-statutory partners to deliver youth justice services in Southampton. Beyond its statutory role as a Youth Justice Management Board, it tackles wider issues affecting young people, such as safeguarding, education, wellbeing, and risk, through a child-centred, restorative, and trauma-informed approach.

Work undertaken by the VAB has included:

- Through dedicated activities, regularly listening to and considering the voices and views of children and young people (CYP) which are presented at VAB meetings.
- Oversight of proactive police work aimed at reducing serious youth violence in Thornhill.
- SCC and Hampshire constabulary have been awarded funding from the Violence Reduction Unit to support the development of the Focus Deterrent Model which will involve a 12-month approach with a fixed cohort of young people aimed at reducing serious youth violence. The impact will be reported on in the next yearly report.
- The creation of a programme throughout the summer to ensure that support remains in place for CYP during periods of increased staff absence.
- Supervision of the rollout of the focused deterrent model.
- Ongoing discussions in relation to custody passports and remand thresholds.

From this work, the numbers of CYP being remanded or sentenced to custody has reduced notably, and the numbers of CYP entering the youth justice system locally have continued to decrease. In addition, CYP who are involved with youth justice services have engaged more with education and skills development opportunities.

First time entrants into the youth justice system (rate per 10K 10 – 17- year-olds)

Youth Justice Service	Target	Jan 23 – Dec 23	Apr 23 – Mar 24	Jul 23 – Jun 24	Oct 23 – Sep 24
Southampton	206	164 (36)	196 (44)	182 (41)	173 (39)

Number of children on remand

2022 / 23	14
2023 / 24	10
2024 / 25	6

Number of children sentenced to custody (rate per 10K 10 – 17- year-olds)

Youth Justice Service	Jan 23 – Dec 23	Apr 23 – Mar 24	Jul 23 – Jun 24	Oct 23 – Sep 24
Southampton	0.50 (11)	0.41 (9)	0.32 (7)	0.22 (5)

# Finance

During this reporting period the three safeguarding partners contributed financially to separate budgets for the safeguarding children and adult's partnerships. Probation contribute to the children's partnership. In addition to the financial contribution, the wider partnership contribute to a significant amount of time and dedication to the sub-group activity, review progression and development of policies and toolkits. Southampton city council continue to invest the greater proportion of funding and host the partnership team. Should the contributions decrease or fail to increase with the agreed uplifts in future years, the impact on the work of the partnership will be a reduction in activity to embed improvements to safeguarding practice across the partnership. The executive leaders will review and monitor the financial contributions.

## SSCP contributions

Organisation	Contribution
SCC	£141,062
ICB	£65,214
HIOW constabulary	£26,353
Probation	£3,799
<b>Total</b>	<b>£236,455</b>

## SSAB contributions

Organisation	Contribution
SCC	£108,479
ICB	£63,734
HIOW constabulary	£25,494
<b>Total</b>	<b>£197,707</b>

# Agency scrutiny and reflection on safeguarding governance, processes and practice

## Keeping children safe organisational responsibilities (s11) [Section 11 of the Children Act 2004](#)

The focus for 2024 / 2025 was to revisit the action plans from the previous year for review as part of the two-year cycle of self assessment.

The Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) arrangements enable a review of action plans for agencies that cover the four areas and is overseen by the HIPS executive board. Agencies will be asked to complete the full self-assessment in 2025 / 2026.

The process;

- All agency action plan responses received were reviewed by the HIPS partnership managers
- Individual feedback will not be provided to agencies this year (year 2).
- A letter outlining themes arising from this year's review of action plans and highlighting the process for 2025/26 (year 1 full self-assessment) will be shared with all agencies.

Emerging themes:

- There wasn't consistent evidence of improvements under standard 11 relating to safeguarding and children with disabilities. Organisations safeguarding policies and procedures should routinely include reference to the increased vulnerability of disabled children to abuse and neglect.
- Safer recruitment training is used widely within larger organisations. It was apparent that lack of access to safer recruitment training was an emerging theme for smaller organisations.
- Acronyms are still used widely. The use of acronyms by different professional disciplines is a challenge to the effective sharing of information. Agencies were reminded of the need to share information in a way that can be understood by everyone
- Organisations should consider how they can be assured that practitioners access and understand policies that are shared within their organisation, for example a whistleblowing / freedom to speak up policy.



## Key strengths

- A strong culture and commitment of safeguarding across agencies was evident.
- Some agencies had increased their monitoring of staff engagement in safeguarding training and workforce development opportunities.
- There was further evidence of single agency quality assurance processes happening across agencies (this was a theme arising from the 23/24 S 11 self-assessment) and agencies will again be encouraged to share this with LSCPs as appropriate, so that relevant learning can be shared across the multi-agency safeguarding arrangements.
- It was pleasing to see reference to the increased awareness of the importance of supervision and taking a trauma informed approach.
- With regards to children with additional needs and disabilities, it was positive to see greater awareness from agencies around neuro-divergence. It is important not to forget the broad range of disabilities.



The 4local safeguarding adult board and local adult safeguarding self-assessment is undertaken every 2 years with the full self assessment planned for 2025 / 2026.

# Impact of scrutiny

The role of the independent scrutineer is pivotal to the oversight and scrutiny of safeguarding arrangements. With the amalgamation of the safeguarding children and adult safeguarding partnerships, the independent scrutineer extended their remit to both partnerships, enabling the focus on the safeguarding of children, young people, their families and adults, promoting a safe and prosperous future for children and adults as they enter adulthood. The scrutineer chairs the amalgamated systems board and provides professional challenge over partnership arrangements. There have been several developments in systems and models of practice which have required the close attention of the independent scrutineer and are in line with the social care reforms, the Children's Wellbeing and Schools Bill, the Families First Partnership programme and Working Together to Safeguarding Children 2023. This has added great value and insight for open and transparent working across the city.

- The introduction of the Family Safeguarding Model is governed through the systems board and executive board, where partners are provided with data and qualitative auditing for analysis of impact. This model of practice involves multi-disciplinary teams working together to support children to remain with their families when safe to do so, through understanding the needs of the whole family. By recognising the need to explore and enable sustainable change by working with parents, carers and wider networks, better outcomes are achieved for all ages through interventions with experts in domestic abuse, mental health and substance use. The model was launched in September 2024, and its introduction is being closely monitored to track impact and effectiveness. One identified challenge has been filling all the roles, and there remains a gap practitioners who are experts in mental health with adults for the model to be truly embedded.
- The introduction of the conversational model in the children's resource service promotes the exploration of concerns through a strength-based approach to ensure the right service is provided to the right child at the right time. There have been two scrutiny visits in the CRS over this reporting year with recommendations that are overseen through the MASH strategic group. It has been identified that there is a lack of capacity for the health contributions to provide valuable information for decision making. This has been escalated at both a local and HIPS level and a review of health contributions across the four regional areas has been commissioned by the Integrated Care Board.
- Adult social care are undergoing a period of improvement and transformation. This will be overseen through the safeguarding partnership with scrutiny visits planned to the front door in the coming year. The scrutineer has ensured that greater communication and partnership cohesion is promoted through the governance structure.



# The Integrated Care Board

The ICB continues to contribute to all subgroups and will lead/chair on some of these areas for the Southampton Children and Adults Safeguarding Partnership and contribute or chair some of the wider 4 local safeguarding adults board (4LSAB) and Hampshire and Isle of Wight Portsmouth and Southampton (HIPS).

Health and other colleagues such as the police have led on learning events and reviews which has been enlightening and helpful as there is already a good insight to the local community and this has helped identify learning and where exploration is needed in relation to how agencies work together in promoting better outcomes for people in the local community who have vulnerabilities and fluctuating capacity. This has included ICB Led practice reviews and supporting the partnership in producing 6 step briefings to identify good practice and areas of improvement.

The ICB has developed a one-minute guide for primary care colleagues to use when thinking about the needs and risk to individuals where there are vulnerabilities and how those individuals can be supported by onward referrals, use of escalation protocol and by arranging multiagency meetings, identified from learning from reviews.

The ICB supported the partnership delivering the “Let our Voices be Heard” conference last Autumn. The planning of the event included meeting children and young people with lived experience in the city to support the co-production and ensuring that their voices and experiences were heard throughout the day.

The interactive conference was well attended by local partner organisations and provided opportunities for partner agencies to work collaboratively, discussing scenarios which focused on the key themes identified by the partnership whilst supporting all professionals to remain curious and child centred throughout the day.

Feedback provided following the event was extremely positive, and professionals felt re-energised in their daily work.

The ICB remains a statutory function of the partnership, the partnership continues to grow and strengthen through the joint working across adults and children, whilst supporting the additional work of the Community safety partnership, DA board, Prevent board and the corporate parenting Board.

# Hampshire & Isle of Wight Constabulary

The constabulary remains committed to keeping everyone safe by prioritising the relentless pursuit of criminals, delivering exceptional local policing and putting our victims first. In 2025, as part of the national inspection process, the constabulary received a 'good' grading in relation to protecting vulnerable people. As one of only 6 forces across England Wales to reach this grade, we take pride in the recognition of ongoing work whilst accepting we want to continue to improve our service.

Some examples of this include:

In 2024 the force launched a **Vulnerability Strategy** covering Child Protection, Harm & Exploitation and Violence Against Women & Girls (VAWG) with a steering group for each of the areas feeding into the main Vulnerability Board.

The strategy has five main aims:

- Continually enhance and improve our services to vulnerable victims
- Ensure effective performance and governance across all vulnerability strands
- Ensure effective safeguarding practice across the force
- Work effectively with other safeguarding agencies across the HIOWC area
- Ensure effective prevention, pursuit and risk management of perpetrators of crime against vulnerable people.

The **Violent Crime Taskforce** (VCT) are established to operationally deliver the constabulary's serious violence strategy, taking a problem-solving approach to target the most serious offenders across Hampshire and the Isle of Wight. By working in partnership to focus on serious violence hotspots and serious violence perpetrators, vulnerable adults and children are identified and protected.

Improvements to police investigations has positively impacted the police response to sudden deaths. **Operation Respectful** was introduced in early 2024 to focus on investigation standards at unexpected deaths in the community. The improved quality of investigations has assisted in recognising when an individual has experienced neglect or abuse and where that individual may have unmet care and support needs. This aids the coronial process, and internal processes ensure that where abuse/neglect is present the death is reviewed for consideration as to whether it will meet the criteria for a referral for review (DARDR/SAR/CSPR).

The force has invested heavily in prioritising MASH & Safeguarding with a staffing uplift and prioritisation of robotic process automation across our processes. The challenge remains for MASH around capacity versus demand and ensuring referrals are promptly shared with partners. In the near future we are looking at utilising robotics across our safeguarding teams to assist in gathering of information to produce reports for Multi agency Risk Assessment Conferences (MARAC) and Domestic Violence Disclosure Scheme (DVDS). This will in turn speed up sharing of information and ensuring an improved safeguarding response.

The constabulary are a statutory member of the partnership and remain fully committed to supporting and working to strengthen and improve joint working to safeguard adults and children within Southampton.

## Children's social care

Over the year, Southampton Children's Social Care has worked closely with safeguarding partners to enhance multi-agency collaboration and improve outcomes for children, with a specific focus on family safeguarding and the introduction of the conversational model. The implementation of the Family Safeguarding Model has involved collaboration from partners, who signed a partnership pledge to ensure the model is embedded throughout organisational cultures.

Alongside the launch of the Conversational Model in the Children's Resource Service, there is a real drive to ensure the right services are provided with the right children at the right time. Both these models support the recommendations of the 'Stable Homes Built on Love' social care reforms [Children's social care: stable homes, built on love - GOV.UK](#) and Working Together to Safeguarding Children 2023 [Working together to safeguard children 2023: statutory guidance](#) and are overseen through the safeguarding partnership to scrutinise the impact for children and families.

The amalgamation of the Safeguarding Children's Partnership and Safeguarding Adults Board into the Southampton Children and Adults Safeguarding Partnership (SCASP) in January 2025 has strengthened joint working and decision-making, with an important focus on transitional safeguarding.

Children's social care data is provided quarterly to the Practice and Performance Improvement Group for analysis and scrutiny, with the introduction of other organisations' data beginning to add more sophisticated insights into the experiences of children and families.

The service has contributed to the Child Sexual Abuse audit and the Child Exploitation Risk Assessment Framework (CERAF) audits, which have been conducted to identify areas for improvement and ensure effective safeguarding practices, particularly for young people at risk of contextual harm.

The Risk Outside The Home (ROTH) pilot, with oversight from the University of Durham, is now embedded in practice to ensure that services and communities are working with families to understand the contextual risks faced by young people in Southampton, identifying that a different approach is required to reduce harm in the city.

The service has benefitted from participating in events like the "Let Our Voices Be Heard" which brought together various agencies to discuss and consider the voices and views of children, young people, and their families.

These examples show the maturity of the local safeguarding partnership, which creates a firm foundation for us to successfully embed the local response to the national social care reforms.

# Adults social care (ASC)

ASC maintained its contribution to the safeguarding partnership through attendance at sub-groups and contributions to safeguarding adult reviews. There have been significant changes in ASC during this period with a restructure and recruitment to leadership posts resulting in some challenges in maintaining consistent attendance at all groups, but this was resolved in early 2025. The creation of the Systems Board has been a further significant change, this brings benefits in areas such as transitional safeguarding and a family approach, and ASC is committed to bringing expertise in Mental Capacity, strengths-based and positive risk-taking approach to the Systems Board and sub-groups.

ASC has found participation in the partnership themed audits very beneficial, the joint working and engagement with this process has enabled ASC to develop audit tools and processes to better embed this into day-to-day practice. Working collaboratively with children's social care has further contributed a nonjudgemental and shared approach, enabling staff to feel supported and open to learning. The multi-agency collaboration further develops information sharing and professional relationship building.

Liaison between the safeguarding allegation management advisor (SAMA) role and the local authority designated officer (LADO) has enabled ASC to develop good practice by incorporating learning and contacts developed by children's social care, including MASH support, police liaison, information sharing and best practice protocol. Engagement in this process has supported ASC to develop great professional relationships with police colleagues enabling prompt exchange of information, advice and speedy resolution of matters.

ASC has engaged in the police led multi agency action against fraud network, this engagement has led to closer working with Trading Standards and a proactive response to local threats, harms and patterns of activity. As a result, ASC has engaged with the anti-fraud police inspector to deliver teaching sessions to social work staff, share information and support community working.

The Transitional Safeguarding Project (research complete, implementation evolving) has benefited from ASC engagement in the research and development project enabling Public Health researchers to fully understand the safeguarding context of young adults moving between services, language used and processes in play. Collaborative working enabled triangulation of key data and outcomes to be considered in the context of transitions, thus enabling better protection and routes for further development in supporting young people and their families through this significant life change.

ASC have engaged with the SCAS (South Coast Ambulance Service) process and practice improvement group to review SCAS referral issues, understand county wide impact / processing issues including development of a new referral form in collaboration with children's and neighbouring authorities. This open collaboration has enabled SCAS to better understand ASC requirements, avoid duplication / omissions in reporting and navigate different local authorities. This work has improved relevant information sharing and responsiveness to concerns of risk raised by partners.





# Lay member

As a Lay Member working in the community and local church projects supporting vulnerable families, I have found great support from the team to connect and raise awareness and standards of safeguarding for staff and volunteers serving on the front line of community projects. Being part of the partnership, attending meetings can help bring the voice of the local community needs. It is great to have this connection and support to help those at risk of harm who might not feel able to ask for help. Promoting the free training, events and resources made available through the partnership websites have been really helpful to many projects who wouldn't be able to afford this regularly and helps build connections with the safeguarding partnership.

Elaine Davison, Lay Member





## Looking forward to 2025 / 2026

- The already strengthened partnership arrangements with the amalgamation between the children and adults safeguarding partnerships will continue to undergo review, challenge and scrutiny through the mature governance structures.
- The new strategic priorities will be tracked to monitor progress and impact.
- The DfE social care reforms continue to be discussed across the partnership, with local arrangements under development and where possible those agencies who work across the four HIPS areas (Hampshire, Isle of Wight, Portsmouth and Southampton) have requested uniformity of approach. The challenge of consistency with differing landscapes and levels of deprivation and need will continue to receive healthy discussion and debate through the mechanism of the HIPS executive.
- The partnership will work together to understand and develop partnership arrangements as required with the future of Local Government reform across local councils.
- A Cultural Inclusivity Strategy is in the early stages of development to ensure that the partnership is working with the diverse communities within Southampton, adopting a co-production approach and the ambition of a co-production charter.
- Further development of work with the Youth Commission and a proposal for a group of Young Ambassadors within social care will support the journey towards co-production within the work of the partnership.
- A thematic review is underway to understand and recommend system changes to the partnership interventions and support for those sleeping rough on the streets of Southampton. This review involves the voices of those with lived experiences and considers the severe and multiple disadvantages faced that can become barriers to accessing services in the traditional format.
- The partnership are working across the 4 local safeguarding adult boards to develop learning, guidance and toolkits for working with alcohol use and the impact following several safeguarding adult reviews with similar themes.
- Southampton partnership are leading on the development of Harmful Practices Guidance across both children and adult partnerships in the 4 local areas.

- Planning is in development to assess and review the impact of learning in relation to the initial response and identification of child sexual abuse, the multi-agency responses to missing episodes, children who are cared for by Southampton and have been victims of sexual assaults and rape and sexual risk outside the home to recommend practice change across the partnership.
- Recommendations from the commissioned report concerning transitional safeguarding will be governed through the working group for impact and system change.



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