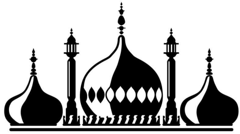

Brighton & Hove City Council

Shadow Health & Wellbeing Board

Title:	**Shadow Health & Wellbeing Board**
Date:	**5 December 2012**
Time:	**5.00pm**
Venue	**Council Chamber, Hove Town Hall**
	Board Members
Councillors:	Jarrett (Chair), Bennett, Duncan, Meadows, K Norman, Shanks (Deputy Chair), Wilson
BHCC: CCG Youth Council HealthWatch	Heather Tomlinson, Interim Statutory Director of Children's Services Denise D'Souza, Statutory Director of Adult Social Care Dr. Tom Scanlon, Statutory Director of Public Health Dr. Xavier Nalletamby, Clinical Lead Geraldine Hoban, Non-clinical member Hayyan Asif Robert Brown
Contact:	**Caroline De Marco** Democratic Services Officer 01273 291063 caroline.demarco@brighton-hove.gov.uk

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- Do not stop to collect personal belongings;
- Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions; and
- Do not re-enter the building until told that it is safe to do so.

Democratic Services: Shadow Health & Wellbeing Board

SHWB Business Manager

Councillor Jarrett Chair

Lawyer

Democratic Services Officer

Councillor Duncan

Councillor Shanks

Councillor Bennett

Councillor K. Norman

Councillor Meadows

Councillor Wilson

Interim Statutory Director of Children's Services Heather Tomlinson

Statutory Director of Adult Social Care Denise D'Souza

Statutory Director of Public Health Tom Scanlon

Clinical Commissioning Group Xavier Nalletamby

Clinical Commissioning Group Geraldine Hoban

Youth Council

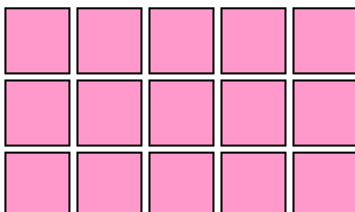
Hayyan Asif

Health Watch Representative Robert Brown

Public Speaker

Member Speaking

Public Seating



Press

AGENDA

PART ONE **Page**

20. PROCEDURAL BUSINESS

(a) Declaration of Substitutes - Where Councillors are unable to attend a meeting, a substitute Member from the same Political Group may attend, speak and vote in their place for that meeting.

(b) Declarations of Interest – Statements by all Members present of any personal interests in matters on the agenda, outlining the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct.

(c) Exclusion of Press and Public - To consider whether, in view of the nature of the business to be transacted, or the nature of the proceedings, the press and public should be excluded from the meeting when any of the following items are under consideration.

NOTE: *Any item appearing in Part Two of the Agenda states in its heading the category under which the information disclosed in the report is exempt from disclosure and therefore not available to the public.*

A list and description of the exempt categories is available for public inspection at Brighton and Hove Town Halls.

21. MINUTES — 1 - 10

Minutes of the meeting held on the 12 September 2012 (copy attached).

22. CHAIR'S COMMUNICATIONS

23. PUBLIC INVOLVEMENT

To consider the following matters raised by members of the pubic:

(a) **Petitions** – to receive any petitions presented to the full council or at the meeting itself;

(b) **Written Questions** – to receive any questions submitted by the due date of 12 noon on the28 November 2012;

(c) **Deputations** – to receive any deputations submitted by the due date of 12 noon on the 28 November 2012.

24. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

To consider the following matters raised by councillors:

(a) **Petitions** – to receive any petitions submitted to the full Council or at the meeting itself;

(b) **Written Questions** – to consider any written questions;
(c) **Letters** – to consider any letters;
(d) **Notices of Motion** – to consider any notices of motion.

25. NOMINATION OF A MEMBER TO REPRESENT THE SHWB TO THE KENT, SURREY & SUSSEX LOCAL EDUCATION & TRAINING BOARD **11 - 18**

Report of Director of Public Health (copy attached).

Contact Officer: Giles Rossington Tel: 01273 291038
Ward Affected: All Wards

26. JOINT HEALTH & WELLBEING PRIORITIES

a) Smoking – Presentation from Tim Nicholls, Head of Regulatory Services and Sue Venables, Health Development Specialist (Tobacco Control) on the Tobacco Control Alliance & Joint Health & Wellbeing Strategy Smoking Priorities.

b) Health, Weight & Good Nutrition – Presentation from Lydie Lawrence, Public Health Development and Improvement Manager, BHCC and Vic Borrill of the Brighton & Hove Food Partnership.

27. SHADOW HEALTH & WELLBEING BOARD REVIEW - FACILITATION BY LOCAL GOVERNMENT ASSOCIATION **19 - 30**

Verbal Presentation by Jeremy Crabbe of the Local Government Association.

28. REFERRAL FROM HWOSC: "TALK HEALTH" PARENT CARERS' VIEWS ON HEALTH SERVICES **31 - 54**

Letter from Councillor Rufus & “Talk Health Paper” (copies attached for information).

29. LOCAL SAFEGUARDING CHILDREN'S BOARD (LSCB) ANNUAL REPORT FOR 2011/12 **55 - 114**

Report of the Local Safeguarding Children’s Board (copy attached).

Contact Officer: Sharon Healy Tel: 01273 290728
Ward Affected: All Wards

The City Council actively welcomes members of the public and the press to attend its meetings and holds as many of its meetings as possible in public. Provision is also made on the agendas for public questions and deputations to committees and details of how questions and deputations can be raised can be found on the website and/or on agendas for the meetings.

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For further details and general enquiries about this meeting contact Caroline De Marco, (01273 291063, email caroline.demarco@brighton-hove.gov.uk) or email democratic.services@brighton-hove.gov.uk

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Date of Publication - Tuesday, 27 November 2012

BRIGHTON & HOVE CITY COUNCIL

SHADOW HEALTH & WELLBEING BOARD

5.00pm 12 SEPTEMBER 2012

COUNCIL CHAMBER, HOVE TOWN HALL

MINUTES

Present: Councillor Jarrett (Chair) Councillor Cobb, Duncan, Meadows, K Norman and Shanks (Deputy Chair)

Other Members present: Denise D'Souza, Statutory Director of Adult Social Care, Dr. Tom Scanlon, Statutory Director of Public Health, Geraldine Hoban, Clinical Commissioning Group, Hayyan Asif, Youth Council, and Robert Brown, HealthWatch.

Apologies for absence: Terry Parkin, Statutory Director of Children's Services Dr. Xavier Nalletamby, Clinical Commissioning Group.

PART ONE

10. PROCEDURAL BUSINESS

10A Declarations of Substitute Members

10.1 Councillor Cobb declared that she was substituting for Councillor Bennett.

10B Declarations of Interests

10.2 There were none.

10C Exclusion of the Press and Public

10.3 In accordance with section 100A(4) of the Local Government Act 1972, it was considered whether the press and public should be excluded from the meeting during the consideration of any items contained in the agenda, having regard to the nature of the business to be transacted and the nature of the proceedings and the likelihood as to whether, if members of the press and public were present, there would be disclosure to them of confidential or exempt information as defined in section 100I (1) of the said Act.

10.4 **RESOLVED** - That the press and public be not excluded from the meeting.

11. MINUTES

11.1 Councillor Meadows asked for an amendment to paragraph 9.3. It should now read "Councillor Meadows stated that she was happy for the Statutory Directors to send a representative to advise the Board." ~~as long as they did not vote.~~

11.2 **RESOLVED:** That the minutes of the meeting held on the 30th May, 2012 be approved as a correct record of the proceedings and signed by the Chair subject to the amendment mentioned above.

12. CHAIR'S COMMUNICATIONS

12.1 There were none.

13. PUBLIC INVOLVEMENT

13.1 There were no petitions, written questions or deputations from members of the public.

14. ISSUES RAISED BY COUNCILLORS AND MEMBERS OF THE BOARD

14.1 There were no petitions, written questions, letters or notices of motion from councillors or other members of the Board.

15. CHILD POVERTY UPDATE

15.1 The Board considered a presentation from Sarah Colombo, Child Strategy Manager/Stronger Families Stronger Communities. The presentation set out the focus for the Child Poverty Strategy over the next year in Brighton and Hove. The presentation explained the four strategic outcomes and how child poverty would be monitored. The Board were informed that responsibility for the Child Poverty Strategy now sat within the Stronger Families and Stronger Communities Partnership and Programme Boards.

15.2 Robert Brown asked how the strategy was being embedded into planned commissions and how it was informing future budget decisions to ensure that the most vulnerable were receiving services. He asked if officers had thought of having a connection with the fire service in dealing with matters such as setting fires.

15.3 The Child Strategy Manager replied that with regard to embedding, more work needed to be done to ensure that the key child poverty focus was embedded. There was a decision not to develop a specific Child Poverty Task Group but rather to keep the child poverty focus alive across the work of the Local Strategic Partnership to which child poverty would report. With regard to the question about the fire service, the focus on secondment was around agencies who were most closely involved, however the fire service was involved in the discussion. Denise D'Souza confirmed that the fire service were very much involved and were part of the steering group.

15.4 Councillor Meadows referred to the payment by results model. She asked how this differed from the target driven model. She referred to the three criteria for eligibility and

asked how success could be measured. For example, if a child went back to school there would be a payment, but the child might still have problems.

15.5 The Child Strategy Manager replied that payment by result sharpened resolve. That there were differing payments for different success outcomes such as gaining employment, a child attending school etc. There was more work planned in order to identify the impact of the relevant agencies in any successful outcomes for families. She was not sure to what degree payments by results changed the way of working from target driven funding. The three national criteria were set out by government and were not subject to local change. However the local resolve is to learn through the programme how to change services in order to better prevent families from finding themselves in a range of complex problems.

15.6 Councillor Meadows asked if resources would be withdrawn if there was success with the targets. The Child Strategy Manager replied that the issues families eligible for the programme face were complex and for a family to move on required more than one outcome to be achieved. Payment by results outcomes were only one part of that holistic support to enable families to be more resilient.

15.7 Denise D'Souza stated that a great deal of work was being carried out in identifying the 675 families in complex need. The criteria and payment by results was a very complex process. It was a reward for success.

15.8 Councillor Meadows asked about ongoing support. Denise D'Souza replied that it was a changing service which relied on pump priming. It involved a close working relationship with partners. As the work commenced the service might need to be commissioned in a different manner. The reward money was paid to the local authority. There would be a debate on how this money was used.

15.9 The Chair referred to ongoing support. He stressed that there were families that the council was already working with and would continue to work with. This work would not stop when the targets were met and support for families would not be withdrawn.

15.10 Tom Scanlon asked for more detail on phase 2 of the Stronger Families Stronger Community Delivery. He expressed concern about the perceived connection between troubled families and poverty. He suggested that many troubled families were not poor, and that not all poor families were troubled families.

15.11 The Child Strategy Manager replied that the focus of the work of phase 2 was developing effective ways of working with the third sector and developing support for programme participants to be involved in the delivery and decision making about the programme, recognising the expertise and resources they bring.

15.12 Denise D'Souza stated that families were already being worked with on Phase 1. She suggested that as the programme progressed it might be necessary to look at a 4th criteria involving more complex families who were involved in substance misuse etc.

15.13 Councillor Shanks referred to family coaches and asked if they came from a professional background. The Child Strategy Manager replied that a range of people

have been recruited to the new Family Coach roles ranging from social workers to those with advocacy experience.

15.14 Councillor Cobb asked how long officers intended to work with families and how much progress had there been to date. Denise D'Souza explained that there were a range of professionals with different priorities working on the strategy. The length of time would vary depending on the individual circumstances of each family. People had to sign up to goals and targets as part of the programme.

15.15 The Chair stated that the perception of government was that an integrated approach was needed. It appeared to be a good approach and a better use of resources.

15.16 Hayyan Asif expressed the view that the focus should be on children not in education rather than children not in schools. The Child Strategy Manager concurred and explained that the issues would be where children are not getting their education in whatever way it was delivered.

15.17 Councillor Shanks considered that the core issue was children not attending school. Many people were doing a very good job in home educating their children.

15.18 Robert Brown asked if children in hospital with long term illnesses would be classed as coming from troubled families if they were not attending school. The Child Strategy Manager stated that children in these circumstances would definitely not be considered eligible on this basis alone.

15.19 **RESOLVED** – That the presentation be noted.

16. JOINT STRATEGIC NEEDS ASSESSMENT SUMMARY 2012

16.1 The Board considered a report of the Head of Public Intelligence and the Consultant in Public Health which updated the Board on the progress of the 2012 Joint Strategic Needs Assessment Summary and which asked the Board to support its publication. The report also presented the results from the consultation on the summary in July 2012. From April 2013, local authorities and clinical commissioning groups would have equal and explicit obligation to prepare a Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy.

16.2 Members were informed that the response to the consultation was broadly supportive and that the feedback had been useful.

16.3 Robert Brown asked what plans were in place to work through resolving gaps in data, particularly gaps around key equality groups, to include in future JSNAs. He also asked how Patient Participation Groups could be involved in future JSNAs. The Head of Public Health Intelligence replied that these key questions would be taken forward by the City Needs Assessment Steering Group. Officers will be working with the Community & Voluntary Sector on gathering more evidence from them. This year the consultation had been sent out through Practice Managers to go to Patient Participation Groups. This needed to be reviewed in future. Geraldine Hoban added that there had already been some engagement with the Patient Participation Groups through the Clinical Commissioning Group.

16.4 Councillor Shanks referred to wider consultation and asked if there had been any thought about consulting with trade unions and schools. The Consultant in Public Health agreed with this suggestion and stated that a more formal engagement strategy would need to be put in place. The Chair suggested that there would also be a role for the Board to support future engagement.

16.5 Councillor Duncan pointed out that there was a need to consult with the City Engagement Partnership.

16.6 **RESOLVED** – (1) That the publication of the JSNA Summary 2012 be supported.

(2) That the feedback from the 2012 JSNA consultation be noted.

17. JOINT HEALTH & WELLBEING STRATEGY (JHWS)

17.1 The Board considered a report of the Strategic Director, People which stated that from April 2013 each local Health & Wellbeing Board would have a statutory duty to publish a Joint Health and Wellbeing Strategy (JHWS). At the last meeting, the Board agreed that the local JHWS should focus on five high priority areas: Smoking; dementia; cancer and access to cancer screening; healthy weight and good nutrition; and emotional wellbeing (including mental health). An action plan for each priority had been produced by officers and was attached as appendix 1 to the report.

17.2 Robert Brown asked the following questions.

a) Has life expectancy in all wards across the city improved over the last 5 years, and if not why? Could we have this information for every ward as it is known that life expectancy varied by almost a decade across the city?

b) How many responses did you receive on just the strategy through the consultation portal?

c) If this is a draft strategy, will there be time to share it with Community & Voluntary Sector organisations and members of the public for comments and input before the final version is signed off in April.

d) What is the process for translating these priorities into commissioning intentions? Will members of the public be involved in all tendering around these priorities?

e) How will commissioners be supported to undertake Equality Impact Assessments in the priority areas if the strategy is not covering this, and how will the board receive this information?

f) What work is being done to ensure that health services have the staff and resources they need to handle increased demand in cancer screening caused by public health campaigns, and will be caused by it being a priority area for this strategy? The LINk newsletter could be used to raise awareness of public health messages, cancer prevention and screening.

17.3 The Deputy Director of Public Health referred to question (a). He confirmed that life expectancy had improved overall but he could not say with certainty at that time if it had increased in all wards. Robert Brown referred to page 34 of the agenda which stated that life expectancy in Brighton and Hove was 77.7 years for males. However, there was a large difference in the figures for Queen's park and Patcham. The Deputy Director agreed that there was a gap in life expectancy between wards which needed to be addressed, but stressed that the overall trend for the city was increasing.

17.4 The Shadow Health & Wellbeing Board Business Manager referred to question b). He stated that less than 10 responses had been received on the strategy through the consultation portal. Most of the consultation had been carried out through the Community & Voluntary Sector.

17.5 The Shadow Health & Wellbeing Board Business Manager referred to question c). He stated that officers were planning to engage with the CVS and the LINk.

17.6 The Deputy Director of Public Health referred to question (d). He confirmed that the strategy would be turned into an action plan. Where they already exist, the relevant steering groups will take forward the actions. New groups may need to be established to progress this work and officers would be also be consulting groups that were already in existence.

17.7 The Shadow Health & Wellbeing Board Business Manager referred to question e). He stated that the JSNA process had a great deal of support from the Council's equalities team. There was not a full EIA on the draft strategy. Most of the equalities work would be in the detailed commissioning plans.

17.8 The Deputy Director of Public Health referred to question (f). He confirmed that plans were in place to manage the increased demand in cancer screening.

17.9 Dr Tom Scanlon acknowledged the work that had been carried out on the JHWS and thanked the authors. In terms of outcomes, he found it helpful that the number of priorities had been reduced. The Deputy Director of Public Health stated that in terms of outcomes there was a need to identify short-term, intermediate and long term outcomes.

17.10 Councillor Meadows referred to the campaign that prevented breast cancer screening services being moved from Brighton to Haywards Heath. She asked how that campaign had affected the document and whether the strategy would achieve similar campaigns. The Deputy Director of Public Health replied that it would be for the Board to decide how it wished to amend the strategy in response to such campaigns. The Chair commented that the Board could make observations regarding the accessibility and location of services. The Shadow Health & Wellbeing Board Business Manager stated that if there were major changes to services it would be a matter for the Health & Wellbeing Board to consider.

17.11 Geraldine Hoban informed the Board that there were wider determinations of health and wellbeing and there was a proposal to weave these through the various sections. Employment and housing was a key element in all the sections. There needed to be a more joined up approach. The Shadow Health & Wellbeing Board Business Manager replied that he wanted to get the view of the Strategic Housing Partnership and other

partnerships. The Chair suggested communicating with the relevant council committees and asking them for their view on the JHWS.

17.12 Councillor Duncan informed the Board that he had attended a meeting of Brighton Action for Wellbeing where there had been a talk on mental health and happiness. Councillor Duncan also referred to smoking and made the point that many people had given up without any contact with the NHS. How would that be measured? He also asked if there was any data on tobacco products that were sold. The Deputy Director of Public Health replied that the government had developed a happiness index to measure happiness. With regard to smoking, the NHS currently had an outcome of the number of people successfully quitting at four weeks, but that from 2013 the outcome measured will be population smoking prevalence. He hoped that local data would be gathered on a more regular basis. Local supermarkets were wary of releasing information about sales of tobacco products.

17.13 Dr Tom Scanlon stressed that there was a need to have information on the contribution of partnerships. He suggested that there should be a paper on that issue. The Chair suggested that the partnerships should be approached to ask them how they could be involved and what they thought of the board's priorities. There needed to be an agreement with each partnership. It was agreed that the Chair & the Shadow Health & Wellbeing Board Business Manager would make an informal approach to partnerships before a more formal approach was agreed.

17.14 Hayyan Asif referred to the action plan for healthy weight and good nutrition. He asked what measures were in place to ensure that the academies would follow the plan. Councillor Shanks stated that the Healthy Schools Partnership did some work in academies. A great deal of youth work was carried out with youths outside mainstream schools.

17.15 The Chair asked if there had been any consideration of working with children outside the state system. Was there a remit or intention to engage with public schools? Councillor Shanks replied that she did not think the Healthy Schools Partnership worked with private schools. The Chair considered that there needed to be further thought about this issue as these young people would become adults who would be included in the council's figures.

17.16 The Chair stated that he was concerned that HIV was not a priority. He felt that there might be specific problems in Brighton and Hove that could not be left purely to the NHS to deal with. The Deputy Director of Public Health explained that there was a recently established Sussexwide HIV Network and a local sexual health CRG. A great deal of work is carried out on prevention and early diagnosis. Dr Tom Scanlon stated that he considered that it was important to continue to support the five high priority areas agreed at the previous meeting.

17.17 Councillor Shanks referred to paragraph 7.6 of the previous minutes relating to breast cancer screening and asked if there was clarification about this issue. The Deputy Director of Public Health replied that there was a national review of breast cancer screening and it was best to wait for the outcome of the review before having a further discussion on this issue. The report would be available before April 2013.

17.18 Councillor Cobb pointed out that some pages of the Joint Health and Wellbeing Strategy quoted percentages and other pages quoted numbers. She asked for a consistent approach. The Shadow Health & Wellbeing Board Business Manager agreed that there was a need for a consistent method of reporting data.

17.19 **RESOLVED** – (1) That the draft Joint Health & Wellbeing Strategy (Appendix 1 to the report) be endorsed.

18. DEPARTMENT OF HEALTH CONSULTATION ON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND JOINT HEALTH & WELLBEING STRATEGY (JHWS)

18.1 The Board considered a report of the Strategic Director, People which set out a suggested response to the Department of Health consultation on statutory guidance relating to the JSNA and JHWS duties. The draft guidance and consultation questions were included as Appendix 1 to the report. The draft response was set out in Appendix 2.

18.2 Councillor Duncan supported the responses and welcomed the local determination. Dr Scanlon stated that he fully supported the replies in Appendix 2.

18.3 **RESOLVED** – (1) That it is agreed to submit a response to the DH consultation on statutory guidance relating to the JSNA and JHWS duties.

(2) That the Shadow Health & Wellbeing Board uses the officer response to the consultation (Appendix 2 of the report) as a basis for its submission.

19. CCG VISIONS/VALUES & STRATEGIC COMMISSIONING PRIORITIES

19.1 The Board considered a presentation from Geraldine Hoban, Chief Operating Officer, Clinical Commissioning Group. The presentation set out the development of the CCG along with its vision, values, aims, strategic objectives and draft strategic priorities. Copies of the slides were circulated to members at the meeting.

19.2 Councillor Duncan noted that the presentation had mentioned a great deal about engagement with the public. He asked where community pharmacists would fit in. Geraldine Hoban replied that the CCG would not be commissioning community pharmacists. She would investigate this matter.

19.3 Robert Brown asked what plans were in place to ensure that Community and Voluntary Sector organisations and patients were involved in developing the CCG's priorities. Mr Brown further asked when the public would be allowed to attend CCG Board meetings. Geraldine Hoban replied that the CCG would share information with CVS organisations and patients as part of the process of developing priorities. She stated that the CCG would want to open meetings to the public as soon as possible and she would raise this matter at the next CCG Board for discussion. Meetings would be open to the public by April 2013 at the latest.

19.4 Dr Tom Scanlon referred to the draft strategic priorities. He stated that he expected the CCG to take the lead on cancer. He asked for wellbeing to be included under Mental Health.

19.5 Councillor Shanks referred to Maternity and Children. She stated that she would like to see support for more home births and community midwifes. Geraldine Hoban replied that home births would have an important place in the priorities. The CCG would endeavour to have better community services.

19.6 Denise D'Souza reminded the Board that the Council had joint commissioning arrangements with the current PCT which would transfer to the CCG.

19.7 Hayyan Asif referred to the consultation process and the fact that young people and older people had different issues that needed to be considered. Geraldine Hoban replied that the CCG would consult with representatives differently. For example, through the Older Peoples Forum, and through special interest groups. The Children's Board had representatives from families. The CCG would welcome sharing their plans. The Chair mentioned that there would be engagement with the Youth Council.

19.8 The Chair stated that there had been a positive response, with a general feeling of broad agreement with the work being carried out. He looked forward to further detail.

19.9 **RESOLVED** – That the presentation be noted.

The meeting concluded at 7.05pm

Signed Chair

Dated this day of

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 25 Brighton & Hove City Council

Subject:		**Nomination of a Member to Represent the SHWB to the Kent, Surrey & Sussex Local Education & Training Board**	
Date of Meeting:		**05 December 2012**	
Report of:		**The Director of Public Health**	
Contact Officer:	**Name:**	**Giles Rossington**	**Tel: 29-1038**
	Email:	**Giles.rossington@brighton-hove.gov.uk**	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 Local Education & Training Boards (LETB) are part of the new NHS structures, working alongside NHS providers to manage and co-ordinate NHS training on a regional basis.

1.2 The Kent, Surrey & Sussex LETB has recently written to all Shadow Health & Wellbeing Boards (SHWB) in its patch requesting that the SHWBs each nominate a board member to act as the board's representative in dealings with the LETB. (The LETB letter is included as **Appendix 1** to this report.)

1.3 It is proposed that the Brighton & Hove SHWB nominates the Clinical Commissioning Group (CCG) Chief Operating Officer to be the SHWB representative to the LETB. The CCG Chief Operating Officer is content to be nominated in this way.

2. RECOMMENDATIONS:

2.1 That SHWB members agree to nominate the CCG Chief Operating Officer to represent the Board to the LETB.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Under the new NHS arrangements, NHS staff planning and training will be the joint responsibility of NHS providers, Health Education England (HEE) and Local Education & Training Boards (which are the sub-regional spokes of HEE).

3.2 In order to carry out its functions the Kent, Surrey & Sussex LETB has written to all local authorities, CCGs and SHWBs in its patch requesting that they nominate an individual with lead responsibility for working with the LETB.

3.3 It seems unlikely that the interaction between individual SHWBs and the LETB will be particularly extensive, as the LETB's duties are largely discrete from those of the SHWB. However, CCGs will need to build strong relationships with the LETB, and it therefore seems sensible to nominate a CCG member of the SHWB as the local SHWB representative. This has been the course pursued by our immediate neighbours (i.e. East and West Sussex).

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None has been undertaken – this is not a matter of obvious interest to the local community.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There is no financial implications relating to this report.

Finance Officer Consulted: Anne Silley Date: 16/11/12

Legal Implications:

5.2 There are no legal implications arising from this report.

Lawyer Consulted: Elizabeth Culbert Date23/11/12

Equalities Implications:

5.3 None directly

Sustainability Implications:

5.4 None

Crime & Disorder Implications:

5.5 None

Risk and Opportunity Management Implications:

5.6 There is a need for SHWBs to have a relationship with the LETB, aqnd therefore a risk in not nominating a representative. However, the opportunity is a relatively minor one, as it is unlikely that the LETB will be instrumental in the work of the SHWB. It therefore seems sensible to nominate a CCG SHWB member, as the CCG will in any case need to build a relationship with the LETB.

Public Health Implications:

5.7 None directly for the SHWB. Public Health (and BHCC social care services) may seek to build relationships with the LETB, but they will do so separately from the SHWB.

Corporate / Citywide Implications:

5.8 Having an adequate and properly trained NHS workforce is important for the city, particularly in terms of the key corporate objective to reduce inequalities. However, the key relationships with the LETB are likely to be those forged by the CCG and the relevant council departments rather than the SHWB.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 The SHWB could have declined to nominate a representative, but this might be unwise should the SHWB need to work closely with the LETB at some point.

6.2 The SHWB could have nominated a non-CCG member to represent its interests, but this would have required the member to develop a relationship with the LETB whereas the CCG will in any case need to build its own relationship.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 The recommendation enables the SHWB to develop a relationship with the LETB whilst making minimal demands on the nominated SHWB member.

SUPPORTING DOCUMENTATION

Appendices:

1. Letter from the LETB to BHCC Chief Executive

Documents in Members' Rooms
None

Background Documents
None

Appendix 1

17th August 2012

South of England

York House
18-20 Massetts Road
Horley
Surrey
RH6 7DE

01293 778 899
www.southeastcoast.nhs.uk

John Barradell
Brighton and Hove Unitary Authority

Dear Mr Barradell,

Re: Kent Surrey and Sussex Local Education and Training Body (KSS LETB)

Please find enclosed an introduction to the KSS LETB that has been established for Kent, Surrey and Sussex to commission and develop education and training on behalf of its network of NHS Providers.

The purpose of this communication is to seek to work with someone within your Health and Well-Being Board to establish an appropriate process for engagement for this important agenda.

Therefore could you please bring it to the attention of your shadow Board and provide us with details for your nominated representative so that we can contact them and begin this process.

If you require any further information please don't hesitate to contact me.

Yours sincerely

P S. Spicer

Philippa Spicer
Associate Director of Education and Training Commissioning
Corporate Responsibility for East

Chair: Dr Geoffrey Harris **Chief Executive: Sir Ian Carruthers OBE**

***NHS South of England** comprising South Central, South East Coast and South West Strategic Health Authorities*

Kent, Surrey and Sussex Local Education and Training Board (LETB) – Engagement with Health and Well-Being Boards

1. Background

As you will be aware the Kent Surrey and Sussex Local Education and Training Board (KSS LETB) is a new organisation being developed to implement the changes within the NHS and wider health system.

KSS LETB will be part of Health Education England (HEE), and will be accountable for the commissioning of education, and the quality of the outcomes of that education. This in turn will impact on the outcomes for patients.

Health and Well-Being Boards and the KSS LETB will need to develop a relationship and ways of working with each other. This note sets out the context and proposes a way forward which establishes our initial relationship.

2. KSS LETB

The national guidance states that the purpose of the LETB is to:

- Identify and agree local priorities for education and training to ensure security of supply of the skills and people providing health and public health services;
- Plan and commission education and training on behalf of the local health community in the interests of sustainable, high quality service provision and health improvement; and
- Be a forum for developing the whole health and public health workforce.

The KSS LETB is developing a five year Skills Development Strategy that will articulate the educational and development actions to ensure the future supply of workforce within the area.

The KSS LETB will have a 'Governing Body', which will be a formal sub-committee of HEE. The LETB is, by design, a provider led body. The majority of the membership will be CEOs of NHS provider organisations. This will be the group accountable for the decisions made by the wider members of the KSS LETB. The membership of the Governing Body includes representatives from primary care provision and higher education.

There will also be three Partnership Councils (one for each County), each chaired by a provider Chief Executive, with senior provider representation, together with representation from Higher Education and the KSS Deanery. There will also be an open invitation to wider stakeholders such as yourselves, CCGs, independent sector, voluntary sector, local authorities and social care.

3. Measuring outcomes

Current legislation places an explicit duty on the Secretary of State to maintain a system for professional education and training as part of the comprehensive health service. The Education Outcomes Framework (EOF) sets out the outcomes that HEE will expect the Kent Surrey and Sussex LETB to meet. It also sets out the national indicators that DH will use to measure the progress of HEE and our LETB in delivering and improving patient outcomes across five key areas:

- Excellent education;
- Competent and capable staff;
- Innovative and flexible workforce;
- NHS values and behaviours; and
- Widening participation.

4. Kent, Surrey and Sussex LETB – Engagement with Service Commissioning

The Kent, Surrey and Sussex LETB needs to engage with the new service commissioning framework. We need to work with the National Commissioning Board, CCGs and Health and Well-being Boards to ensure that we can support our providers in securing the future supply of workforce required to deliver the services commissioned to meet patient need.

We will plan engagement with each part of the service commissioning framework at appropriate points in the education commissioning cycle. The central feature of the Kent, Surrey and Sussex LETB will be the delegation of decision making to employers, as they understand the labour market for the communities they serve and the skills they need for the services they are commissioned to provide.

5. Authorisation

The Kent, Surrey and Sussex LETB, will undertake an authorisation processes before the end of this financial year and will need to demonstrate engagement with the appropriate parts of the new system. As part of the LETB authorisation process LETBs need to demonstrate alignment of education and training needs to service commissioning intentions. Both service commissioners and the KSS LETB need to demonstrate that our responsibilities towards education and training are understood and delivered so that the needs of patients and the public are served by a workforce that has the skills and capabilities to provide safe, effective and compassionate care at all times.

6. Engagement between Kent, Surrey and Sussex LETB and Health and Well-Being Boards

- It would be helpful to have an agreed point of contact from our respective teams to be the primary link for communication and engagement;
- There will have an open invitation to attend the relevant (i.e. County level) Partnership Council which will provide the opportunity for engagement with the service providers in the area of workforce strategy and development. If Health and Well-Being Boards choose to work together and nominate a lead to represent more than one at the Partnership Councils, we will leave that entirely up to yourselves;
- Health and Well-Being Boards will be engaged in the development of the five year Skills Development Strategy, and the associated implementation plan (as described in Section 2 above). This will ensure the strategy it is aligned with the population need, planned service commissioning and will provide the opportunity for you to contribute to the strategy and to influence the way in which it will deliver the workforce to meet the needs of the population we serve.
- Within the LETB business cycle there will be an annual stakeholder event early in each calendar year which will focus on population need, commissioning intentions and service provision.

Brighton and Hove Health and Wellbeing Board Development

Jeremy Crabb

Local Government Association

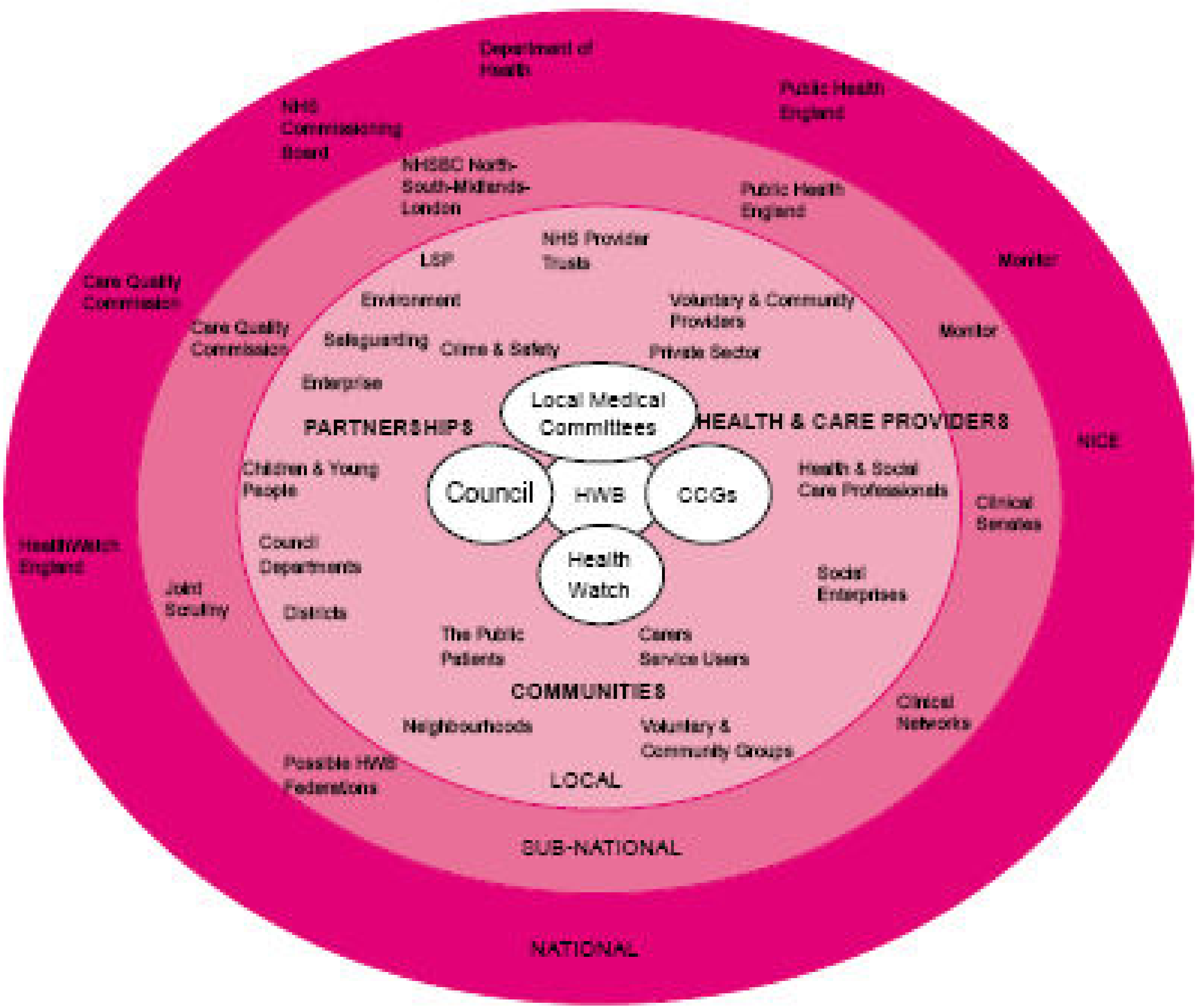
Structure

- Introduction
- Who am I?
- Why bother?
- Suggested approach
- Discussion and further information

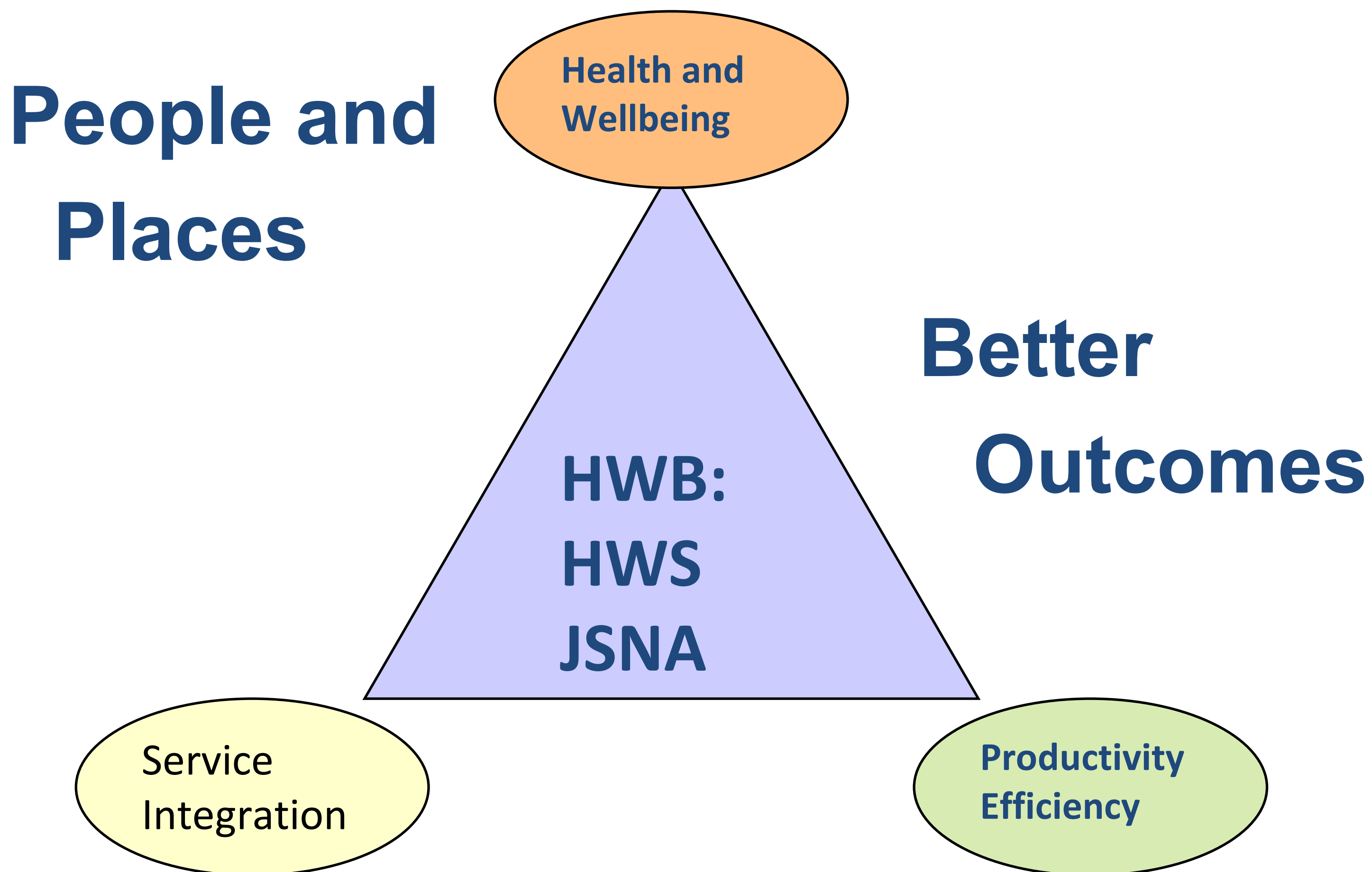
Who am I?

- Health and Wellbeing Boards, National HWB Learning Sets
- NHS Boards
- NHS/Local Authority senior teams
- Clinical teams, Royal Colleges
- Coaching Local Authority, NHS Executives, GPs, Consultants, Headteachers, Police
- PCT Director, PCG CEO
- MSc Organisation Development and Consulting (Distinction), BA (Hons), Cert in Coaching

Why bother?



Why bother?



Why bother?

- Complex landscape (even just the NHS)
- How HWBs handle it differs – Brighton and Hove will have/need its own way
- Identity not duplication
- Ability to work as a whole Board crucial
- Important to understand where you are up to, and then how you want to go forward

Suggested approach

- One to one telephone interviews (individual)
- LGA HWB development tool (collective)
- Further work based on areas of development identified

LGA HWB Development tool

Health, adult social care and ageing

A new development tool for health and wellbeing boards

LGA HWB development tool

- Purpose is to help HWBs go beyond assessing how ready a Board is, towards how effective it is being in practice, and how that effectiveness is enhanced over a period of time

Strategy, vision, purpose, values			
Strong relationships, agreed ways of working	Good governance	Roles and contributions	Measures and accountability
Outcomes			

LGA HWB Development tool - examples

Area	Now	In 1 year	In 3 years
Strategy, purpose governance	The Board understands its unique potential contribution and is ambitious to improve health and wellbeing	The Board has agreed a realistic set of priorities on which to focus its efforts.	The Board has demonstrated achievement against its priorities. It has a track record of enabling efficient, effective and integrated re-commissioning of services
Leadership, values, relationships and ways of working	Members have effective working relationships and are beginning to influence each other's organisations	Board members look for win-win solutions focused on beneficial health outcomes for the community. Relationships enable members to influence beyond their own organisations	Local organisations seek to contribute to the Board

Discussion and further information

- Any questions?

- Further information:
- jeremy.crabb@btinternet.com
- www.local.gov.uk

SHADOW HEALTH & WELLBEING BOARD	**Agenda Item 28** Brighton & Hove City Council

Councillor Rob Jarrett,
Chair of the Health and Wellbeing Board

Date: 4 October 2012

Dear Rob,

As you may be aware, the Health and Wellbeing Overview and Scrutiny Committee (HWOSC) recently received the attached 'Talk Health' report from Amaze and the Parent Carers' Council.

Whilst the HWOSC has not endorsed the specific recommendations, it recognised that it was an important and comprehensive piece of work and felt that it was vital that it was both seen by the appropriate audience and that there was a timely response to the recommendations within the report.

The HWOSC therefore agreed to table the report with commissioners. It is also seeking responses to the recommendations from the relevant service providers.

The HWOSC has agreed to use its statutory and constitutional powers to refer the report on to both the Health and Wellbeing Board (HWB) and to the Clinical Commissioning Group for their consideration.

I am writing to request that the 'Talk Health' report is covered at a future HWB committee meeting. I am also contacting the CCG to ask that the report is tabled there.

Please could I have your assurances that you will be willing to table the report as requested. It would be helpful to have this by 31 October 2012; an update on the recommendations is due to come back to the next HWOSC meeting.

I look forward to hearing from you in due course.

Yours sincerely

Councillor Sven Rufus
Chair, Brighton & Hove HWOSC

"Talk Health..."

Parent Carers' Views on Health Services in Brighton & Hove 2012

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1. Executive Summary

Every parent's first wish is for their child(ren) to lead as healthy a life as possible. When you become a parent you may expect to have some involvement with health services. You would expect to visit the GP and have, maybe, the odd visit to A&E. You might expect the occasional broken bone and high temperature.

Yet nothing prepares you for the journey you begin when you have a child with a disability. Due to their complex health, mental health and wellbeing needs this group of children use a wide array of health services.

> "This year, my child has seen two community paediatricians, a gastroenterologist, a neurologist, an occupational therapist, a physiotherapist, a speech and language therapist, a dietician, a ketogenic diet team, a geneticist, a surgeon, a school nurse, a community nursing team, several different teams of doctors and nurses at the children's hospital, ten different paramedics and her GP. She has attended medical appointments or hospital visits over 40 times."

a. Who are we?

The Parent Carers Council (PaCC) is a group of 190 parent carers of children with disabilities, complex needs or long term conditions from across the city. The group was set up in 2007 as a work stream of Amaze, a long established parent led organisation supporting parents of children with any special need in Brighton and Hove. Amaze supports approximately 1,600 families of disabled children in this area. PaCC is mostly funded by NHS Brighton & Hove with some funding from the Integrated Disability Services in Brighton & Hove and the DFE (Department for Education).

b. Why listen to us?

Disabled children's interaction with a wide range of health services can be intensive, extensive and expensive: they are high cost, high incident users of health services. A range of different health services are required including universal services (such as GPs), specialist services (such as specialist neurology services) and condition specific services (such as a service for children with visual impairment). Many of our local children travel up to London to see specialists in a specific field. However, this report is concerned with the services that are provided locally, in Brighton & Hove.

Health professionals from across acute, primary care, specialist services, palliative care and community-based services must actively seek the views of these young patients, and those of their parent carers, if they are to ensure that their experience of health services are as positive as possible. We have sought the views of parent carers who use health services extensively in order to create this report which we hope will help to improve the efficiency and quality of the health services from the perspective of children with disabilities and special needs. For instance, children with disabilities and complex health needs and their families may have used A&E services at all times of the day or night and can provide expert views on what could be improved more than the occasional users. We hope that by addressing the concerns of parent carers, the following outcomes could be achieved:

- More efficient use and targeting of scarce health resources
- Improved quality and 'fit' of service
- Greater user satisfaction with services and fewer complaints

c. Key Recommendations

See the report below for our full lists of recommendations but the top three key areas that we urge further attention and investment in order to improve the lives of disabled children and young people and to assist them to fulfil their potential are:

- Further improving Parent Participation

The parent carer voice needs to be represented at the highest level in order to ensure that services are as good as they can be for disabled children and their families. The Care Quality Commission's (CQCs) review of services for disabled children [see below] showed that there were few care plans across Sussex with little information about waiting time for therapies but that Brighton and Hove was the only area with "adequate involvement of children and families in assessments, inductions and training". This is very positive and can be built upon. The voice of parent carers needs representation on the new Health and Wellbeing Board, Children's

Committee and Clinical Commissioning Group's Children's Review Board. The PaCC needs increased financial support to ensure that it continues to carry out its vital participation work and reach new, further marginalised groups of parents in the city. We believe that Public Health should match the investment in PaCC that the PCT/CCG makes in order to continue this very valuable work, and that the new CCG should continue this funding at a higher level, if possible, to reach families who face multiple disadvantage and face health inequalities. There needs to be better evaluation of health services. Parent Carer feedback could be standardised across all health service using a standard form. Health services should invite parent carers in to 'evaluate' their services using the Partnership Charter [see appendix 1]. CAMHS has already asked to do this and this should form part of a wider 'parent review' of CAMHS.

- Increased resource for services

The need for increased community support is a strong theme throughout health services. A specialist paediatric epilepsy nurse would be cost effective in the long run, reducing stays in hospital and greatly reducing stress levels in family members looking after children with very complex epilepsy. The community nursing team is under resourced, and there are only two specialist health visitors, who provide vital 'early' support. Also, the disability liaison nurses in adult services are making a huge difference to the experience of adults with learning difficulties in hospital. The same post for paediatrics would greatly improve the experience of young people and their families in hospital. This would reduce complaints and even reduce hospital stays as this valuable professional can give advice over the phone too. Many parents play a 'keyworker' role in their child's health care and this should be recognised and supported with increased access to resilience training (Insiders' Guide offered by Amaze). For those families who do not feel able to play this role, a keyworker is needed and this will become even more vital with the implementation of the new single Education, Health and Care Plan.

- Improved communication and transparency

It is frustrating to see that after 5 years of review, access to therapies is still a huge problem for many children and waiting times are still unacceptably long. There needs to be a citywide code of practice for GPs and young people in transition. Parent journey training (taken up by some professionals) should be made mandatory for all professionals, including consultants. This would greatly improve communication between health professionals and families and reduce complaints. Communication needs to be improved between the multitude of health professionals involved in children and young people's lives. Parent carers should be routinely copied in to any correspondence about their young person and should be routinely given details of eligibility criteria and waiting times.

2. Focus on Health: Why Now?

a. Increasing levels of disability and complex health needs

Nationally, we have seen a marked increase in the number of children with disabilities and complex health needs, due to the increased survival of pre-term babies, children making a better recovery from severe trauma and illness and an increase in children on the autistic spectrum and with mental health issues. This trend is reflected locally.

b. Child Poverty & Health Inequalities

There is a well-documented link between disability and poverty. It costs 3 times more to bring up a disabled child than a non-disabled one and over half of all families with disabled children are living in (or on the edge of) poverty. [Appendix 2 shows the membership of the City's Disability Register, The Compass, by ward].

In Education, there is a City-wide, strategic drive to 'narrow the gap in attainment' between children in schools with Special Educational Needs (SEN) and we believe there should be a focus on reducing health inequalities (as far as possible) in this population. It is known that inequalities exist for adults with learning disabilities, as underlined by Mencap's report Death By Indifference (which highlighted cases of undiagnosed illness and even avoidable death). A new Children and Families Bill will set in place provisions to allow families with a single Education, Health and Care Plan access to a personal budget by March2014. If successful, we believe the single planning aspect will provide an opportunity to see a more joined up approach.

PaCC representatives have been significantly involved to date in the SE7 Pathfinder looking into some of these new ways of working. It is still unclear how planning for health outcomes will be incorporated and whether any elements of health budgets will be passed to the family to direct. What is clear is that t is parent carers are provided with sufficient support in any new system to ensure the family get the desired benefits in terms of increased feelings of choice and decision making/buying power.

c. New Health Bill

The PaCC aims to represent the views of local parent carer in the areas that really matter to them and their children. During 2010-11 we reported on parent carer views on education at a time when SEN (special educational needs) was going through huge change and reform (and this work is ongoing). The same is now happening within health, with the biggest changes in the system for 60 years.

We want to ensure that disabled children's very unique needs are prioritised within this, not only at a national level, but also locally in Brighton & Hove. Amaze and the PaCC have fed into the Children's and Young People's Health Outcomes Forum, co-ordinated by the Council for Disabled Children.

Our focus on health has also been timed to coincide with the establishment of the City's Clinical Commissioning Group (CCG) and the movement of Public Health back into the local authority and we hope to present our findings to these Commissioners and feed into the City's Joint Strategic Needs Assessment (JSNA) and new Health and Well-Being Board

d. The evolution of parent participation

Parent Partnership working is evolving in a really exciting way in the City, in some areas resulting in true co-production and this must certainly be the way forward. When parents and professionals work together, from the earliest stages of service design, outcomes improve for disabled children. We need to ensure that the voice of parents of disabled children is heard at every level and this is starting to happen in Brighton & Hove because key people operating at a strategic level are working closely with parent carers.

Parent carers are represented on the city's key decision-making boards including the Disabled Children's Strategic Partnership Board, the CAMHS Partnership Board, the SEN Partnership Board and the Learning Disability Partnership Board. They are involved from the outset on the development of information for families about local services for children with disabilities. Parent carers are also now being included on interview panels for key health professionals such as occupational therapists, speech and language therapists and nurse consultants.

In fact, Brighton & Hove is by national standards, well advanced in parent partnership work. Last year saw the launch of the Partnership Charter, a ground-breaking piece of work based on the principals of Aiming High for Disabled Children where teams of trained parent carers 'assess' local services. [see Partnership Charter in Appendix 1].

Although locally, parent partnership has come a long way as with many things, some services and individual professionals are doing this better than others. We hope this report will set out some of the good practice that is occurring in health and highlight where this can improve.

3. Methodology and Report Structure

This report has been written to capture a snapshot of parent carers' views of local health services. Given the number of different health services families with disabled children make use of, the PaCC Steering Group decided to prioritise discussion about just four. These are:

- The Royal Alexandra Children's Hospital (RACH)
- Seaside View Child Development Centre (Seaside View)
- Child And Adolescent Mental Health Services (CAMHS)
- General Practitioners (GPs)

At the event we did ask parent carers their views on community health services. However many of the comments that parents made were about community services provided by RACH and Seaside View and therefore we have decided to incorporate these views in to the relevant sections.

We asked parent carers to feed into this report in a number of ways:

- The PaCC held a 'Talk Health' event [in March 2012] providing parent carers with the opportunity to discuss the four areas above, with a senior professional from each service area in attendance to listen to their feedback. [Appendix 3 lists the professionals who attended.]

- The Amaze Health Information Fair took place in November 2011 as a launch event to our focus on health and providing parents and practitioners to come together and share information. A focus group was facilitated to allow parents to discuss 'communication with healthcare providers'.

- The Amaze Parent Carer Survey circulated via the Amaze newsletter to 1200 families. 114 responses returned.

- In addition, we carried out telephone interviews with a further 30 parent carers and asked for feedback on the PaCC Facebook group, which has a current membership of 50 parents.

As such, this report is the result of PaCC talking face to face to over 50 local parent carers about their experiences of local health services as well as email, Facebook and survey results from 164 parents. Our hope is this report will clearly present a picture of the common experiences which families with disabled children face when using healthcare services in Brighton and Hove.

We aim to table this report at the newly established Health & Well-Being Board and the new Health & Wellbeing Overview and Scrutiny Committee, among other key strategic meetings in the City. Our purpose is to facilitate discussion and raise the agenda of improving health services and ultimately the health outcomes for this disadvantaged group of children and their parent carers.

4. Parent Carer Findings

This is a snapshot of parent carer experiences in Brighton & Hove. It aims to represent the wider local experiences of health services that families encounter on a daily basis.

a) The Royal Alex Children's Hospital (RACH)

Positive findings

- The hospital

Parent carers acknowledged that the new RACH was a fantastic resource to have on your doorstep, without having to travel out of area. The new children's A&E department was really well received by parent carers and many recalled the 'horror stories' of taking their child to the adult A&E. The triage system worked well and mainly the feedback about communication and understanding of disabled children's needs was good.

- Community services linked to the hospital

Parent carers told us that community support was good, but would like to see the service expanded. Parent carers were very positive about the community nursing team which provided excellent support to parent carers in their homes teaching them to care for nasal gastric tubes or gastrostomies. Parent Carers described them as "well briefed" with a "good understanding" of their child's condition.

"My son is on the autistic spectrum and is very anxious. They had really thought through the whole experience. They had an extra member of staff to help and had his favourite DVD poised to play as they took the blood."

- Departments providing an exceptional service

Phlebotomy services came out as particularly strong in the way they interact with disabled children. This was reported by several parents who also noted that the service had "really improved" over recent years. There is also regular paediatric first aid training offered for parents free of charge and this has been offered on a 'bespoke' basis for one family who have a child at risk of choking and having breathing difficulties. This is really exemplary.

Areas for improvement

- Parents were left unsupported prior to diagnosis

Often children with disabilities need to be monitored for long periods of time before they get any firm 'diagnosis' or plan of action. Parent carers understand this need to 'wait and observe' approach but felt that some sort of early support while they are waiting would have been ideal.

"My little girl had a very traumatic birth but despite the fact that her EEG showed abnormalities we were left to 'watch and wait'. We went up to the main hospital and she was 'observed' by junior doctors but nothing seemed to be moving. We found it very difficult to get in to the process, despite the fact that I, as her mother, knew something was wrong."

- Communication between different professionals was often poor

Disabled children have many assessments carried out by a myriad of different professionals. Communication between them could sometimes be improved.

Communication also needed to be strengthened between RACH and Seaside View and parent carers reported a 'disconnect' between specialists at Seaside View and, particularly, reports of A&E visits or unplanned admissions at RACH. Many of the children were treated in specialist units in London and communication could break down between these specialist London hospitals and RACH. One parent reported that having been transferred from Kings College Hospital in London to the RACH, they were approached by a member of staff who asked them "why they were there". The parent became quite agitated before a plan of action was drawn up.

- Parent Carers had to repeat their 'story; over and over (and over) again

Parent carers told us that this can be really irksome. Some noted that taking their child's 'most recent letter' helps but even this didn't totally prevent the repetitive process. The Disabled Children's Acute & Community Liaison Group is looking in to improving this experience by producing an All About Me document that would be carried with the disabled child and their family. This gives basic information about diagnosis, medication and communication methods etc. Hopefully this will help to improve the in-hospital experience of families of disabled children. This is not a 'local' problem but a national one and has been noted in the Kennedy Report.

"I feel that the liaison between consultants at the hospital and professionals at Seaside View is not strong enough. My son has severe seizures and cerebral palsy and when we arrived at hospital, they said that did not know him and could not advise. We had to tell our story again from the beginning. It was if the consultant we were talking to knew nothing about children who attended Seaside View."

"They just don't have time to talk, or to listen"

"The consultant presumed that my son has no understanding of language, because he is wheelchair bound and has a progressive disorder. He started to talk about 'end of life' options in front of him! I was absolutely horrified."

"We were given the first appointment, only for the consultant to be late. He sauntered in 30 minutes late, as my child finished dismantling the over-stimulating waiting room."

"My son hated being on a mixed age ward. No adjustment was made for different ages - in terms of waking times etc… It wasn't an appropriate environment for a teenager."

- Nursing could be inconsistent.

Parent carers reported examples of outstanding practice. They reported that some nurses had extensive experience of working with children with disabilities and special needs. For instance, one child was looked after by a nurse who had worked at a local children's hospice.

However, there were also examples of inconsistent practice. Parent carers told us about nurses who appeared to lack basic disability awareness training, had little understanding of parent carer experiences in hospital and the demands this placed on them. This meant that even to make a simple trip to the toilets had to be planned to ensure that their child was not left unattended, even for a minute. Staff were not always proactive at offering this help and only did so when they were asked. Some staff gave confusing and conflicting advice about specialist equipment and had a 'rushed' approach to parents.

Parents overwhelmingly felt that they were the 'experts' on their child's care and that without them, many nurses would not know how to effectively care for their disabled child. Several parents reported that the lack of a paediatric neurologist on site was difficult when a child with complex epilepsy presented in A&E in 'status epileptics'.

- Consultants can lack sensitivity and make judgements about children with disabilities.

Parent carers reported that some consultants could be patronising or distant. Often there were several students in the room "who were not introduced to me or my child". Some interactions with consultants had lasting and devastating effects. One new mother was told to put her newborn baby down in the cot while she was told 'what was wrong with her'. One family were treated with a lack of empathy and told that "their daughter had half a brain" with no appropriate explanation or a caring delivery of such devastating news.

- Waiting times.

Consultants did not automatically put children, with special needs, first on the list so children who found it difficult to wait had to wait for long periods of time. This was improving, but consultants needed to be mindful that they needed to start their clinics on time, where possible.

- Parking facilities are unacceptably poor

There is one disabled bay at the Children's Hospital. All the parent carers were dismayed by the parking facilities. There were bays in the car park but most of the time, there was such a long queue (often a waiting time of half an hour or more). This was very stressful for families who had a child with special needs. The on road parking nearby was on a hill and parent carers reported "struggling" up and down hills with a wheelchair or a child who was unwilling to walk. One parent carer reported that the experience was so stressful for her child, who is on the autistic spectrum, that her son started to "head bang and hit us" before they had even made it to A&E.

- Mixed Wards and Transition anxiety

Teenagers with a learning disability were placed on a 'mixed age' ward and while difficult for any teenager, this was particularly difficult for a teenager with a disability or special need.

Parents reported a general anxiety about the transfer to adult services, particularly if they had not had a brilliant experience at the children's hospital.

Parent Carers' Recommendations about RACH

- Parking

Priority should be given in the car park to those with a disabled badge allowing them to queue jump as the bays are there but parents can't get to them and more bays that are currently for 'drop off') freed up for 'disabled badge' holders only. The parking situation frequently puts a visit to hospital off to a really bad start. This could easily be solved.

> "I cannot think how my son [now 14] could manage being in a mainstream adult ward in hospital! We need to know he will be catered for and supported in adult services by making available specialist 1:1/2:1 staff to be with him on the wards, appropriate medication/equipment with a single room, giant cot/portable safespace, sedation etc."

- Parent carer involvement in regular groups

Since the PaCC health event, a PaCC representative is now on the Disabled Children's Acute & Community Liaison Group (a group that aims to improve the experience of disabled children and their families at RACH and also the links with community health services) but parent carers want a wider consultation group and opportunity for senior managers to listen to their concerns.

- Parent journey training for all

Parent journey training should be part of the standard induction for RACH staff and should include consultants, doctors and nurses working at RACH. Amaze offers training workshops, delivered by parent carers, which cover the parent carer journey. We could also develop a protocol on how to treat parent carers differently when they arrive at RACH, in partnership with staff there.

- 'All About Me' Documents

Since holding the health event, it has emerged that this is an area that is being looked at. Although this is a great idea in principal, professionals need to think carefully about who holds this document and how several copies need to kept updated (in settings such as school, respite home, GP and family). There needs to be a really clear explanation of the difference between these and the 'passports', traditionally used by the main hospital. Many parents will need help filling these in. There needs to be thought about how these documents will change/be modified during transition.

- Disabled children given priority

Disabled children should routinely be put first on the list and where possible consultants should ensure that they arrive on time for clinics especially when the first appointment is for a child with special needs. There needs to be some liaison to ensure that as many appointments as possible are on the same day so that parent carers aren't having to repeat the trauma of a hospital visit unnecessarily.

- Specialist disability liaison nurses

This would be the ideal. There isn't a paediatric 'disability' specialist available and it is 'hit and miss' whether you get a nurse with any real experience. A specialist nurse could train up nurse teams on ethos and approach and ensure consistency. For instance, Kings College Hospital employ a Nurse Patient Liaison Officer that parents can contact at any time. She is able to give direct advice over the phone or contact another professional for advice if required. This has meant that unnecessary trips to London have been avoided because parents can be reassured over the phone.

> "CAMHS has really taken on board everything that has been said by parents and their stories all correlate with each other. So hopefully we will see some improvements."

b) CAMHS

Positive findings

- New Parent Group

The service is listening to parent carer concerns and is keen to develop its partnership working with parents to improve the service.

> "We had to wait nearly a year to be seen and they also said they would review my son [once seen for the first time] and this hasn't happened. You can only be seen by a specialist in ASC if you have a statement."

- Specialist Nurses offer home visits

Several parent carers reported a really positive experience with the specialist CAMHS nurses. One said that she felt "supported and understood" and that really useful, practical help was given with daily challenges, such as going on a simple shopping trip.

Areas For Improvement

Out of all our local health services, parent carers report that CAMHS is the hardest to access and the most difficult to negotiate.

- The waiting time for an assessment is too long (and no support is given in the meantime).

Parent carers reported being "stuck in the system" and "left to it". Guidance for parents as to how to deal with

This story, from a mother who has a son with mental health problems, is typical.

"I have a child with mental health problems. CAMHS? Where can I begin? It takes far too long from point of referral to actually seeing someone, even if your child is really quite poorly. They take stance of it being a family problem as opposed to a medical one or with the child. I have found psychiatrists quite arrogant and often not up to date with the latest developments. I had to make formal complaint and see a third psychiatrist from another county before got anywhere. This psychiatrist said that that my son should have had a proper care plan from the outset. It is the most stressful and exhausting experience I have ever encountered."

their children at home whist waiting to be seen by the consultant was not forthcoming and parents felt that time was wasted.

- Parents were not empowered or treated as equals in their child's care and reported that they felt their confidence had been eroded

Many parents reported a feeling of 'disempowerment' when engaging with CAMHS. Several parents described feeling as if professionals felt they were to 'blame' for their child's autistic spectrum disorder. Parents were universal in their criticism. Several parents reported turning to voluntary organisations, such as Amaze and Ayme (Action for Young People with ME) as they were not getting a quality service from CAMHS.

- Transparency was poor

Parent carers reported that there was little transparency on how to access the CAMHS system, and how it works once you are in. Also, this feeling of a lack of transparency was exacerbated by the use of 'psychiatrist's' language and lingo that parent carers did not understand.

Parent Carer's Recommendations about CAMHS

- Better information (about what CAMHS does and who is and isn't eligible for input and the different sections of CAMHS). Parent carers need to be involved in the creation of this information from the outset.

- User satisfaction survey to be sent out (as agreed by the Children's Overview and Scrutiny Committee last Autumn) and results analysed and presented back to the Disabled Children's Partnership Board and Health and Well-Being Board.

- Transparency about pathways of care and waiting times.

- Training for psychiatrists in the parent journey. There needs to be an ethos change so that parents are seen as the experts in their child's care. This was a very powerfully voiced recommendation from parent carers who said that psychiatrists (some of whom were very newly qualified) made them feel "patronised".

- Autism specialist needed.

- Behaviour network for children with severe behavioural difficulties set up. This would provide much needed support for families who are struggling with behavioural issues, allowing them to support each other as well as get professional input.

c) Seaside View Child Development Centre (Seaside View)

The relatively new integrated child development service has been well received by parents and this is a huge strength in Brighton & Hove, compared to other areas which do not have integrated services. Parents reported a feeling of 'joined up' care and really good liaison between different professionals.

Positive findings

- The coordination and communication between professionals at Seaside View was very good

This was universally reported by parent carers. One talked of the new 'invitation to join', which meant a key Seaside View professional was able to refer you to a new service, without having to get the parent to revisit their story from the beginning again. Seaside View was also working really well with outside agencies (one parent carer reported that the therapists worked really well together at her child's mainstream school). Parent carers also reported the excellent service by the receptionists who always passed messages on efficiently. They were also very welcoming to families and included the children and young people when they visited the unit.

- Personable and approachable staff

One parent carer reported that her child on the autistic spectrum was very anxious about her visit to the

occupational therapist but viewed it as a very positive experience. She was very understanding and had a real grasp of her child's difficulties.

- Excellent team of paediatricians

All the parent carers gave positive feedback about paediatricians who they described as 'knowledgeable' and 'empathic'. Many parents described their paediatricians as 'going the extra mile'. Almost all parent carers reported that they were "treated as equals" in their child's care.

- Keyworkers and Specialist Health Visitors

The new team of keyworkers was well received by parent carers. However they were a very small team (of two) so many families (who have multiple professionals involved with their child) were left without a keyworker. This will become even more resonant, with all the changes proposed by the SEN green paper and there will need to be very careful consideration as to how families are supported. Parent carers were universally positive about the small team of specialist health visitors at Seaside View but as it is only a team of two, it is limited.

Areas For Improvement

- Waiting time transparency

One parent reported their child had been referred two years ago and was still waiting for an appointment. Another parent carer reported that her child was referred every two to three years and was still waiting for an OT appointment. Her child was now due to start secondary school in September. Eligibility for Seaside View services and how children are prioritised needs to be clearer.

"When giving the diagnosis (of a rare chromosome disorder) we felt they could tell us very little but surely they could have referred us to Unique or even used it themselves to download information?"

- Better signposting

Parent carers reported that, on the whole, professionals at Seaside View were very good at pointing them in the direction of Amaze of further help/advice. However it was felt that this could be improved. Parent carers felt it would be helpful if Seaside View staff could have signposted them to national support services as well and would have preferred a professional steer rather than "scaring myself on the internet."

- Equipment

This was a widespread problem. Parent carers reported huge delays in equipment (a 6 month wait for a sling/slide, for example). They also reported a lack of highly specialised equipment. The waiting time could be so long, that by the time the specialist equipment arrived the child had outgrown it. This is a particular problem at transition, too. There is confusion over who has responsibility to provide/replace/monitor equipment once a young person reaches 19.

- Therapies

Significant problems still existed with the provision of therapies. The PaCC and Amaze produced a report, "More Therapies", four years ago see http://www.amazebrighton.org.uk/editorial.asp?page_id=253 and whilst there had been some improvements with improved information about the services provided many of the problems identified in that report had still not been resolved. There was a perceived lack of parity about who was eligible for therapy and how much input they got as well as serious concerns about waiting list times for referrals as well as appointments.

Waiting times from referral to treatment were above the national average in 2011 for occupational therapy and physiotherapy see Care Quality Commission's review of Support for Families of Disabled Children see: http://www.cqc.org.uk/sites/default/files/media/reports/20092010_Support_for_families_with_disabled_children_BrightonandHoveCityPCT.pdf

In particular, parents reported some children were receiving speech and language therapy (SALT) once or twice a year and others got SALT in intensive blocks of weekly provision for a set number of weeks. Parent carers reported finding it very difficult to get sufficient physiotherapy and OT input, even if it was on their child's statement as services were 'overstretched'. One parent reported that it was not clear how occupational

therapy was broken down. One family was told they could not get any 'sensory integration' input for their child and it was only when they complained that this was provided. Some parents reported a high staff turnover within the physiotherapy team had led to inconsistency of provision. Some parent carers were buying in private services to supplement what they get. Parents also report that therapy input appears to be reducing in schools and there is confusion as to whose responsibility this is. Also, there needs to be better planning for therapy provision once young people reach transition. Parent carers report that often families have "no idea" what is going to happen next or who is responsible for next steps. There are problems within Speech and Language therapy services as adult services use a different set of symbols to the Makaton symbols young people are used to and need to embrace the continuing use of VOCAS (Voice Output Communication Aids).

We have been provided with the current (July'12) waiting times for therapy services and some of these still seem unacceptably long:

Speech and Language Therapy	referral to first assessment 6 weeks	referral to first treatment 8 weeks	
Physio	urgent/semi-urgent 4-8 weeks	non-urgent 52 weeks	
Health OT	pre school children with complex needs as part of a multi-disciplinary assessment 10-12 weeks	School age children as part of a multi-disciplinary assessment 22-26 weeks	
	pre school children with complex needs 12-18 weeks	School age children 52 weeks	
Social Care OT	urgent needs 5-10 days	High priority 10-20 days	Chronological order of referral 9-12 months

Parent Carers' Recommendations about Seaside View

- Therapy Assistants

Following the More Therapies report several years ago, the local authority carried out a review by an external consultant. One of her recommendations was to introduce therapy assistants. Whilst parents would rather have fully qualified therapists working with their children, there is acceptance that this is unlikely to happen given the current lack of additional funding. In this climate, we would welcome a renewed discussion on how therapy assistants could supplement the work of fully trained therapists – providing guidance to TAs and parents about how they can help their children in between appointments.

- Transparency about waiting times and eligibility

There needs to be a coherent system (across therapy services) telling parent carers who is eligible for what and why and what estimated waiting times are. Parent carers need useful advice in the form of advice sheets/ parent groups (such as the Hanen Programme which was run at the child development centre in the past) to help them feel 'skilled up' to help their child in the interim period.

- Information at Seaside View is good but could be better.

Professionals need to ensure that they have the very latest information on different conditions and that they can always signpost parents to other areas of support. Whether this is locally (Amaze or local parent groups such as Pebbles or Sweet Peas) or nationally (websites, support groups such as Unique, for children with a rare condition or Swan, for children with an undiagnosed condition). We understand the Council and Amaze are undertaking a joint project to improve web based information for parents which might help to resolve some this

"OT is particularly hard to get. My child has cerebral palsy and severe epilepsy and we still struggle to get any advice about what do at home. The only service we get is that they advise school on a termly basis. We have sourced and paid for all our equipment apart from his commode. We would benefit from advice on exercises that would help with my son's self help skills but this service has been overstretched and understaffed for as long as I can remember. There seems to be a real inequality in this service"

situation but it needs to be recognised that not everyone has access to the internet. Information needs to also be produced in hard format.

d) GPs

Research carried out by Contact a Family shows that 75 per cent of families with disabled children do not visit their GP about their condition. The relationship between families with a disabled child and their GP is particularly vital on many fronts particularly as children's care is transferred to their GP at 18. GPs knowledge base is understandably wide and their in depth knowledge about specific medical conditions can be limited. For children who have learning difficulties and/or other medical needs but are not eligible for a paediatrician, the GP is absolutely the key medical figure in that child's life.

Positive findings

- Innovative local solutions

Parent carers reported that some GPs offered services that were making a real difference to families. Such services included an Online booking appointment system for GPs, a drop in clinic for children, a separate room organised for child with challenging behaviour, 'telephone' appointments and home visits.

- GPs see the family as a whole

Parent carers reported that their GP was very holistic, seeing the family as a whole and gave 'carers' support. Families reported being regularly asked how 'their' health was as the main parent carer. GPs also got involved in much needed referrals for respite. Parent carers reported GPs asking if they got enough respite and if they could write letters to support their access to more help.

- Some GPs are taking annual health checks seriously

All adults and young people in transition will have to have annual health check and some GPs are ahead of the game on this. One parent carer reported that her daughter had already had a health check at 14. It is hoped that health checks will pick up health problems that may have gone unnoticed or undiagnosed.

Areas for Improvement

- GPs sometimes lacked knowledge about specialist services

Parent carers reported having to 'fight' to be referred to specialists or that GPs knew nothing about the variety of specialist services which might be available. Parent carers may find visiting their GP so stressful and demoralising that they avoided taking their young person to their GP. This sometimes resulted in a child becoming very ill before their parent accessed medical health. Some parent carers reported going to A&E as an alternative.

"My son has a very complex health problem. Our GP knows him really well. But the problem is when you see a locum GP out of hours. Our son needs antibiotics at the first sign of a chest infection as, otherwise, it can turn into a life threatening problem and he ends up in hospital for weeks needing suction. A locum GP told us that he was not 'ill' enough for antibiotics."

- Prescription errors

Parent carers reported incidences where the GP had written a prescription for their child which was inaccurate. Medication and dosages had been changed by specialist consultants who had not communicated this change to the GP. There seemed to be an understanding that parent carers would update the GP which was felt inappropriate. One parent carer reported that her GP was brilliant at double checking medication but that the labels on the bottles of medicine were often out of date and inaccurate.

- Inconsistency across the city

Whilst some parent carers reported that they had a very good relationship with their GP, others find it problematic. One parent reported that her son, who was on the autistic spectrum, did not have a community paediatrician and that she only took him to the GP if he was 'really ill' as he had little understanding of her son's complex needs. Also, out of hours doctors didn't always know the family history and needed to ensure that they respect the views of parent carers. When visiting the surgery, parents reported differing experiences of their initial contact with reception staff. There was a lack of understanding and, as one parent put it a "can't do" attitude.

"My GP is very helpful but there is little recognition of the emotional and mental problems that go with a disability, both for the young person and the parent. Also, appointment times are too short when your child has such complex difficulties. GPs need improve how they signpost to other agencies"

"I am hugely worried about transferring care to the GP. My son is unable to wait in a waiting room, there is no disabled parking at my GP and he has not specialist knowledge of learning disability. One parent I know had an awful experience when her child had to stay in the car, as they were restrained, in order to be seen by their GP."

- Some GPs do not 'take care' of the whole family

Many GPs do not realise that they have a statutory responsibility for the health of parent carers.

When young people reach 18 the main professional becomes the GP. In the lead up to this, if families and young people have not built up a relationship with their GP this transition is problematic because the GP does not always have enough understanding and knowledge about their complex medical condition. This did not give families confidence in the GP's ability to look after their young person. Challenges were also faced by parents whose children were 16 and had learning difficulties . They were not able to take responsibility for their own health needs and parents found that professionals who lacked knowledge in this area were asking them to do things they were not allowed to do.

Parent Carer Recommendations about GPs

- A route map of services that will give GPs information and points of referral to specialist services when a parent goes to them for a consultation. This information also needs to be given to the parent so that they have a clear idea of possible wider medical concerns. Information could be provided by Amaze.

- Disabled children need to be prioritised

Waiting times should be reduced. Disabled parking bays need to be provided routinely outside GP surgeries. If access is not possible, then provision needs to be made for disabled patients to park in the private GP car park.

- Home visits given routinely to children with disabilities and SEN who find it difficult to successfully visit the surgery. More thought must be given to out of hours GP services to allow families that have difficulty accessing the services during the day time to go to the GP when the surgery is also less busy.

- Training for GPs and families on power of attorney/mental capacity act so that families are clear about their responsibilities and GPs do not put families in a difficult position by asking them to make decisions for their young person that they have no power to act on in the eyes of the law. GPs also need to be given the parent journey training alongside other professional so that they can empathise with families who have a caring role.

- A holistic approach needed by all GPs.

They have a duty to look after parent carers too and should routinely look at their health/coping capacity. GPs should produce a protocol to ensure that the needs of the wider family are taken in to consideration when a young person visits the GP.

- Transparency and communication

Eligibility for referrals needs to be clearly explained to parents. All communication from specialist consultants should be routinely copied to parents and the child's GP. There needs to be really careful monitoring of medication and communication between the parent, GP and the pharmacist. This is particularly pertinent when new medications are introduced or doses are changed. GPs, pharmacists and specialist consultants need to routinely review the medication and ensure all labels are up to date and accurate. Many children receive respite care in other settings and inaccurate labelling could lead to medication errors resulting in serious harm. Information stored in the All About Me document needs to be transferred so that it includes the out of hours service provided by the GP.

- Health reforms- need a parent voice

The new CCG is currently consulting on how to engage patient populations and are keen to develop Patient Participation Groups (PPGs) at GP practice level. Amaze has fed into this consultation that it is very unlikely PPGs will be accessible to parent carers so there needs to be other attempts made to hear their voices. We suggest Amaze and the PaCC can represent parent carer views on a city-wide basis and we should be invited onto key strategic decision making groups where possible to present these views and be influential at service design.

- Extend examples of good practice that are making a real difference to all GP surgeries.

Code of practice for disabled children and their families to be disseminated throughout.

- GPs who are responsible for a child with a learning difficulty or other special need that do not have a specialist paediatrician, need extra support and training.

They are the key person and need to be supported to fulfil this role. This group should be earmarked and liaise with each other and access specialist training (e.g.: training on the autistic spectrum, how children with communication difficulties express pain and so on…). This could be done through the Nurse Consultant at RACH.

5. Conclusions and Parent Carer's Key Recommendations

So what are the priorities for parents? Often, it is not blue sky stuff, such as a magical cure or revolutionary new treatment, but the less measurable, subtler nuances of care. Parents, who are at the coal face after all, experience the care, rather than live it. It is an emotional journey that is their daily life.

a) Parent Participation

i. A seat for parent carer (PaCC) representatives on the new Health And Wellbeing Board, Children's Committee, and Clinical Commissioning Group's Children's Review Board. The parent carer voice needs to be represented at the highest level in order to work in partnership to drive improvement in health services for the most vulnerable children in our local community. This is a vital starting point.

ii. Recognise the value of parent participation and partnership working and invest in it
As mentioned earlier in the report, the PaCC (receives some funding for its engagement activity via the PCT (now emerging CCG) but this contract will expire at the end of March'13. It is vital that the CCG can replace and if possible increase this funding so that this group of disadvantaged children can be well represented by their parent carers.

Indeed we are keen to reach more families who are not currently engaged with the work of PaCC and Amaze to improve our ability to represent the full diversity of needs across the City, but additional funding is required to do so. We believe Public Health should match the investment in the PaCC that the PCT/CCG makes in order for us to help them in their target to reduce health inequalities for this group further.

iii. Recognise and value the parent carers' role as child's keyworker in health care provision
Our comments come from our proven expertise of being the 'key worker' and deliverers of health care, therapies, education and emotional care to our children 24/7, 365 days a year, for their childhood, through their adolescence and often for many decades of their adult lives.

Navigating the health care system is not a skill that parents of disabled children are born with. It is one that they have to learn 'on the job' (a job they did not apply for…). They find that, not only do they need to adjust to new parenthood but they need to adjust to their role as a 'parent carer'. Parents describe themselves as having to be multi-skilled and have almost super human powers of resilience.

iv. CAMHS Parent Carer review
Parent carers need to work in partnership with CAMHS to review transparency and communication across the service at all tiers.

v. Service evaluations and user satisfaction surveys
It is good practice for 'customers' to be asked what they thought about a particular service and all health services should be asking for feedback as a matter of course. A standardised form could be developed and then rolled out across all services, including health. These would need to be allowed to be completed anonymously and sent into a centralised research team and results presented to the new Health and Well-Being board.

In addition, all the health services discussed here should be encouraged to invite pairs of parent carers to independently assess their service using the Partnership Charter. CAMHS has already asked and is due to be evaluated in the autumn of 2012. The (0-3) star ratings should also be made public and presented to the Health and Well-Being Board, Children's Committee and other key groups and communicated to families via the Amaze newsletter and most importantly by the service itself.

“I am my daughter’s nurse, her psychologist, her OT, her speech and language therapist, her gastroenterologist, he epilepsy specialist, her teacher, her advocate, her pharmacist, her PA… I am everything in my daughter’s world and it takes enormous amounts of energy and resilience to keep everything together. Sometimes, I just want to be her mummy.”

b) Increased resource for services

i. Bolster Community Support
Support in the community is very powerful, supports the principles of early intervention and is cost effective. For example, a specialist epilepsy nurse (which Brighton & Hove does not have in paediatrics) would give much needed support in the community. This would cut down visits to A&E, 999 calls, the input needed by community paediatricians and greatly reduce stress levels within families who have children with very complex epilepsy. The community nursing team gives invaluable support to children and keeps them out of hospital but they are under resourced and sometimes can’t make it to families when needed. Specialist Health visitors are a key professional at the very early stages and offer vital ‘early support’ but there are only two of them and many children cannot access their help. We need more specialist nurses and specialist health visitors (with greater focus on disabled children) working in the community to support our most vulnerable families optimise their health chances.

ii. Paediatric Disability Liaison Post at the RACH
Parents need somebody to liaise with over their child’s stay in hospital. At the moment, the hospital experience is not consistent. Such a post would greatly improve the experience of children with disabilities and young people and their families. This would reduce complaints and reduce stress levels in already over stretched services.

iii. Where necessary parents should be allocated a key worker
However, parents feel they are often expected to bring everything together, in a ‘key worker’ type role, and this is not always possible e.g. many parent carers might also have a disability or health concern of their own, there are other siblings to care for etc. Indeed, the ability of a parent carer to navigate all the health services their child needs, might be more or less do-able depending on where they are on their carer journey‘.

As such, some parent carers are unable to take on this keyworker role and in some instances this is not appropriate. This will be even more necessary with the implementation of the new Single Plan.

iv. The need to invest in parent carers’ resilience
We also need to be very mindful of the health of the whole family. Families who have a child or young person with a disability or special need experience immense levels of stress. Research by Contact a Family reveals that 49 per cent of the parents surveyed had been to their GP about feelings of depression and isolation and received either medication or counselling. In Brighton & Hove, 52 per cent of all carers have been treated for stress related illness.

Many parent carers in the PaCC have attended the Amaze ‘Looking After You’ and ‘Insiders’ Guide – Building Resilience’ 6 weeks courses which have been highly evaluated as invaluable by parent carers as they tackle feelings of isolation and provide techniques and strategies for dealing with everyday situations, asking for help and building their family’s resilience. The PaCC would like to see these courses being built into the Amaze core funding so they can be offered to families each year, and delivered in ‘harder to reach’ neighbourhoods where families may be more at risk of crisis.

c) Improved Communication and Transparency

i. Improved Communication about services, eligibility and waiting lists
Parents would like to see improved communication between GPs, consultants, hospital departments and families. Parent carers would like to be routinely copied in to any correspondence written by these professionals. They would also like to be kept informed of the eligibility criteria for services provision and the length of waiting lists so that expectations of service delivery times can be realistic. Parent carers are still ‘in the dark’ across many services about who is and who isn’t eligible and how long they will have to wait to receive a service. This needs to be urgently tackled so that there is absolute transparency for families from the outset. Greater transparency of the services provided will ultimately lead to increased confidence in the system and fewer complaints.

"As a Parent Carer, years are spent in an adrenalin-fuelled, 'flight or fight' mode. Life is truly a rollercoaster of emotion. I have seen many families break down under the stress of it all and most of my friends, who are parent carers, are on (or have been on) antidepressants and have regular counselling to cope with the immense pressures they face parenting their child."

ii. Therapy waiting times

This is still a problem despite therapy services being the subject of the first PaCC report in 2009 and subsequent internal and external reviews following this. We need to reduce waiting times urgently and be transparent with families about why the waiting times are so long.

iii. Training opportunities extended to all staff in the health care profession

The PaCC would like to see the 'Parent's Journey' adapted into mandatory training for all health care professionals working with children with disabilities and complex health needs. This will give professional a much better understanding of the context that being a parent carer has e.g. practical difficulties as well as emotional and physical demands. This would result in fewer complaints and much improved communication between the medical profession and families.

iv. GPs and transition

There needs to be a city wide code of good practice for GPs on disabled children's transition. Too many GPs lack an understanding of their young people who have a disability or special need and this can be calamitous when they take over their 'care' at 18.

Content provided by parent carers, compiled by:

Amanda Mortensen – Chair of PaCC
Debbie Collins – Amaze Parent Participation Officer
Rachel Travers – Amaze CEO

July 2012

Appendices

Appendix 1

Partnership Charter Outline

The Parent Carer Partnership Charter comprises 4 staged elements, each the result from extensive consultation and each supported by full documentation. They are:-

- Partnership Standards short checklist
- Parent carer star assessments
- Partnership Standards full checklist
- Disabled Children Integrated Services action planning strategy

Under each of the core offer standards the Parent Carer Partnership Charter sets out delivery milestones in three categories; 'at basic stage', 'in development', and 'advanced' – to give clarity to local areas about what they need to do in order to meet the core offer standards. The milestones:

- 'at basic stage' will have been met by local areas just beginning to think about and plan services that deliver on the core offer.
- 'in development' will relate to local areas that have progressed further and have many of the necessary elements in place.
- 'advanced' will have been met by local areas who are fully delivering on the core offer standards, with families firmly at the heart of their service planning and delivery.

This document will continue to be updated as practice develops.

The aim is to provide a constructive vehicle for on-going improvement in quality of partnership working between families of disabled children and service providers across all sectors. The function of the Partnership Standards is to provide an agreed baseline of good practice in partnership working and offer a constructive framework for on-going service improvement.

Key Features and Characteristics

The key elements which we believe are integral to the Parent Carer Partnership Charter and which we believe define it as a product are:

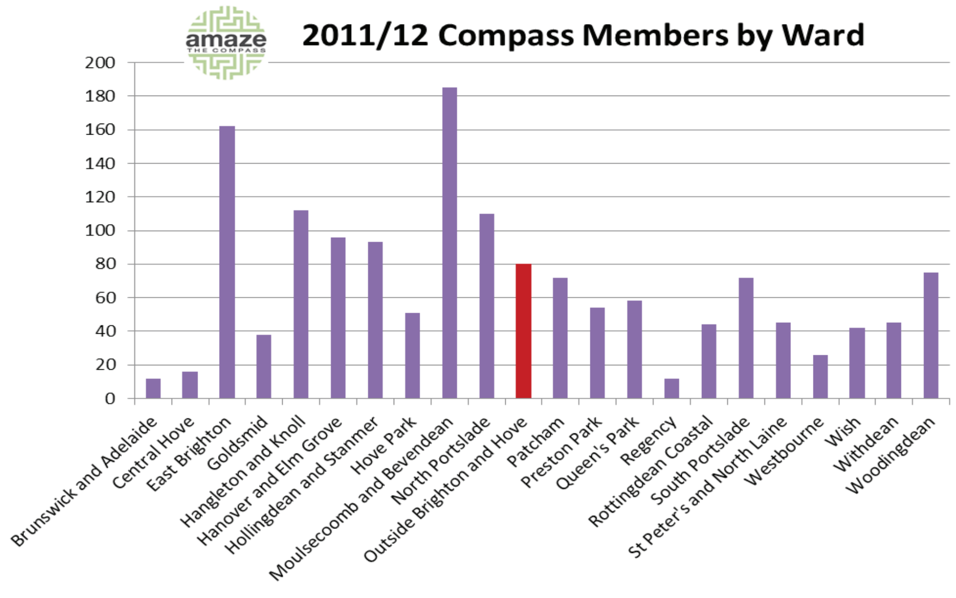
a. Defining and agreeing the standards and process in partnership with parents right from the start of the project

b. Training up of parent ambassadors to carry out the assessments, with this role being paid for in line with the Amaze Parent Engagement Policy, recognising parents as equal professionals. The Parent Ambassadors are suitably supported, supervised and accountable.

c. Positive assessment approach focussing on identified strengths as well as areas for development and allowing for the development of a relationship and dialogue between professionals and parents

d. The assessment findings are published an transparent including an agreed plan of actions with commitment where improvements are needed

Appendix 2



Appendix 3

Key senior officers/professionals attending the 'Talk Health' event were:

For RACH:
Janet Lee
Linda Gilmour

For CAMHS:
Tim Ojo
Peter Joyce

For Seaside View:
Jenny Brickell
Sian Bennett
Tracey Young

For GPs:
Dr Xavier Nalletamby

SHADOW HEALTH & WELLBEING BOARD	Agenda Item 29 Brighton & Hove City Council

Subject:		**Local Safeguarding Children's Board (LSCB) Annual Report for 2011-12**	
Date of Meeting:		**12 November (Children and Young People Committee) 5 December 2012 (SH&WB)**	
Report of:		**Alan Bedford, LSCB Independent Chair**	
Contact Officer:	**Name:**	**Sharon Healy, LSCB Business Manager**	**Tel: 29-0728**
	Email:	Sharon.healy@brighton-hove.gov.uk	
Ward(s) affected:		**All**	

1. SUMMARY AND POLICY CONTEXT:

1.1 The Apprenticeship, Skills, Children and Learning Act 2009 introduced a requirement for Local Safeguarding Children's Boards (LSCBs) to produce and publish an Annual Report on the effectiveness of safeguarding in the local area. Working Together to Safeguard Children 2010 (the statutory guidance) says "It should recognise achievements and progress as well as providing a realistic assessment of the challenges that still remain." Current guidance requires it to go to the Children's Trust and the Children and Young People Committee is has subsumed its functions. Draft revised statutory guidance, if implemented, will require reports "to be submitted to the Chief Executive and Leader of the Council, the local Police and Crime Commissioner and the Chair of the health and wellbeing board". The LSCB plans to send it to all chief officers of agencies concerned with children.

1.2 The Council has a statutory duty to ensure that there is an effective LSCB, but also is a provider of safeguarding services and a member of the LSCB. This item therefore looks at the report from a range of perspectives.

2. RECOMMENDATIONS:

2.1 That the Children and Young People Committee receives the Report, and recommends other Council committees where this might go in addition to the Health and Wellbeing Board.

2.2 That the Shadow Health and Wellbeing Board notes the content of this report, which was submitted to the Children and Young People Committee on 12 November 2012.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 This is the third LSCB annual report since it became a statutory duty. It covers the objectives, accountability, and organisation of the Board; progress against the 11-12 business plan; key areas covered by the Board especially those where a difference has been made; learning from case reviews; performance information; and summaries from reports from member agencies including the council's children's social care. The Chair identifies key issues in the year and 2012-3 onwards.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 A final draft of the 2011-12 report was sent to lead members of the LSCB's member agencies on 26 Oct 12 and agreed. The DCS was also consulted. It will be publically available including on the LSCB web site http://www.brightonandhovelscb.org.uk/

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 There are no financial implications directly resulting from the recommendations of this report. The financial information presented in the LSCB Annual report is accurate and a true reflection of the LSCB financial position within Brighton & Hove City Council's accounts.

Finance Officer Consulted: David Ellis *Date: 01/11/12*

Legal Implications:

5.2 The Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB). There is a requirement under the Children Act 2004 (as amended by the Apprenticeship, Skills, Children and Learning Act 2009) that at least once in every 12 month period, a LSCB must prepare and publish a report about safeguarding and promoting the welfare of children in its local area, and submit a copy of the report to the local Children's Trust Board. Under the council's changed governance arrangements the report will be submitted both to the Children and Young People's Committee, and the shadow Brighton and Hove Health and Wellbeing Board, and all member agencies. Section 14(1) of the Act defines the objective of an LSCB as (a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established, and (b) to ensure the effectiveness of what is done by each such person or body for those purposes. Whilst the LSCB has a role in coordinating and ensuring the effectiveness of local individuals' and organisations' work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partner retains its own existing lines of accountability for safeguarding and promoting the welfare of children by their services. The Committee will be assisted by the report in understanding the operational effectiveness of each agency.

Lawyer Consulted: Natasha Watson *Date: 05/11/12*

Equalities Implications:

5.3 The LSCB annual report is very important to the implementation of Brighton & Hove Council's Equalities Policy and to the achievement of the priorities set out in its annual business plan. The board champions our most vulnerable young people and as such the board needs to ensure that every child irrespective of their age, disability, race, ethnicity or sexual orientation is safeguarded in the city. One of the key objectives of the LSCB is to improve outcomes for children and young people from diverse communities and groups, and for those who live in deprived geographical communities.

An EIA is not applicable as the LSCB Annual report is not implementing a new policy or strategy.

Sustainability Implications:

5.4 This report does not directly address sustainability issues but it is linked to the priorities in the CYPP which supports the council's sustainability strategy

Crime & Disorder Implications:

5.5 The LSCB aims to support young people to engage in law abiding and socially acceptable activity and behaviour. There are no specific implications in the report in relation to crime and disorder but as the board is concerned with children who are at most at risk in Brighton and Hove they may be at increased risk of becoming known to the criminal justice system.

Risk and Opportunity Management Implications:

5.6 The LSCB will assist the partners in understanding safeguarding and child protection in Brighton and Hove and assist in meeting their duties to children in need of protection.

Public Health Implications:

5.7 One of the key objectives of the LSCB is to improve outcomes and health and wellbeing for children and young people from diverse communities and groups, and for those who live in deprived geographical communities.

Corporate / Citywide Implications:

5.8 The LSCB annual report describes the collective responsibilities that members and officers of Brighton & Hove City Council and its partner organisations have towards safeguarding children and young people.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 Not applicable.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 As set out in section 1.

SUPPORTING DOCUMENTATION

Appendices:

1. Local Safeguarding Children Board Annual Report 2011-12

Documents in Members' Rooms

1. None

Background Documents

1. None

BRIGHTON & HOVE
LOCAL SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2011 - 12

Prepared by
Alan Bedford, LSCB Independent Chair and Sharon Healy, LSCB Business Manager

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1 INTRODUCTION FROM THE CHAIR

I am pleased to introduce the Brighton and Hove Local Safeguarding Children Board's (LSCB) third Annual Report since it became a statutory requirement. The Government regard these reports as an important part of local accountability for safeguarding services, and the newly formed Association of Independent LSCB Chairs has been commissioned by the Department for Education to identify best practice in such reports, which hopefully can be incorporated in the 2012-13 one. The report will be submitted to the Children and Young People's Committee of the Council, the Brighton and Hove Health and Wellbeing Board, and all member agencies. It is a public document.

Last year, I said that it was important the LSCB remained a strong fixed point during considerable change and this continues to be the case. The Council has been changing its governance arrangements to a Committee structure, the shadow Clinical Commissioning Group (CCG) is closer to taking on the role of the Primary Care Trust (PCT), the Strategic Health Authorities will soon be no more and a new NHS Commissioning Board in place. Also later this year, the Government will be publishing radically reduced guidance on safeguarding with the aim of freeing professional decision making. Through all this, it is important that the LSCB keeps its eye firmly on its core duties of co-ordinating agency work, promoting the welfare of children, and monitoring the effectiveness of local services.

In this report you will see how the LSCB is governed and how it is constituted, its working sub-groups, training, how we achieved on last year's business plan, and the key issues addressed by the Board highlighting where a difference was made. There are also sections on the implications for LSCBs from NHS and other Safeguarding reforms, and performance information. To give a flavour of what is happening in our member agencies we summarise what they reported to us in their Annual Reports. The report ends with the challenges for 2012-13 and beyond, and shows the Business Plan for 2012-13. A summary of key achievements and onward priorities is in appendix A.

2011-12 was the first full year of the Chief Officer led LSCB Executive, which is designed to ensure full attention is given to needed changes and to ensure safeguarding is on the 'top of the office' agenda. This has proved to be a successful innovation and given safeguarding a higher agency profile. Two senior Council figures who have put considerable weight behind the LSCB and its Executive, Director of Children's Services Terry Parkin and CEO John Barradell, have recently moved on and we were very grateful for their commitment to safeguarding.

While there were no Serious Case Reviews in 2011-12, the findings of a 'local management review' relating to a case of neglect by drug and alcohol abusing parents was completed and agencies have been implementing action plans arising, and the LSCBs shared the learning at multi-agency seminars.

The Ofsted Unannounced Inspection of March 2011 reported in early 2011-12. It was reported in full in last year's Annual Report (as it was published

after the results were released) and rated safeguarding as 'adequate' overall but with 'good' for the following areas:

- capacity for improvement
- children being and feeling safe
- the contribution of health agencies
- performance management and quality assurance
- partnership working
- the safety of looked after children
- ambition and prioritisation (safeguarding and looked after children)

The health of looked after children was rated outstanding. It described the LSCB as well managed with good challenge, pro-active in learning lessons, with comprehensive training.

In November 2011, Ofsted piloted a new style of inspection in Brighton and Hove. The results were not published as it was a pilot, but reported good progress in the majority of key actions following the unannounced visit, and said that the LSCB had made considerable progress and was fulfilling its statutory functions and discharging its professional and community leadership with increased confidence and authority.

Both Ofsted Reports refer to a key issue for Brighton and Hove which can be seen in this report. This is the disproportionately high numbers of children on Child Protection (CP) Plans, and the implications this has on the amount and quality of 'early help' given and case management processes which prevent cases drifting to the highest levels of care. 2011-12 has begun to see a drop in children on CP Plans, and rise in children managed at the less serious child in need category. The Board is giving a focus in 2012-13 to understanding and developing 'early help' which is a top national priority after the Munro recommendations. The challenge of getting the numbers of families assessed and supported through the Common Assessment Framework (CAF) to the levels of other areas has not yet been achieved, and without this Children's Social Care staff have to spend time on less serious referrals when such cases could be managed by other agencies working together.

The Board continues to be well attended, with a high degree of openness and willingness to bring problems to the table for mutual support and resolution and, as can be seen in this report, substantial progress has been made in 2011-12, for example, around the quality of child protection medicals, and pre-birth planning. There has also been a real focus on learning from audits around cases involving domestic violence. The main challenge for 2012-13 and beyond is to respond to the enhanced expectations of LSCBs to increase our capacity to evaluate service quality and safeguarding organisation.

Alan Bedford
Independent Chair
Brighton & Hove LSCB
October 2012

2 GOVERNANCE AND ACCOUNTABILITY

A full account of LSCB objectives, statutory requirements and governance arrangements has been set out in the last two Annual Reports, so this is a more summarized version. Additionally, the Statutory Guidance (Working Together to Safeguard Children 2010) is under review and subject to national consultation - with the final Government decision expected in late 2012. The below relates to the current guidance.

2.1 *Objectives of an LSCB*

The LSCB is the key statutory mechanism for agreeing how member organisations within Brighton & Hove co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do. The duties are very extensive and it is clearly not possible to achieve all fully. Indeed the guidance is clear that ensuring the co-ordination and effectiveness of child protection is the core priority, and other work comes after that core is achieved.

The functions of an LSCB are set out in primary legislation and regulations. The core objectives of the LSCB are as follows:

- to co-ordinate what is done by each person, or body, represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the Authority and
- to ensure the effectiveness of what is done by each such person or body for that purpose.

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment; preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;
- undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully.

Safeguarding and promoting the welfare of children includes protecting children from harm. Ensuring that work to protect children is properly co-ordinated and effective remains a primary goal of LSCBs. When this core business is secure, however, LSCBs should go beyond it to work to their wider remit, which includes preventative work to avoid harm being suffered. This will help ensure a long-term impact on the safety of children.

2.2 *LSCB Scope*

This is defined as:

- activity that affects all children and aims to identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe, effective care; pro-active work that aims to target particular groups; and responsive work to children who are suffering, or are likely to suffer, significant harm.

2.3 *LSCB Functions*

These are defined as:

- developing policies and procedures for safeguarding and promoting the welfare of children. This includes issues such as setting out thresholds for intervention, inter-agency procedures, the Common Assessment Framework (CAF), training, the recruitment and supervision of people who work with children, the investigation of allegations concerning people who work with children, and the safety of children in private fostering;

- communicating the need to safeguard and promote the welfare of children, raising awareness of how this can best be done, and encouraging it;

- monitoring and evaluating the effectiveness of what is done by the Local Authority and Board partners individually, and collectively, to safeguard and promote the welfare of children and advise them on ways to improve;

- producing an Annual Report on the effectiveness of safeguarding in the local area;

- participating in the local planning and commissioning of Children's Services to ensure they take safeguarding and promoting the welfare of the child into account;

- collecting and analysing information about the deaths of children in its area.

2.4 *Accountability*

The LSCB is not accountable for the operational work of member agencies. Board members retain their own lines of accountability for safeguarding children, and the LSCB does not have the power to direct other organisations. The Chair is presumed to be independent of member agencies, and is required to secure an independent voice for the LSCB. The LSCB must be able to form a view of the quality of local activity, to challenge organisations as necessary, and to speak with an independent voice. Local Authority members and non-Executives on other bodies should hold their Officers to account for their contribution to the effective functioning of the LSCB.

Despite the LSCB members retaining their organisational accountability, the guidance is clear on their duties when acting as LSCB members. The individual members of the LSCB have a duty as members to contribute to the effective work of the LSCB, for example, in making the LSCBs' assessment of performance as objective as possible, and in recommending, or deciding upon, the necessary steps to put right any problems. This should take precedence, if necessary, over their role as a representative of their organisation. This means that members must feel free to contribute as they think fit as members, regardless of agency views.

The Local Authority Director of Children's Services (DCS) has statutory duties in relation to ensuring that the LSCB functions well, and the LSCB Annual Report is submitted to the Children's Trust. As Children's Trusts are no longer statutorily required, this report will go to the Health and Wellbeing Board, BHCC Children and Young Peoples Committee and Agency Chief Officers.

An LSCB is not an operational subcommittee of the Council and the LSCB should not be subordinate to, nor subsumed within, any other structure in a way that might compromise its separate identity and independent voice.

There must be a clear distinction between the roles and responsibilities of the LSCB and successor arrangements to the Children's Trust Board. A protocol defining the relationship in Brighton & Hove was agreed by the LSCB in December 2010 and was confirmed by the Council in March 2011. It will need adaptation by the end of 2012-13 when the new National Guidance is published.

2.5 *LSCB Team*

The LSCB Team currently consists of the following:

Independent Chair:
The Independent Chair (Alan Bedford) commenced work in June 2009 and is employed for 24 days per year. He previously held a number of Chief Executive posts in the NHS, following a career in social work, mainly with the NSPCC. He is accountable to the LSCB and to the Director of Children's Services for the effective functioning of the Board.

Business Manager:
The LSCB Business Manager (Sharon Healy) was appointed in January 2010 and is the Senior Administrator for the Board. The post holder is responsible to the LSCB for the smooth running of its business and is line managed within the Council by the Head of Safeguarding.

Head of Safeguarding:
The Head of Safeguarding (Jane Doherty) took up post in April 2010. The duties of this post are primarily for Brighton & Hove City Council, but include facilitating and advising the work of the LSCB. The Head of Safeguarding line manages the LSCB Business Manager and reports directly to the Director of Children's Services.

Director of Children's Services – DCS:
The DCS was Terry Parkin (until October 2012). The DCS has delegated responsibility from the Council Chief Officer to oversee the effectiveness of the LSCB. He and the three above form the LSCB Management Group which plans meeting agendas and steers the LSCB business between Board Meetings.

LSCB Training Manager:
The LSCB Training Manager (Michael McCoy) has been in post since June 2005 and assumed responsibility for managing the LSCB multi-agency training programme in September 2009. The Training Manager is line managed by the LSCB Business Manager.

LSCB Administrator:
A part-time LSCB Administrator was appointed in December 2011 for 18.5 hours per week in order to support the LSCB Team.

2.6 ***Membership***

The statutory membership of LSCBs is set out in Section 13(3) of the Children Act 2004 and in Working Together to Safeguard Children 2010, Chapter 3. Member organisations are required to co-operate with the Local Authority in the establishment and operation of the Board and have a shared responsibility for the effective discharge of its functions.

LSCB members should have a strategic role in relation to safeguarding and promoting the welfare of children in their respective organisations. They should be able to speak for their organisation with authority, commit their organisation on policy and practice matters, and hold their organisation to account.

The LSCB membership consists of senior representatives from statutory and voluntary sector agencies as follows:

- Brighton & Hove City Council (DCS, Children and Families, Education, Youth Offending - with the Lead Member for Children as a participant observer)
- Three Head Teachers representing schools
- Sussex Police
- Surrey & Sussex Probation Trust
- South East Coast Strategic Health Authority
- East Sussex Fire and Rescue Services
- NHS Brighton and Hove
- Brighton & Sussex University Hospitals NHS Trust
- Sussex Community NHS Trust
- Sussex Partnership NHS Foundation Trust
- South East Coast Ambulance
- Community and Voluntary Sector Forum
- Domestic Violence Forum

- CAFCASS
- Two Lay Members (from September 2012)

In addition to the Senior Representatives above, the LSCB values the input of professional advisers, and the Designated Nurse and Doctor, the Council Head of Safeguarding, the Police Safeguarding Adviser attend the Board and its Executive, and agencies can bring at least one named professional.

A Member's Guide to the LSCB was published in March 2011 and can be seen at: http://www.brightonandhovelscb.org.uk/files/

2.7 *LSCB Budget*

The budget statement is shown at appendix B. Quarterly statements are provided to the Board/Executive, and are available at any time to Board members. Contributions from members were as follows, and there was also a carry forward from 2010-11 as a result of the budget for serious case reviews not being required.

Brighton & Hove City Council	£85,010
Brighton & Hove PCT	£32,000 (on behalf of all NHS bodies)
National Probation Service	£4,000
Sussex Police	£9,000
CAFCASS	£550
Carry Forward from 2010-11	£23,000
Total:	**£153,560**

In addition there was grant of £18,300 from the Children's Workforce Development Council (CWDC) for LSCB Development which was mostly carried over to be spent in 2012-13.

The carry forward from 2010-11 was committed on a range of schemes for priority development: £4,550 on a quality assurance tool for the third sector, £8,886 short term extension of the named GP role to enhance GP safeguarding development, £932 on a Fabricated Induced Illness Workshop, and £472 on Court training for a named Doctor. The balance was used on general expenditure.

The majority of the £20,000 underspend in 2011-12 relates to the ring fenced grant from the CWDC, with only a small carry forward of £3,800 from recurring budget lines, which will be needed in 2012-13 as it is probable that unavoidable case review costs will exceed the £10,000 annual allowance.

In 2012-13 we will have similar income from member agencies, but the majority of agencies have committed to re-examine their contribution in year should new statutory requirements emerge when the new Working Together Guidance is published.

For 2013-14, it is most likely that member agencies will need to increase their contribution as the expectations on LSCBs to conduct much more comprehensive evaluation of local services, especially around early help, are rising considerably. The Board has less capacity to tackle this than many LSCBs.

2.8 *Action from 2011-12 Business Plan*

The majority of the actions in the Business Plan for 2011-12 (which was appended to the 2010-11 report) were completed. The outcomes are summarised below.

Effectiveness of Safeguarding Arrangements:

- A robust Section 11 audit programme (of agency safeguarding arrangements) was put in place with a new Sussex wide tool implemented. Chief Officers presented their findings for peer review at the LSCB Executive.
- A thematic audit on child sexual abuse case files was conducted, and findings presented to the Board in September 2012 and the Executive in October 2012. (To be covered in the 2012-13 Annual Report.)
- Member agencies responded to the Board on progress following the domestic violence audit conducted in 2010-11 and it was re-run to assess progress from the original Action Plan. The update was taken to the Board and Executive by January 2012, and some considerable improvement was noted in planning and recording, and the overall standard of case management had risen.
- Findings of the external inspections were disseminated with a joint Action Plan.
- On understanding the high numbers of Child Protection Plans, Council research identified no demographical factors to explain the numbers. This was a main topic at the 2011 LSCB Annual Conference.

Governance Arrangements:

- The Annual Report was submitted to the Children's Trust and the Board Chair attended the Committee to discuss the findings. Member agencies did submit their own Annual Reports to contribute to this process.
- We needed to ensure the Board was receiving Annual Reports/summaries from key services and the majority are reflected in last years and this Annual Report. In September 2012 the Board had a major report from the Local Authority Designated Office (re allegations against staff) for the first time.
- A survey was conducted of audits within agencies. We now understand the volume of work, but need to move to collation of findings.
- The Chief Officer led LSCB Executive is now firmly embedded.

- The Board has developed a formal relationship with the Shadow Health and Well Being Board, and has been part of the consultation process in its creation.
- Work with the Shadow Clinical Commissioning Group began in 2012-13, and its Accountable Officer now attends the Executive.
- The Munro proposal, the Government response and the implications for LSCBs were widely discussed.
- Two lay members were appointed in 2012-13 and more details will be given in next year's Annual Report.

Case Reviews lessons:

- Arrangements by which the LSCB Chair is informed of cases that might need review have been strengthened.
- Large numbers of multi-agency staff attended specially commissioned training on Serious Case Reviews.
- Lessons from the LSCB's Local Management Review, on a case which fell just short of the criteria for an SCR, were disseminated by a Chair's letter to agencies, discussions at the Board and Executive, and two seminars for multi-agency staff.

Training, Staff Support and Staff Development:

- A revised LSCB Training and Development Strategy was introduced in July 2011, with a self-assessment tool for agency use.
- Agencies reported on their safer recruitment practices in their Section 11 audits.
- A themed Development Day for LSCB members was held in November 2011.

LSCB Profile and promoting safeguarding through communities

- As in previous years, other priorities squeezed out the objective on the production of an LSCB Communication Strategy.
- The links between the LSCB and Community Safety Partnership still have room for development.
- The LSCB web site introduced in 2010 has continued and is regularly updated.

The plan for 2012-13 is in appendix D, and key challenges are summarised in Section 12 of this report.

3 KEY ISSUES ADDRESSED IN 2011-12

The following section summarises some of the main issues discussed at the Board during its meetings in 2011-12 (where not covered elsewhere in the report). It highlights where a difference has been made.

3.1 *Child Protection Medicals:*
Brighton and Sussex University Hospitals NHS Trust (BSUH) and members had shared concerns about the capacity at the hospital to provide prompt enough medicals by senior enough staff. This was monitored closely by the Board (and Executive) and support and advice given by members. As a result of measures introduced by the Trust, there is expanded consultant capacity for CP Medicals (including a new Consultant post), improved supervision of Registrars, weekly peer reviews of CP medicals, and improved quality of medical reports.

3.2 *Pre- birth Assessments:*
Getting the right professionals to share the right information at the right time is a complex process when there are growing concerns about parental capacity post birth is not easy and there had been some differences of view between agencies. LSCB members were concerned that the existing process was not tight, or comprehensive enough, and the matter was discussed at a number of meetings. Agencies agreed to work together to find a way forward, and in September 2011 BSUH and Brighton and Hove City Council Children's Services reported back to the Board on joint progress describing the joint meetings to be held, the circulation of details of impending high risk cases to appropriate professionals, and oversight of the process by senior staff in BSUH and the Council.

3.3 *Local Management Review:*
More detail of the learning about the case is in Section 6.2 below, but agencies considered the implications at a Board meeting, submitted notes on actions they had taken, and the LSCB held a multi-agency seminar to share the learning.

3.4 *Domestic Violence:*
Responses to the 2010-11 audit of domestic violence cases were considered, and the process of Police notification to Health and Social Care Staff of attendances at incidents where children were in the family was reviewed and agreed between agencies. See 6.1 below.

3.5 *Sexual Exploitation of Children and Young People*:
The multi-agency Sexual Exploitation Steering Group described in the previous is now incorporated as a formal subgroup of the LSCB to reflect the growing recognition of these issues. The Board had a session on the 'What is Sexual Exploitation (WISE)' project run by the YMCA which is a service for 13-25 year olds who are experiencing sexual exploitation, or are at risk of experiencing it. The project is also a point of call for advice and guidance for those working with young people who have suffered from sexual exploitation. Another major briefing session was the Sussex Police on organised immigration crime, human trafficking and exploitation.

3.6 *Common Assessment Framework (CAF):*
Another main issue was the CAF, where take up has not been as high as needed, despite support processes being in place. This is believed to put additional pressure on Children's Social Care which gets referrals that could

be dealt with by other agencies together. Both the Board and the Executive have considered this and in 2012-13 each agency has been asked to give special attention to this and report on progress to the LSCB. Progress will be reported in the 2012-13 report. This is also covered below in Section 7 on Performance Information.

3.7 *Accountability Framework for Designated and Named Professionals:*

The designated and named Doctors and nurses play a crucial role on safeguarding, not only in health, but in facilitating multi-agency work. The LSCB agreed an accountability framework which clarified the role of advisers in organizational structures, the Board's expectations, and how advisers relate to the LSCB. The framework has been given to the Clinical Commissioning Group which takes over most PCT safeguarding functions in 2013.

4 SAFEGUARDING AND NHS REFORMS, AND THE LSCB

Over the year the LSCB and Executive have considered the reports from the Munro review which focused on three key themes. Firstly, the expansion and development of 'early help' to support families before problems have escalated and are much harder to resolve. Secondly, to reduce the amount of national guidance so that there is a greater chance that staff can use more professional judgment about what is right for a child/family. Thirdly, the development of a more learning culture, specifically through a systems approach to SCRs that delve deeper into why, and not just what happened. There were also recommendations about LSCBs and strengthening accountabilities.

In its response the Government said "LSCBs have a unique, system wide, role to play in protecting children and young people and the Government believes that their role and impact should be strengthened…". The Government strongly agrees that LSCBs are a fundamental aspect of local multi-agency arrangements to help and protect children and young people. They occupy a central position in being able to assess the effectiveness of local help and protective services, and it is important that this role is strengthened". This means that LSCB's evaluation role must be expanded to provide greater assurance that services, especially early help are meeting required standards. Developing this role, and operationalizing improvements to early help are key LSCB tasks for 2012-13. The revised statutory "Working Together" Guidance - to implement the Munro recommendations has been consulted on and the 2012-13 Annual Report will describe the LSCB's response to those changes.

Other reforms have seen the creation in Brighton & Hove of a Shadow Health and Wellbeing Board to oversee the commissioning of health and Social Care. It is expected that the new guidance will require LSCB Annual Reports to go there, instead of to Children's Trusts. The LSCB Chair is invited to that Board, and he has participant observer status at the Council's Children

and Young People's Committee which has subsumed the functions of the Children's Trust.

The NHS is going through considerable change in its commissioning arrangements, and the Board and Executive had had presentations by NHS Sussex so that the changes are understood. In 2012-13 the LSCB will engage with the Clinical Commissioning Group (CCG) that will take on many PCT safeguarding functions in 2013. Both the CCG and the NHS Commissioning Board for Surrey/Sussex will become members of the LSCB by 2013, instead of the PCT and SHA.

5 LSCB SUB-GROUPS

During 2011-11, the following nine LSCB sub-groups were operating within Brighton & Hove:

- LSCB Executive
- Child Death Overview Panel
- Child Protection Liaison and Safeguarding
- Education Safeguarding Child Protection Strategy
- Monitoring and Evaluation
- Pan Sussex Procedures
- SCR Standing subcommittee
- Sexual Exploitation sub group
- Training

5.1 *LSCB Executive*

This was the first full year of the Executive which is a chief officer led sub-group designed to keep top managers aligned with safeguarding, and ensure prompt clear decisions if needed. Key safeguarding advisers also attend. The chief officers take turns to present their organisations safeguarding audit for peer scrutiny. In 2011-12 Probation, Police, Sussex Community NHS Trust, and Sussex Partnership NHS FT presented.

The Executive gave a clear steer on the need for improvement after the domestic violence audit and identified improvements in the follow up audit (see section 6.1), monitored progress on the BSUH CP medicals issue (see section 3.1), and on Ofsted/CQC inspections, and agreed/monitored the Business Plan

The Executive has taken a special interest in case reviews, and has duties in relation to advising on holding serious case reviews. (It recommended the commissioning of one in 2012-13, the learning from which will be in next year's Report, confidentiality allowing). It reviewed the findings of an SCR from East Sussex. On the local management review described in section 6.2 the Executive had a lengthy discussion and committed all agencies to report to the LSCB on action taken as a result.

5.2 ***Child Death Overview Panel***

The LSCB has not yet considered the CDOP 2011-12 annual report, so only some extracts are summarized below. The Child Death Overview Panel (CDOP) is an inter-agency forum that meets regularly to review the deaths of all children normally resident in East Sussex and Brighton & Hove. It acts as a sub-group of the two LSCBs for Brighton & Hove and East Sussex and is accountable to the two LSCB Chairs if, during the review process, the CDOP identifies the following:

- an issue that could require a Serious Case Review (SCR);
- a matter of concern affecting the safety and welfare of children in the area; or
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area.

a specific recommendation would be made to the relevant LSCB(s).

There were no recommendations made to B&H LSCB regarding the need for a serious case review but the following recommendations were made regarding matters of concern about the safety and welfare of children and wider public health concerns.

- To consider with the relevant agencies how best to support children that are vulnerable and are severely obese when parents are resistant to support and services offered.

This is being considered by the Sussex Procedures child protection and safeguarding sub group in line with national guidance around this subject.

- To consider developing with the relevant agencies (road traffic police and public health) a campaign around the dangers of MP3 players and similar devices (mobile phones).

Please note that the CDOP has consulted with other CDOPs nationally regarding this particular concern and will be recommending that this issue be considered nationally as other CDOPs have reported similar deaths.

National Developments, Challenges and Achievements: There has been no change to national guidance regarding the functioning of CDOP during the last year. Information on the functioning of Child Death Overview Panels is still required to be reported to the Department for Education on an annual basis. It is understood that there are discussions at a national level about how public health data from CDOPs can be collected and analysed; in the interim there is an informal network that exchanges information. There are also specific national research projects to which CDOPs are encouraged to contribute data – e.g. research into deaths through asthma and continued research around sudden unexpected deaths in infancy. East Sussex Brighton & Hove CDOP is intending to contribute to this research subject to the LSCBs agreeing to the data being made available. The local funding for CDOP has been maintained

and the cost of the CDOP process within East Sussex and Brighton & Hove is less than the funding provided by Government.

Local Developments, Challenges and Achievements: Input by parents to the CDOP process has continued to improve and throughout 2011 and 2012 parents contributed to reviews.

A conference was held in October 2011 with West Sussex CDOP for members of the three LSCBs East Sussex, Brighton & Hove and West Sussex enabling wider learning from the panels' activity. Dr Sheila Fish provided a keynote speech regarding the SCIE systems review process and its relevance to all child death reviews. There was also an informative presentation on the role of the coronial service and Winston's Wish, a service providing support and care for children with terminal illness and their siblings and families.

There is improving practice around immediate responses to child death. The CDOP continues to work closely with the coronial service providing coroners with information and receiving information from them.

The CDOP has held 14 meetings in the past year (including 3 Brighton & Hove neonatal panels and 6 East Sussex neonatal panels).

The main work of the panel continues to be the reviewing of all child deaths across East Sussex and Brighton & Hove on behalf of the two Local Safeguarding Children Boards (LSCBs). Between April 2011 and March 2012 the CDOP was notified of 21 deaths of children who were resident in Brighton & Hove. The CDOP has reviewed a total of 15 deaths in B&H during 202011-12.

Child Death data: In Brighton & Hove 18% of the population are aged under 18 years (47,000 out of 259,000). This compares to 21% for the South East region and 21% for England. (Source: ONS 2010 Mid-Year Estimates)

Table 1: Deaths notified to the CDOP 2007 – 2012

	1/4/07-31/3/08	**1/4/08-31/3/09**	**1/4/09-31/3/10**	**1/4/10-31/3/11**	**1/4/11-31/3/12**	**Total**
Brighton & Hove	X[1]	16	20	11	21	**73**

Deaths notified to CDOP in both East Sussex and Brighton & Hove increased during the last year. There had been a reduction in deaths over the previous two years however it seemed likely that this was cyclical and so the increase is not unexpected. This data will need to be monitored for a much longer period before trends can be identified.

[1] no data for 2007/08 for Brighton and Hove as n<5 due to data collection processes not being fully established.

5.3 ***Child Protection Liaison and Safeguarding Group***

The Child Protection Liaison and Safeguarding Group (CPLG) is a multi-agency forum that meets on a monthly basis. Its main purpose is to review and improve joint working practice in respect of multi-agency child protection processes; including analysis of examples of operational practice within the context of child protection enquiries and investigations. The CPLG also acts as an additional quality assurance and audit mechanism on behalf of the LSCB.

In 2010-11 the Child Protection Liaison Group strengthened its links to the LSCB by being chaired by the Head of Safeguarding. This has continued in 2011-12 and the Designated Nurse for Child Protection chairs the meeting in the absence of the Head of Safeguarding.

The CPLG continued to be very well attended by a range of agencies including health, social care and the police and the following issues were discussed and addressed.

- There continued to be an analysis of current child protection enquiries and processes by detailing particular cases that had been subject to some scrutiny by the group because they had not gone as well as the LSCB would have liked.

- Detailed discussions of the way in which child protection medicals are conducted as there had been some concerns about the timeliness and quality of these. This resulted in a piece of work undertaken with BSUH, the Chair of the LSCB, the DCS and the Head of Safeguarding to try and improve the quality of CP medicals. A number of meetings were held and BSUH undertook to review each CP medical in a peer review meeting. Members of the social work service and the Head of Safeguarding have been invited to attend some of these meetings which has resulted in a much better understanding of each other’s roles and responsibilities. BSUH also committed to recruit to a specialist post to facilitate the timeliness and quality of the medicals carried out.

- Discussion re older children who make allegations who wish these to remain confidential – professionals were reminded that this needs to be the subject of thorough assessment and they need to consider the safety of other children in the household before honouring a commitment re confidentiality.

- An issue was also raised about how allegations of child sexual abuse were dealt with which resulted in the LSCB making this a priority in the 11-12 business plan.

5.4 ***Education Safeguarding Child Protection Strategy Group***

The purpose of the Education Safeguarding Strategy sub-group is to share information, consider best practice and implement a clear plan of action for child protection and safeguarding for all children's services' education and school-based staff. The group also ensures that all education and school services are clear of their responsibilities and follow agreed procedures.

The group met regularly in 2011-12. Issues discussed included:

The Safeguarding Audit was amended, agreed by the group and sent to all schools in March and again in May. Schools managing risk was discussed particularly around the increase in referrals to social care at the end of the autumn and summer terms. The use of the Common Assessment Framework was linked to this. Discussions are ongoing between the Service Manager for Schools and Communities and schools in order to develop a joined up approach on this issue.

The LADO is a recent new member of the group and provides useful updates regarding the management of allegations of adults who work with children and also provides the group with updates on changes in legislation/guidance.

The area of elective home education has been raised as an area where children may be at potential risk due to possible social isolation. The group will be exploring this issue more in 2012-13.

5.5 ***Monitoring and Evaluation Sub-Group***

This sub-group is responsible for initiating and undertaking both multi-agency and single agency audits and reviews of safeguarding activities on behalf of the LSCB to ensure compliance to the child protection and safeguarding procedures. In April 2010, the Head of Safeguarding became chair of this group and has initiated the following audits during 2011-12:

A repeat audit of how agencies within Brighton & Hove are complying with their safeguarding responsibilities under Section 11 of the Children Act 2004 was undertaken between September and March 2012. This was completed on the Sussex wide template that was developed by the three LSCB Business Managers across East and West Sussex and B&H. The LSCB Executive group will continue to provide a support and challenge function to ensure that partner agencies are fulfilling their responsibilities towards safeguarding.

A repeat thematic audit of domestic violence was undertaken to monitor the effectiveness of working practices across agencies. The report was presented to the January 2011 LSCB Executive with a number of recommendations for improved practice. It is significant to note that there were many improvements to this area of work with all of the cases being graded at adequate or above compared with the previous year when a number of cases were graded as inadequate. It was agreed that the action plan would be monitored by the

Monitoring and Evaluation sub group and updates presented to the executive meeting.

The group also started an important piece of work about how incidences of Child Sexual Abuse are dealt with – this has been completed in 2012-13.

5.6 *Pan-Sussex Procedures Sub-Group*

The Pan Sussex Procedures Sub Group meets 6 times a year, and has a membership drawn from across Brighton & Hove, East and West Sussex LSCBs and Sussex Police. Its main purpose is to act as a steering group for the development and publication of procedural guidance. This includes reviewing and updating the Pan-Sussex child protection and safeguarding procedures regularly in response to lessons learned from Serious Case Reviews. The group addresses local and national issues, changes in legislation and any gaps emerging from practice.

During 2011-12, the group continued to focus on updating the Sussex Child Protection and Safeguarding Procedures and worked successfully on an agreed work plan including the following:

- A Pan Sussex referral form for Children's Social Care was agreed and launched across the 3 Local authority areas.
- A Pan Sussex Section 11 audit tool was agreed, and an audit was carried out in the same time-frame across the 3 areas, with the audits all completed by LSCB partners by May 2012.
- There has been closer co-operation in the delivery of LSCB Training courses across the areas, with some similar training being delivered, and a Pan Sussex Conference focusing on Child Sexual Exploitation, Trafficking and Missing Children planned for October 2012.
- Some agreed small changes in the Pan Sussex Child Protection Procedures have been taken forward with the 6 monthly up-dates to the on-line Procedures. The Procedures can be viewed here: http://www.proceduresonline.com/pansussex/scb/

5.7 *Serious Case Review Subcommittee*

This committee met three times in 2011-12. Its main role is to determine and monitor required actions after case reviews. In 2011 it made a final check that the G SCR could now be closed; monitored progress with actions from, and signed off, a Local Management Review (LMR) which related to a sexual abuse case; confirmed actions from the East Sussex SCR had been completed; and commissioned a Local Management Review (see section 6.2) which concluded in October 2011. Action plans from the fire service, the NHS, and Children's Social Care were produced and are being monitored. The Board and Executive were kept informed of progress and a seminar on the learning was held for member agencies.

The East Sussex case threw up issues of ensuring full exchange of information between neighbouring LSCBs when a review includes services in

the other, and the committee believes arrangements are now in place be more sure of this.

The LSCB also agreed that an independent single agency LMR on issue relating to adoption and safeguarding could be undertaken by the council rather than an LSCB review, and the report will be considered by the LSCB in 2012-13. In 2011, the committee held a multi-agency meeting to discuss a case and made a recommendation to the Chair, with information at the time, not to hold an SCR, but agreed certain actions. See 6.2 below.

5.8 ***Sexual Exploitation Sub Group***

This is a city-wide multi-agency group which seeks to engage all relevant agencies and enables and promotes the delivery of an enhanced service to children and young people at risk of or experiencing sexual exploitation across Brighton & Hove.

Membership is from a range of statutory and voluntary sector organisations across the city including Sussex Central YMCA, the police, BHCC, LSCB and Health and is chaired by Sussex Police. The group supports the work of Sussex Central YMCA's What is Sexual Exploitation? (WiSE) project.
Other key aims of the sub group include:

- To support Community Safety Partnership/Police/LSCB Strategic plans.
- To understand the city problem profile regarding child sexual exploitation (CSE).
- Monitoring ongoing prevalence and responses to CSE.
- To develop and maintain an effective local strategy ensuring that there is a co-ordinated Multi-agency response to CSE.
- Increase understanding of CSE in both the professional and wider communities.

5.9 ***Training Sub Group***

The Training sub-group continues to meet on a quarterly basis. It is responsible for ensuring that single agency and multi-agency training on safeguarding and promoting welfare for children and young people is provided at different levels in order to meet local needs in accordance with the Safeguarding Children Training and Development Strategy 2012 and Working Together 2010.

The group is chaired by the Designated Nurse and membership consists of the LSCB training manager and business manager, representatives from all health care organisations, the voluntary sector, B&H council, Probation, Police. Involvement has been good from members with the exception of the Police due to resource issues in attending the three LSCBs and their sub groups across Sussex. Primary care and Sussex Partnership have also had minimal attendance due to resources, however the impact of this is minimised by the designated nurse membership.

The group assists the LSCB Training Manager in the identification, planning, delivery and evaluation of multi-agency training to ensure all those coming into contact/working with children are competent and up to date with current legislation. The group monitors levels of attendance of multi-agency training by respective organisations and promotes greater attendance by agencies where necessary.

The group continues to evaluate the provision of training available within the LSCB training programme; during the period 2011- 2012 additional courses on MAPPA, sexual exploitation and SCRs have been provided. A Safeguarding Disabled Children course has been incorporated into the programme and the first one of these will run in November 2012.

Key developments during the period include:

- Producing revised terms of reference.
- Producing a revised Children Training and Development Strategy 2012.
- Multi agency seminar on Fraser Competence related to sexually active young people.
- Presentation from Primary Care on the training available to GP's.
- Undertaking an audit of training provided by single agencies.
- Two multi agency lunchtime seminars presenting the lessons learnt from the LSCB case review.

6 LEARNING AND DEVELOPMENT

6.1 *Audits*

Domestic Violence Audit: This audit was undertaken by the Monitoring and Evaluation (ME) Sub-Group of the Brighton and Hove LSCB, and is included as one of the objectives of the LSCB Business Plan 2011-12. This is a repeat of an audit that was undertaken as part of the 2010/11 LSCB business plan as some areas of practice in the audit were identified as weak. The terms of reference for the audit are as follows:

Ten cases of children subject to a child protection plan in September 2011 were audited. All the children chosen for audit were subject to Child Protection Plans due to Domestic Abuse. In this repeat audit cases were chosen of children who had been made subject of a CP Plan in the previous three months from September 2011. The reason for this because many of the weak areas identified in the previous audit were around the very early pieces of intervention and so particular attention was paid to these.

Since the first audit there are some very significant improvements .These include:

- Planning and decision making in relation to the initial stages of a contact or a referral particularly where other information exists was

deemed to be good in this audit as compared to the previous year when many individual sections were deemed inadequate.

- Much quicker response rates were evidenced in almost all the cases.
- The history of the case was taken into account in the decision making.
- Health has much more robust recording systems in place.
- A significant increase in referrals to the police at the beginning of a case to consider a joint approach.
- Education files contain all relevant information.
- No cases were rated inadequate overall.

A multi-agency action plan is updated regularly.

Single Agency Audits: In 2011-12 the LSCB aimed to get a better picture of what safeguarding related audits were being undertaken under the auspices of individual agencies, as opposed to multi-agency audits. Agencies were asked to let the Board know what audits they were doing, and two summaries were taken to the Board in the first half of 2012-13. A number of the agencies whose safeguarding annual reports are summarised in section 8 below referred to their audits (for example BSUH NHS Trust and Probation, and Sussex Partnership NHS Foundation Trust are developing an annual programme of safeguarding audits.

The Board believes there is considerable potential, subject to the necessary coordinating resource, to pool findings for general learning. For example, the council's Children's Social Care undertook 186 internal audits in 2011-12 as part o their quality assurance framework on such issues as the quality if initial and core assessments and section 47 inquiries. Developing the capacity to harness agency audit findings is an important challenge for the Board.

Section 11 Audits: These audits require member organisations to self-assess their readiness on safeguarding. Following an externally commissioned review of the 2010-11audit, the LSCB worked with other Boards in Sussex in 2011-12 to agree an improved audit tool and this was used towards the end of the year in 13 agency returns. The vast majority of assessment categories were rag rated green and agencies have plans for red or amber rated. Results varied across agencies, but there was some consistency in agencies being unable to confirm that at least one member of shortlisting/interview panels were safer recruitment trained, around half of agencies reported improvements needed in ascertaining the views of children and families on service provision, and e-safety policies needed improving or introducing.

There were 6 standards 100% green, covering staff being kept up to date, commitment to the LSCB, participation in case reviews (and subsequent actions), and holding data securely.

In Brighton and Hove, Chief Officers are asked to present their findings to their peers on the LSCB Executive and since July 2011 Sussex Partnership NHS Foundation Trust, Sussex Community NHS Trust, NHS Sussex, Brighton and Sussex University Hospitals NHS Trust, Surrey and Sussex Probation Trust, Sussex Police and Brighton and Hove City Council have presented

either their 2010-11 or 2011-12 Section 11 audits, and discussed their organisational strengths and weakness with senior colleagues.

6.2 *Case Reviews:*

The LSCB commissioned no Serious Case Reviews in 2011-12 but did commission an independent confidential 'local management review' into a case of neglect by substance misusing parents. No details of the case can be given to avoid family identification, but there was considerable learning for agencies across the LSCB. All agencies were asked by the LSCB chair to report to the Board on how the findings had been disseminated, and what action had been taken. A summary of responses went to the March 2012 Board and two learning seminars were held for multi-agency staff. The key learning was about the need for adult services, whilst meeting the needs of their clients, have a more rigorous focus on the needs of children in the family. In addition there were actions relating to a range of issues (edited to ensure anonymity).

- Improvement in antenatal assessment processes
- Support was given to GP practice on capacity related to safeguarding
- The need for more face to face meetings between Health Visitors, Midwives and GPs- especially as community staff are less likely to be GP attached
- Improved assessment of parental capacity by agencies with adult clients

Following information received, LSCB agreed that the council would undertake an internal review of safeguarding in relation to adopted children, with the confidential report (due in 2012-13) to be shared with the LSCB Serious Case Review (SCR) Panel.

In September 2011, the SCR Panel met to consider whether a recommendation needed to be made to the Chair for an SCR on a case of likely serious abuse. The recommendation, which the Chair accepted, was that known information did not meet the criteria for an SCR. Nevertheless, the Panel agreed a range of actions for council and health agencies that would ensure learning occurred, and responses are monitored by the SCR sub-committee. This will be described in the 2013-14 annual report.

6.3 *Training*

A revised LSCB Training and Development Strategy was introduced in July 2011. This includes a new self-assessment tool for agency use regarding evaluation of single agency training.

The LSCB multi-agency training programme derives from the Training and Development Strategy 2012 and sets out the levels of safeguarding training and development needed for the workforce of Brighton & Hove children's workforce. The following multi-agency courses were delivered in 2011-12; this includes 'Preventing and Disrupting the Sexual Exploitation of Children and Young People' which is a new addition to the programme:

Level Two:

- Developing a Core Understanding x 9
- Assessment, Referral and Investigation x 6
- Child Protection, Conference and Core Groups x 5

Level Three:

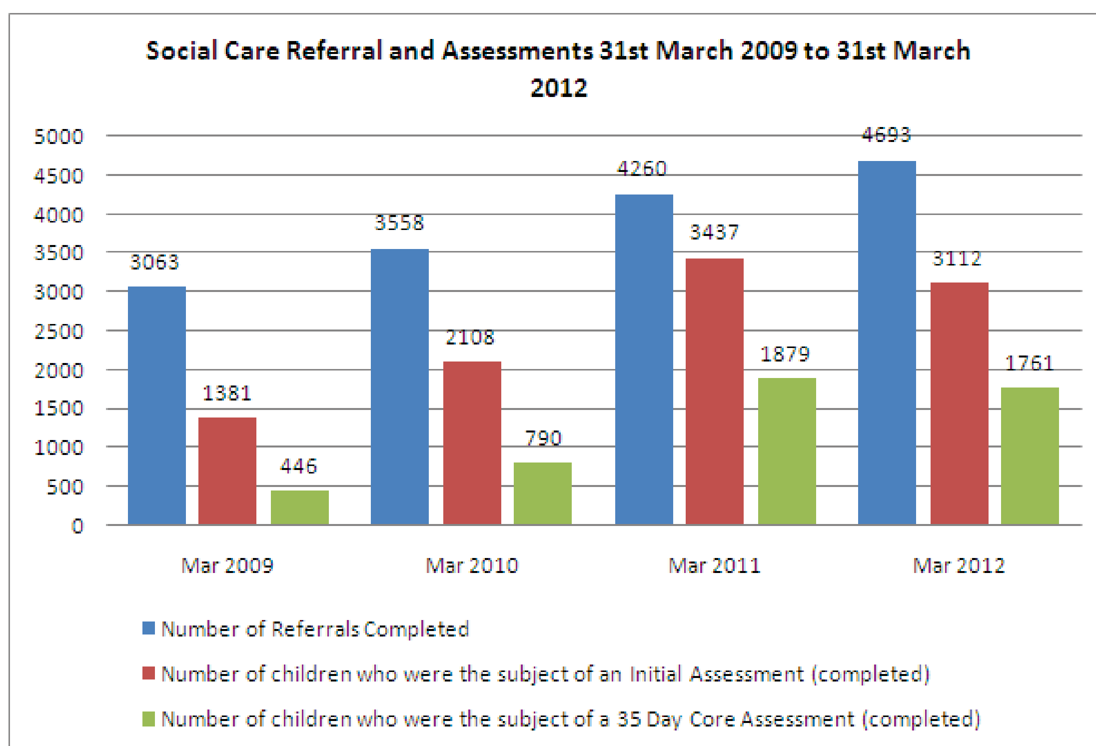
- Domestic Violence and Abuse x 7
- Multi Agency Public Protection Arrangements (MAPPA) x 2
- Preventing and Disrupting the Sexual Exploitation of Children and Young People x 4
- Serious Case Review Workshop x 2
- Substance Misuse and Parenting Capacity Day 1 x 1
- Substance Misuse and Parenting Capacity Day 2 x 1
- Working with Parents with a Learning Disability x 1

A summary of 2011-12 LSCB training attendance data is attached at appendix C.

7 PERFORMANCE INFORMATION

The following data provides a detailed breakdown of child protection activity from April 1st 2011 to 31st March 2012.

Referral and Assessments Year Ending 31st March 2009 to 31st March 2012



Source: Monthly Monitoring

Initial Contacts

In this report the Initial Contacts is used as a proxy for multi-agency activity. In the period under review (2011-12) the amount of referrals into children's social care increased by approximately 10% from 2010-11 and there has been a sharp increase, especially since 2009. This evidently coincides with the Serious Case Review in Haringey which saw a rise in referral rates in an unprecedented manner in many local authorities.

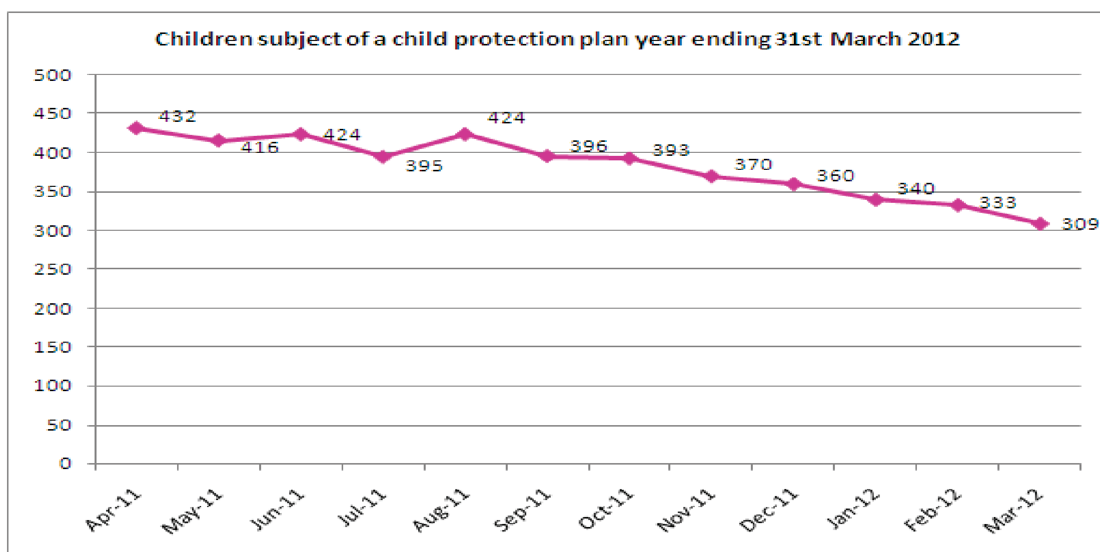
In Brighton & Hove there has been an increase in referrals between 2009 and 2012 of just over 50% which has had a significant impact on resources and workloads. It is significant to note that this increase has continued over a sustained period of time which has increased the pressure considerably on front line services.

Assessments

The number of initial assessments completed has increased by 125% between 2009 and 2012, with core assessments rising by nearly 300% during the same period.

In an attempt to deal with this increase there has been a focus on assessments completed under the Common Assessment Framework to try and redirect some of the lower level work to more appropriate resources and to try to reduce the number of children in need of statutory social work intervention. There were 535 CAFs started in the year ending 31st March 2012. Whilst this strategy has had some limited success the increase in statutory work still represents a significant increase in the volume of work being undertaken by the multi agency groups represented on the LSCB.

Children & Young People Subject of a Child Protection Plan Year Ending 31st March 2012



Source: Monthly Monitoring March 2012

The number of children subject of a child protection plan fell from 432 as at April 2011 to 309 as at 31st March 2012, a decrease of 28.5%. Service Managers have attributed this decrease to CIN Plans being seen as a more robust option and to successful interventions by social workers at the Children in Need stage.

Although the rate of children subject of a child protection plan per 10,000 has fallen from 93.8 as at 31st March 2011 to 66, this remains above the 2011 national average of 38.3 and the statistical neighbour average of 47.3. This would rank Brighton and Hove's CP rate per 10,000 9th highest out of 152 local authorities in England based on the 2011 position.

100% of child protection conference reviews took place on time during the period under review (2011-12). The percentage of children ceasing to be the subject of a Child Protection Plan, who had been the subject of a Child Protection Plan continuously for two years or longer, is 5.3% - below the national average of 6% as at 31st March 2011.

The percentage of children subject of a child protection plan for a second or subsequent time has deteriorated from 12.7% in March 2011 to 21.8%, above the 2010/11 national average of 13.3%. Performance for this indicator has gone from being in the highest banding (10 to 15%) under the old Performance Assessment Framework to second lowest banding.

The majority of children continue to be subject to child protection plans under the categories of emotional abuse and neglect while the major contributory factors are domestic violence, physical care/neglect issues, parental mental health issues and parental drug and alcohol misuse. These are familiar themes in comparator boroughs. Numbers in relation to the category of sexual abuse are low (less than 5%). Although this figure is in line with the national average it was felt that this needed to be the subject of a discreet piece of work for the 2011-12 business plan which is now completed and will result in some actions being taken to ensure that children who make allegations of sexual abuse receive the right support.

Plans are already underway to try and reduce the number of children subject to CP plans as these remain high in relation to our comparator boroughs. A review of the Child Protection process will be undertaken in 2011-12 and a further drive is currently underway to increase the numbers of children subject to CIN plans and for the quality of these plans to be strengthened.

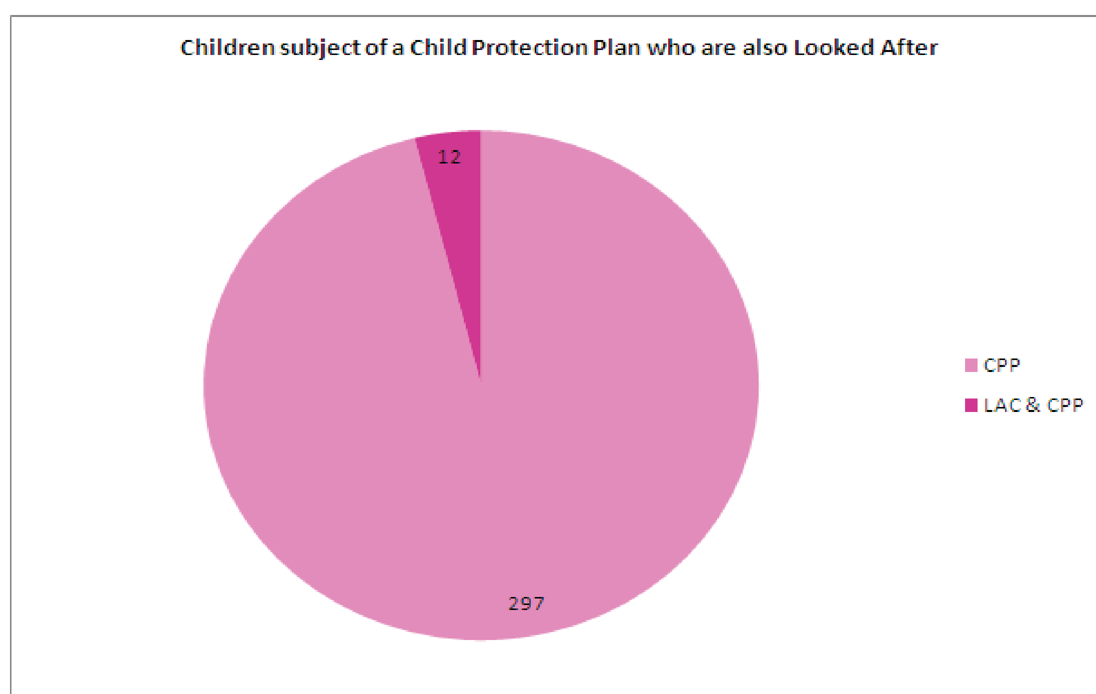
It is significant to note that although the numbers of children subject to Child Protection plans has fallen considerably since the last reporting period the numbers of children subject to Child Protection plans for a second or subsequent time has risen. This suggests that there is work to do to ensure consistency of thresholds and that the numbers are being reduced safely. Management action has been taken around this area but needs to continue to be monitored in 2012-13.

Referrals by Source and No Further Action Outcome Year Ending 31st March 2012

Referral Source	No. Referrals	Referral No further action	% NFA
Police Referrals	1385	193	13.9%
GP	90	10	11.1%
Health/Hospital	563	47	8.3%
Education	766	94	12.3%
Individual	471	41	8.7%
Local/Central Gov't Agency/Dept	635	85	13.4%
Emergency Duty Service	176	21	11.9%
Independent/Voluntary	103	10	9.7%
Other Source	502	44	8.8%
Total Referrals	4691	545	11.6%

There were 4,691 referrals completed in this period, with 29.5% from the police, 13.5% from Local/Central Government Agency or Department (Housing Department, Probation, Other Local Authority etc), 12% from Health, 16.3% from Education and 10% coming in from individuals (Relatives, Carers, Anonymous etc).

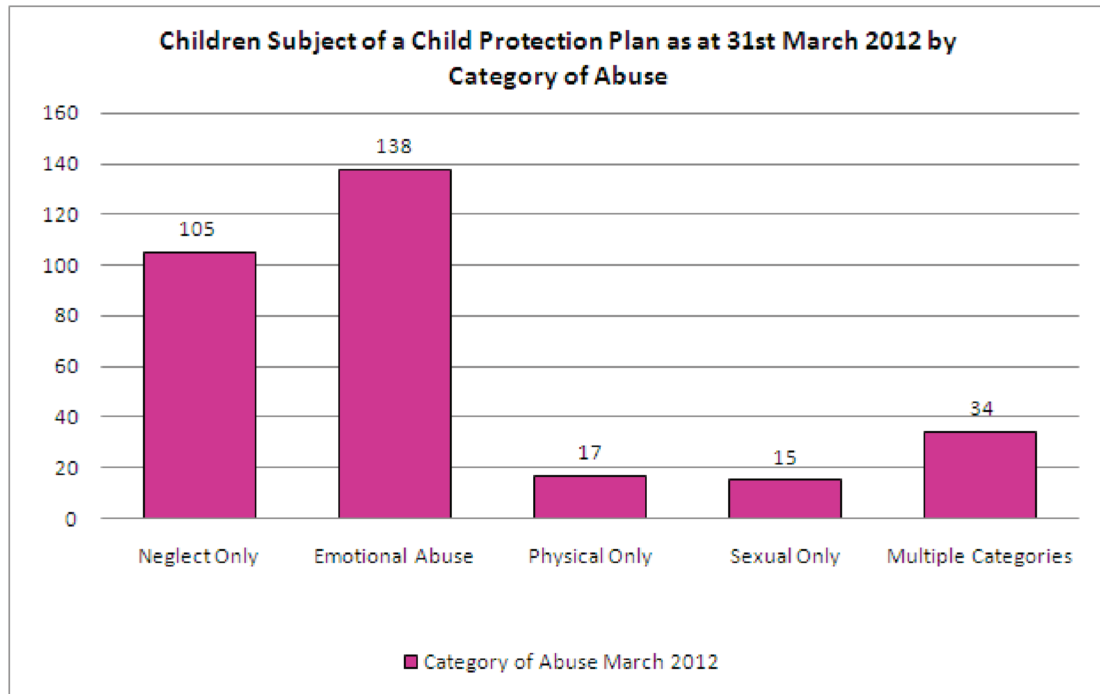
Children Subject to a Child Protection Plan who are also Looked After at 31 March 2012



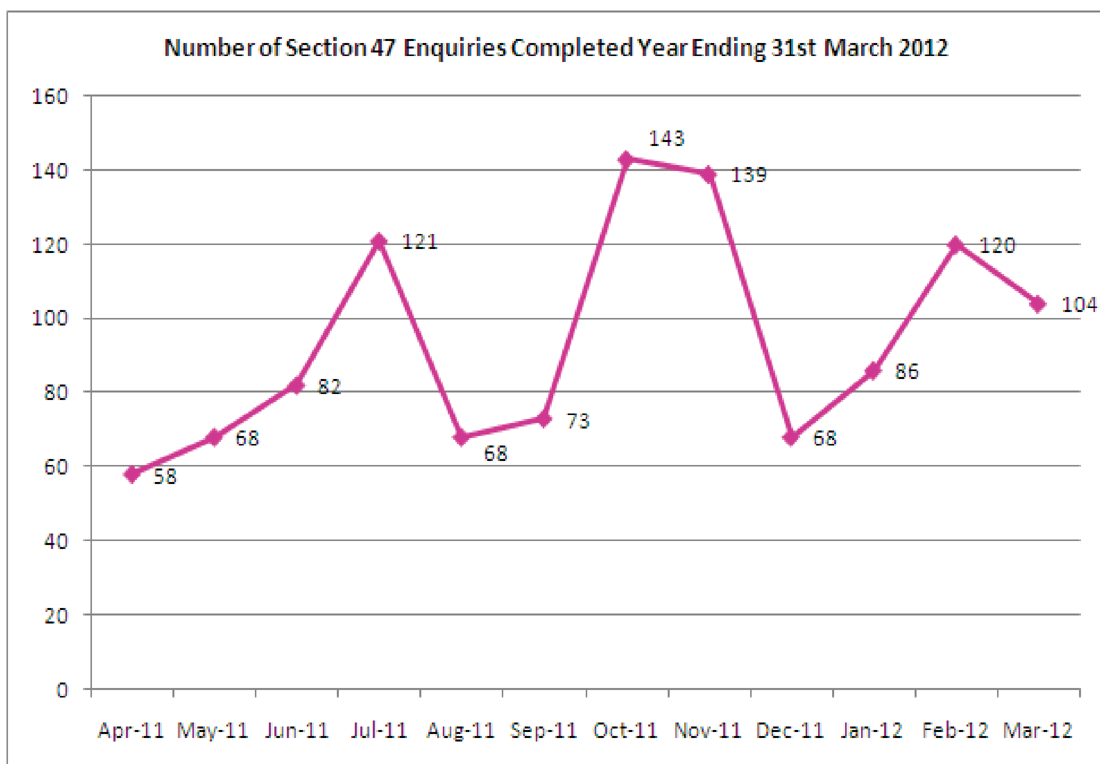
Of the 309 children subject to a Child Protection Plan at 31st March 2012, 12 (4%) were also looked after. This has fallen from 10% as of 31st March 2011. The reduction in this figure is a big achievement as it means a more effective

use of resources as children and their families are not subject to unnecessary duplicate processes.

Category of Abuse Year Ending 31st March 2012



Number of Section 47 Enquiries Completed - Year Ending 31st March 2012



There were 1130 Section 47 Enquiries during the year ending 31st March 2012. The number completed has been variable during the last 12 months, ranging from 58 in April to 143 in October.

Common Assessment Framework

Despite considerable training, mentoring, and practice development offered to support practitioners with Family CAF in Brighton & Hove on an on-going basis, the number of CAFs that have been initiated and completed has fallen in the last year. The support offered includes quarterly modular multi-agency Family CAF training, which covers all aspects of Family CAF practice and activity. Between March 2011 and March 2012 over 350 practitioners accessed Family CAF training.

It is significant to note that only 15% of referrals to CSC have an active CAF in place. The current level of activity is an average of 42 Family CAFs initiated per month - considerably below the target of 60. Despite the investment in training, CAF mentoring and the establishment of a CAF redirect pathway from social work, this rate of CAF activity is not increasing.

March 2011	
CAF started	50
CAF Completed	25
March 2012	
CAF Started	33
CAF Completed	23

In 2012-13 the LSCB will need to challenge partner agencies and establish why the figures remain low. Plans will need to be put in place in order to assist the agenda around ‘early help’.

Conclusions

Services respond well to children in need of protection in Brighton and Hove and there are good systems in place to be able to track performance and address any weak areas. Inspections in the last year have been adequate or better in all areas.

However, it is significant to note that the child protection system continues to be under considerable pressure, with many children coming to the attention of Children’s Social Care. Some targeted work needs to be undertaken in the coming year to safely reduce the children subject to CP Plans and make it more in line with our comparator Boroughs. Areas of concern that will need to be addressed include the high numbers of children becoming subject to a CP

plan for a second or subsequent time and the quality of CP and CIN plans. Work has already begun in 2011-12 to try and address these.

8 LSCB MEMBER AGENCIES' SAFEGUARDING REPORTS 2011-12

Since 2010 the LSCB has agreed that member agencies would submit an annual report for the Board to inform its annual review of safeguarding in the city. This can be in the form of reports submitted annually to Agency Boards, or if not, then a specially prepared note. The aim is to ensure agencies review their own progress on safeguarding, and that the LSCB can see that this is done, and at the same time gain assurance on local work. We ask agencies to report on governance, supervision, audits, training, and lessons learned from reviews. Key points from the reviews submitted (relating to Brighton and Hove) are set out below.

8.1 *Brighton & Hove City Council Children's Social Care*

(The performance report in section 7 contains more detail on Council performance.)

The Annual Report from Children's Social Care (CSC) described the change in 2011 to one central duty team, the Assessment Advice and Contact Service (ACAS) from three geographical teams. The service is managed by the Head of Delivery Unit and supported and challenged by the Head of Safeguarding, who reports to the Director of Children's Service (DCS). The DCS is accountable for the functions of education and social care, for health services seconded in through a S75 agreement from Sussex Community Trust. The DCS is also responsible for public health as Strategic Director for people.

In 2011-12 the council had a number of committees overseeing work with children. The Children's Trust (now the Children and Young People (C&YP) committee) is chaired by the lead member for children who is a participant observer at the LSCB, and the LSCB Chair is a co-opted member of the Committee. There is also a C&YP Cabinet Member Meeting and a C&YP Overview and Scrutiny Committee. The structure is changing for 2012-13.

To ensure there is the best possible services for children and families Children's Social Care have introduced a new Quality Assurance Framework (QAF). The Children's Social Work QAF and auditing schedule was launched in February 2011. It introduced a peer inspection process and a set of audit tools to measure the quality of practice for all social work staff. Early work on the framework helped the social work teams and integrated service to prepare for the new Ofsted inspection framework which was piloted in Brighton and Hove in December 2012. The subsequent Ofsted report recognised this as good emerging practice, which will strengthen and improve our services.

Quality assurance is not just for inspections, but an on-going process to assess the quality of practitioner's interventions with children and young people. Senior managers use it to monitor and evaluate the quality, effectiveness and efficiency of our services and ensure it provides value for

money. The QAF has now become a key part of the day-to-day management of staff and part of the wider performance management system, which includes supervision and appraisal. The audits will also help managers to highlight good practice and any areas for improvement. Key points from the QAF in 2011-12 are:

- Children in Need work is an area for development;
- Child Protection cases are generally adequate, but need stronger management oversight;
- LAC cases are generally good, with evidence of some excellent direct work with children.

In 2011-12 a comprehensive service improvement plan was put in place following the March 2011 Ofsted inspection. The following outcomes were found:

- Partnership work is highly effective, and supported both by good joint commissioning arrangements and joined up work with the CYPT and LSCB.
- Fostering and Adoption Services are good and outstanding.
- Safeguarding, the looked after children service and the Youth Offending Service are adequate with good capacity to improve.
- There has been a considerable reduction in the numbers of children subject to a Child Protection Plan.
- Considerable work has taken place in making the Child in Need system much more robust, thereby reducing the need for as many Child Protection Plans.

In 2011-12, in addition to LSCB training received, the Council delivered two 'core' days at level 2 for those involved in Case Conferences and a range of other programmes at level 3. 140 training events for 1560 staff were completed, a significant increase from 2010-11.

A new system ensuring all staff have an updated CRB check has been implemented, with a 4 yearly recheck. A CRB steering group reporting to the Senior Leadership Group has been set up to oversee the action plan for this key area.

All referrals to Social Care are now routinely screened for the common assessment framework (CAF) to ensure that CAF assessments inform decision making and planning. Since January 2011 a process of redirecting referrals back for a CAF if they do not meet social work thresholds has been in place. The outcome of this process is being tracked and monitored robustly through the Value of Money (VFM) process. Three Social Work Senior Managers sit on the VFM Prevention working group and work extremely closely with the Family CAF team. Redirection to CAF also includes families no longer requiring a statutory social care service, where the social worker supports the transition from a core group to a team around the family process. Despite much activity around supporting partner agencies to undertake CAFs (including the setting up of an advice team which sits alongside the new duty

system run by ACAS) the number of CAFs completed has continued to fall (see section 7). Work is in place to attempt to address this shortfall as it is significantly impacting on the level of referrals dealt with by the ACAS team.

The report concludes by pointing to improved practice as evidenced by the bedding in of the QAF process, and the Ofsted Report concludes that no service is less than adequate, with good capacity to improve. It says that good partnership work is continuing to develop. The numbers of children needing formal Child Protection Plans has reduced due to an increase in Child in Need Plans. A key challenge for 2012-13 is to improve case planning processes.

8.2 ***Brighton and Sussex University Hospitals NHS Trust***

The hospital safeguarding team won the Trust's Team of the Year award in 2011.

There are clear governance arrangements with an annual report to the Trust Board and a twice yearly report to the Trust Quality Group. The Chief Nurse is the Board lead for safeguarding and attends the LSCB Executive. In August 2011 the safeguarding committee signed off the majority of actions stemming from the LSCB/PCT visit from Nov 2010.

The Trust has submitted reports to the LSCB on domestic abuse management, inter-agency management of high risk births, and the process of medical child protection assessments. These have contributed to on-going multi-agency debates and performance improvement, for example formal agreement with Social Care on the joint management process around assessing future risks at the pre- birth stage, and re-auditing with successful results the process of creating individual baby notes for families with known safeguarding issues. On domestic abuse, the Trust has identified a lead person (the named nurse), committed to stronger links with the Brighton MARAC, is working on strengthening links between adult and children's safeguarding, and has introduced and raised the profile of the IDVA in A&E. On medical assessments, the Trust took action to improve the seniority of doctors undertaking child protection medicals and the timing, supervision and review of medicals. The LSCB reviewed progress in early 2012-13 and was pleased with the improvements.

A number of audits were conducted regularly. For example, on A&E notes (timings improved), maternity notes (positive findings) and paediatric referral forms (well completed). There were two audits on the flagging of high risk children and notifications to social workers. Feedback on training was positive.

Training compliance was 75% at level one, 46% at level two, and level 75% at level three. None of these is at their target level but the annual report describes eight specific measures aimed at improving these results.

Key actions planned for 2012-13 are to increase training levels and recording of training, further work on lining adult and child services around domestic abuse, auditing the compliance with safeguarding training compliance at consultant annual appraisal, and continuing to monitor closely the flagging system.

8.3 *Brighton and Hove Domestic Violence Forum*

Primary Role: The Brighton and Hove Domestic Violence Forum acts as the multi agency forum for Brighton and Hove in responding to domestic violence and to promote joint working, co-operation and mutual support. It aims to increase awareness of domestic violence and its effects within the community and the public at large, voluntary organisations and statutory agencies

Key Responsibilities regarding LSCB:

- To give the Domestic Violence Forum perspective in the development and evaluation of safe guarding children policies, procedures and practices.
- To contribute and to comment on documents/issues presented at the LSCB and to disseminate relevant information to Domestic Violence Forum members
- To attend LSCB meetings and development days.
- To promote greater awareness of domestic violence issues, developments and services, and to disseminate information, policies and procedures to LSCB members
- To participate in the audits and evaluations of the LSCB and those carried out by the LSCB.
- To identify gaps in service provision and training needs for members of both forums
- To promote effective communication between the LSCB and Domestic Violence Forum.

Summary of Activities for 2011-2012: The Domestic Violence Forum Chair regularly attends and contributes at LSCB meetings. RISE provides training on domestic violence as part of the LSCB training programme and took part in the Domestic Violence Audits of 2010-2011/2011 -2012. Third sector members of the Domestic Violence Forum completed Section 11 Audits. Representatives from children services attend Multi-Agency Risk Assessment Conferences (MARAC).

8.4 *East Sussex Fire and Rescue Service (ESFRS)*

In its second annual report, East Sussex Fire and Rescue Service (ESFRS) sets out its governance structure. An Assistant Chief Officer leads for the county on safeguarding, delegated in 2012-13 to the Director of Protection and Prevention, who leads on community safety and sits on both the children's and adults' safeguarding boards in the city. There is a ESFR Safeguarding Panel at senior strategic level, and a regular more operational Safeguarding Meeting. There is was a new safeguarding (adults and children)

policy in 2011 to be followed by all staff. A clear account is provided on supervision arrangements to support staff with concerns about children, and how issues arising are monitored. Safeguarding managers receive monthly supervision. All staff have access to an online safeguarding training package and in 2011-12 priority was given to safeguarding training for supervisory managers.

ESFR conducted an internal audit of case files related to children and young people coming to their notice and found good recording, timely action and proper referrals. The service contributed to the LSCBs local management review on a case with which it was involved, and took forward actions as a result , especially strengthening links with social care and offering to do fire prevention checks at the homes of children subject to CP Plans or other concerns. 4 children in the city were reported by staff for specific safeguarding concerns in 2011-12, and increased confidence in staff sharing concerns about children was reported.

The report also outlined the ESFR contribution to 'early help' through the fire setters intervention scheme for children with an unhealthy interest in fire, it has provided funding for over 500 methadone safety boxes in the city (with those households also getting a fire prevention visit), 14000 primary school received safety education in 2011-12.

8.5 *NHS Sussex/Clinical Commissioning Group:*

The report was prepared by the then designated nurse to brief the shadow Clinical Commissioning Group (CCG) which will take over NHS Sussex (PCT) safeguarding duties in April 2013. The designated doctor and nurse attend the LSCB and Executive, and sub-groups and are vital members of the safeguarding infrastructure.

The report describes progress on three recommendations from the Ofsted/CGC inspection of March 2011.The first was about greater engagement of GPs in their safeguarding role has been facilitated by LSCB funding on a non- recurring basis additional 'named GP' sessions to increase training for practice staff and practice safeguarding leads. The second was on the coordination of prenatal baby and mother notes which has been achieved. The third was on training for sexual health workers and school nurses around assessing competence to consent. A seminar was facilitated for 68 members of staff.

The PCT designated nurse worked closely with 2 local management reviews. On one, 13 heath actions were overseen including work on supporting an involved GP practice, antenatal risk assessments, greater face to face contact between GPs, midwives and heath visitors, and improving the Primary Family Assessment process to include more questions on adult drug and alcohol use. Actions on the other case cannot be reported but the LSCB is satisfied appropriate action was taken.

The second multi-agency audit on domestic violence cases in 2011 led to recommendations for better recording of contact with social care in health files, more efficient ways of GPs case conference records and improved training for GPs on a more systematic family based approach to domestic violence and recording of risks across separate files of family members.

The annual report expressed concern about wide variations in compliance with training requirements in the NHS providers it commissions, with no Trust for example reaching the target of 80% compliance with level three training, although GP safeguarding leads were at 100%.

Other key points included: enhanced liaison between GP safeguarding leads and linked health visitors, work in hand to enhance the flagging of children with CP Plans in GO records, and a physical injury pathway has been drawn up to provide clearer guidelines on action record with unexplained injuries. The report also notes key developments in provider Trusts some of which are covered in their own annual reports.

8.6 *Surrey and Sussex Probation Trust (SSPT)*

Whilst the service deals with adult offenders, 20% of those under supervision could be carers of children. Probation staff are required to fulfil their duties in a way that maximises the safety and development of children. The CEO is the designated lead for safeguarding, and the Brighton and Hove Director is on both the LSCB and its Executive.

All operational staff are subject to a quarterly QA audit of their risk assessments, and middle managers must ensure any case involving a medium risk to children is considered in monthly supervision. There is a clear accountability framework, embedded through induction and annual safeguarding training. Job descriptions explicitly states safeguarding responsibilities. Cases meeting MAPPA criteria are subject to rigorous internal and external audit. All contracts let for services set our clear safeguarding expectations.

SSPT recognises the importance of preventative activities in order to reduce the likelihood of children suffering harm. SSPT staff are involved with local initiatives which include the Family Intervention Project (FIP) and the Children and Families of Prisoners Group. More recently they have joined with the Local Authority led ‘Stronger Families, Stronger Communities’ initiative which is Brighton and Hove’s response to the Troubled Families Programme. Two members of Probation staff will be seconded into the team in 2012.
SSPT’s staff at Brighton and Hove magistrates’ court are piloting referrals to Children’s Centres for individuals identified as being in need of family support. A new sentencing options for women offenders in the form of a Specified Activity ‘Thinking Ahead’ have been introduced. This is a cognitive behavioural programme designed to address the specific needs of women offenders and includes modules on positive relationships. They are working in close partnership with Inspire to deliver services to women offenders. Inspire is a partnership of five women centred organisations in the city led by Brighton

Women's Centre. Members include Brighton Oasis; RISE; Threshold (BHT) and Survivors Network. Specialisms covered by Inspire include: substance misuse, domestic abuse and mental health issues. The service includes a family worker and crèche facilities.

A small number of staff have been trained to administer the CAF. Probation staff contribute to CAF, but do not undertake a CAF assessment.

8.7 ***Sussex Community NHS Trust:***

The Trust has been represented at the LSCB by the Asst. Director for Children's Services, and at the LSCB Executive by the CEO. Trust staff also attend 5 other LSCB sub-groups. There is one named nurse and doctor for the city covering the Trust's staff working directly for the Trust, or those seconded into BHCC Children and Family Services. The focus in 2011-12 was to review supervision, training and governance in the special arrangements where most Trust staff working with children do so within the council, but accountability for clinical standards and CQC registration is retained by the Trust. The named professionals are part of the BHCC Children and Families Safeguarding Quality and Governance Group.

Health visitors within the seconded services receive supervision on a 4-6 weekly basis, and the named nurse provides clinical supervision to managers 3 monthly, and she has observed manager- health visitor supervision to audit quality. A health visitor is now part of the children's social care duty team- Advice Contact and Assessment Service.

There was involvement with the LSCB's Local Management Review on a neglect case relating to substance misuse, and the health visiting service took forward actions in relation to reviewing antenatal risk assessment processes.

The Trust acknowledged some difficulty in the recording of training, partly due to staff working in differing settings and having come together from different employers, but did confirm in Brighton and Hove that 100% of school nurses and paediatricians, 97% of heath visitors, and 70% of Allied Health Professionals are level three trained, with named professionals and children's centre team managers all level 4 trained. All heath visitors and School nurses had assessment and management of domestic violence training in 2011.

On audits, the Trust completed the Section 11 Audit and this was subject to peer review at the LSCB Executive. Progress following the domestic violence audit was submitted to the LSCB, and the named/designated doctors (Trust employed) have audited sexual abuse cases and late statementing.

Priorities for 2012-13 include updating the policy on managing allegations against staff, improving the interface with adult services, and improving centralised training data.

8.8 ***Sussex Partnership NHS Foundation Trust*:**

The Trust which covers Sussex has established a locality safeguarding structure with a Named Doctor and Nurse dedicated to the city. They have established a strong relationship with the Brighton and Hove Designated Nurse. A sub-committee of the Board of Directors, the Quality Committee has adult and child safeguarding as a standing agenda item, and a Trust-wide Safeguarding Children Group chaired by the Executive Director of Nursing and Quality oversees local safeguarding groups including the city. The Executive Safeguarding Lead (Director of Nursing and Quality) is a member of the LSCB Executive.

The priorities set for 2011-12 related to training take-up, an additional senior child protection post, auditing the impact of e-learning and establishing a new programme for the Trust's child protection network – have all been achieved.

The Trust played a strong role in the LSCB's Local Management Review in 2011 on a neglect case involving substance misusing parents. Four key actions were taken by the Trust relating to assessment of the needs of children of adult mental health patients, improved working with health visitors about risks to such children and the creation of a daily risk meeting in the substance misuse service.

The Trust as a county wide (and beyond) service continues to be stretched by working with so many LSCBs and has suggested that opportunities to share common agendas and debates across the three Sussex LSCBs would be constructive. The Trust has highlighted the potential risk of their senior presence being diluted by needing to attend three Sussex LSCBs, whose meetings sometimes clash.

Priorities for 2012-13 are to review the form and function of Local Safeguarding Groups, further develop training for safeguarding trainers, establish an annual safeguarding audit programme and to review and re-launch the Trust's Safeguarding Strategy.

8.9 ***Sussex Police***

The Police are very active in LSCB business, and as well as sitting on the Board and LSCB Executive at a very senior level, also participate in the sub-groups covering SCRs, CDOP, Procedures and Training.
The move to referrals from children's social care (CSC) being routed through the Police Contact Centre has continued to assist detectives in spending more time on their investigative duties, and has been introduced across the whole Force area. It also reduces the likelihood of a referral being missed through not being recorded.

Work has continued on developing the way police share information with CSC by use of the MOGP/1 form, and a pilot project has commenced in East Sussex where using an agreed criteria, MOGP/1s are being screened by the

police before being referred to CSC. This has led to a reduction of over 30% in the number of forms being passed to children's social care, and it is intended to discuss extending this process across the whole Force area with CSC colleagues from Brighton & Hove and West Sussex. Discussions have continued with colleagues as to how police child protection teams can co-locate with CSC, and this has now been achieved with a team in West Sussex. Further developments in this area are expected in the year ahead.

In relation to the developing issue of child sexual exploitation, the police have been exploring how they can assist in the collation and development of intelligence provided by professionals in contact with children and young people.

8.10 *Third Sector:*

The Community and Voluntary Sector Forum (CVSF) is represented on the LSCB, and its Executive, but the third sector is not of course a single organisation that produces an annual report but a network of 700 organisations providing services to children and families. However, the CVS Forum has submitted a Safeguarding Survey Report for 2012 which is summarised below.

A major step has been the introduction, with LSCB support, of the 'Simple Quality Protects' QA programme which has so far assessed the safeguarding arrangements in 17 organisations and provided advice and support as they review/develop their policies and procedures. The results from this were warmly received by the LSCB as a good illustration of assuring good practice.

Safety Net as a local children's safety charity has been working closely with the CVSF to put in place support systems for the voluntary sector around its safeguarding responsibilities. Key Milestones and Successes in 2010 – 12 have included:

- Securing funding for 'Let's Protect' a project to provide safeguarding training, individual support and CRB advice to community and voluntary sector groups in Brighton and Hove.
- Recruitment of a Let's Protect Coordinator.
- Research into potential Quality Assurance programmes relevant to the CVS.
- LSCB funded purchase of 'Simple Quality Protects Quality Assurance Scheme' license.
- Rolling out Simple Quality Protects assessment and reviewing of safeguarding practices, including safer recruitment, across 17 organisations.
- Advised, supported and guided these 17 organisations to create, review and develop their Policies & Procedures and Staff & Volunteer Induction packs.
- Roll out of a free CVS safeguarding training programme.
- Take-up of training courses increased by 65%.

- 330 staff and volunteers from 83 groups & organisations attended funded courses.
- 72 community organisations submitted CRB applications for 548 staff and volunteers, nearly a 15% (14.79%) increase on the previous year.
- Development of partnership working between the CVSF Children and Young People's Network and the Local Safeguarding Children's Board (LSCB).
- Establishment of the Safeguarding Forum for CVS groups and organisations.
- Working with and signposting 42 new (small) groups to membership of the CVSF.
- Safety Net nominated by the NSPCC Safe Network as Sussex Safe Network Champion.

The CVS participated in the Section 11 audit focussing on larger organisations and conducted an online survey of smaller organisations.

The key findings were:

- A total of 33 groups and organisations responded to the safeguarding survey – 7 through the Section 11 audit and 26 through the online survey.
- Both the Section 11 audit and the on-line survey indicate a high level of awareness of and commitment to safeguarding the children and young people that the community and voluntary sector are working with. All organisations indicated that they have child protection policies and procedures in place, but there may be development areas for wider safeguarding policies, most notably in relation to e-safety and to a lesser degree whistle blowing.
- The vast majority of staff are aware of their role and responsibilities in relation to safeguarding, and most organisations have a designated child protection Officer (CPO). However, in smaller organisations, a significant number of CPO's had received no training or support and for 57% this additional responsibility was not reflected in their job description.
- Most organisations have a range of safer recruitment processes in place, though few have accessed safer recruitment training. The vast majority are clear on the need to undertake CRB checks, but are aware that this is only part of a safe recruitment package.
- 89.5 % of the organisations who completed the online survey ensure that staff receive basic child protection training every 3 years.
- There is a degree of diversity and confusion among respondents as to the first point of contact for information or advice regarding a safeguarding concern. Some indicated that they would contact ACAS, while others would speak first to other voluntary sector organisations.
- Approximately half of the online respondents had been involved in a CAF case. Among the seven that had experience of involvement, a number of issues and concerns were raised about the process. Some larger organisations have been fully engaged in the CAF process and

in some cases act as lead professional. Some groups would have a reservation about initiating a CAF because of the resource implications.

- User involvement and participation was an area of real strength for both large and small voluntary sector organisations, with some larger organisations having dedicated participation workers in post.
- There is a commitment to improving quality amongst smaller organisations. This includes the rolling out of the 'Simple Quality Protects' scheme.

The annual survey identified a number of areas for action:

- There is a general need for further work to develop e-safety policies and good practice.
- Protocols need to be developed for the frequency of reviewing policies and on how policies and procedures are incorporated into induction processes.
- Some organisations indicated that their designated safeguarding leads did not have this role included in their job description and felt that the role of trustees in relation to safeguarding needed to be more clearly outlined.
- There is also a need to look at the training and support needs of designated child protection leads in some organisations.
- Explore what would be covered in a safer recruitment training course and whether this would be suitable to the sector.
- Check whether there is a need for a separate ISA notification policy and whether organisations have allegations against staff policies included in their complaints policies.
- E-safety training needs to be developed.
- Ensuring that smaller organisations are aware of the free child protection training programme provided by Safety Net.
- Linking the sector to training that already exists like BHCC's Common Core.
- How do smaller voluntary sector organisations become more engaged in the CAF process and what is the process for logging the significant contribution of some of the larger voluntary sector organisations to the CAF?
- Explore advertising CAF training and its purpose again.
- When referrals are made to ACAS from a CVS organisation could ACAS also direct them to Safety Net and CVSF to join up CVS safeguarding and practice.
- A potential open session for CVS to visit the ACAS service.
- Consider how staff and volunteers could be asked for feedback on how well services are working.
- Follow up with organisations who indicated that they do not have data protection/ confidentiality policies in place.
- Update and market list of quality assurance packages and other support available under the Lets Protect Scheme.
- CVSF to undertake follow up visits to all organisations that completed the survey.

- CVSF and Safety Net to consider hosting a day conference for the CVS in partnership with the LSCB. Content could include feedback from the survey, information on Quality Assurance, a consultation session on improving evidencing sector engagement in the CAF process and peer to peer organisation workshops and training sessions.

9 COMPLAINTS REGARDING CHILD PROTECTION CONFERENCES

The LSCB has dealt with one complaint about decisions of Child Protection Conferences in the period under review (2011-12). The decision was reviewed by a multi-agency panel made up of LSCB members and chaired by the Designated Nurse for Safeguarding. This is in line with the Sussex Child Protection and Safeguarding Procedures. The options open to the panel are either to uphold the decision of the original Child Protection Conference or to reconvene the conference with a different chair. The original decision however stands whilst the complaint is investigated.

The nature of this complaint was in relation to:

- The decision made at the conference to make the children subject to child protection plans.
- Reports to the CPC were not shared in the appropriate timescale.

The decision of the panel was to uphold the decision of the original Child Protection Conference.

10 PRIVATE FOSTERING INFORMATION

In line with the local authority's responsibility for monitoring compliance of Private Fostering duties and functions, the following activity occurred during 2011-12:

Trends

- In 2011-2012 there were 2 existing Private Fostering arrangements at the start of the financial year.
- Four notifications of new private fostering arrangements were received during 2011-12 and all of these were confirmed as being appropriate notifications.
- Three arrangements ended during the year, leaving a total of 3 children & young people under private fostering arrangements as of 31st March 2012.
- Of the 4 new arrangements, all are children & young people from the UK.
- Two of the new arrangements relate to one young person (whose private fostering arrangement ended and another one started in the same financial year).
- All new arrangements are for females aged 13-15 years of age.

- During this period (2011-12) all young people and private foster carers were allocated a worker.
- All young people were seen within 7 days of the notification thus meeting the requirements of Regulation 4 of the Children (Private Arrangements for Fostering) Regulations 2005 for carrying out visits.
- In one case the authority did not meet Regulation 8 which requires an officer to visit every child who is being fostered privately at intervals of not more than 6 weeks in the first year of the PF arrangement. The reason for this was that for one of the visits there was a gap of 9 weeks.
- Legislation requires the worker to make a written report to the local authority after each visit. An audit of private fostering cases in March 2012 found that not all visits to young people and private foster carers are recorded on the system.
- There were no cases during 2011-2012 where the authority had to consider enforcing any requirements/prohibitions or disqualifications.

The concerns raised above are being addressed through increased awareness raising about the regulations with staff in the ACAS and CIN Teams (e.g. all staff taking on a private fostering case for the first time will be required to complete e-learning). In addition, we now have a designated social worker and practice manager for private fostering who will provide advice and support for private fostering case holders. They will also closely monitor and scrutinise cases throughout the year and raise any issues with workers and their managers so that remedial action can be taken.

11 MANAGEMENT OF ALLEGATIONS OF ADULTS WHO WORK WITH CHILDREN

Chapter five of Working Together to Safeguard Children (2010) contains the statutory guidance surrounding this issue and requires the Local Authority to investigate any situation where a person may have:

- behaved in a way that has harmed, or may have harmed, a child;
- possibly committed a criminal offence against, or related to, a child or;
- behaved towards a child or children in a way that indicates s/he is unsuitable to work (or volunteer) with children.

Or, in accordance with DfE guidance 'Dealing with Allegations of Abuse against teachers and other staff' 12th July 2011:

- behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children.

In 2011-12 there were 112 allegations against adults working with children across the city. This significant increase from the previous year is due in part to an increase nationally in allegations due the high profile of some cases and work that has been carried out to raise awareness. Locally we now have a

much more robust system in place which has been instrumental in ensuring that all cases are dealt with and followed up. Dealing with allegations against those who work with children is complex and involves suitability issues as well as direct allegations of abuse or harm. The table below illustrates the types of referrers and the types of allegations that have been dealt with in 2011-12.

The figures demonstrate a extent of activity which helps the LSCB to be reassured that safe recruitment procedures are robust and that children who make allegations about those charged with caring for them are dealt with in an appropriate and timely manner.

Allegation by Employer and Type:

Referrals by Employer and Type							
Employer	**Neglect**	**Suitability**	**Sexual Abuse**	**Emotional Abuse**	**ICT/On-Line Internet Abuse**	**Physical Abuse**	**Total**
Early Years	1	8	2		1	3	15
Education Maintained		24	10	1	2	11	48
Education Non Maintained						1	1
Education Non School Staff		1					1
Faith Groups		2	3				5
Health		2					2
Other		2	3				5
Police		1				1	2
Social Care		1	2			5	8
Transport		2	1				3
Voluntary Organisations		7	7			1	15
TOTAL	1	53	29	1	3	25	112

Education continues to be the biggest referrer which is in line with the national picture.

Out of these figures it is also significant to note:

- 24 employees were suspended whilst the allegation was being investigated.
- 39 were subject to a criminal investigation of which 9 received a conviction or police caution and 25 were subject to either a joint or Social Services s.47 investigation.
- Disciplinary procedures were initiated for 27 employees, 11 leading to dismissal.
- The services of 23 employees were ceased to be used.

- There were 9 referrals to the Independent Safeguarding Authority and 17 to a regulatory body such as Ofsted or the General Teaching Council. 2 cases involving foster carers led to deregistration.

Future plans for the management of allegations include;

- The LADO developing a multi- agency training programme for the LSCB, while continuing to provide training for Headteacher, Governors and Designated Teachers.

- The LADO to continue to build links with employers across the city.

- The LADO to consider the impact of changes in Working Together 2012 and the implementation of the new Disclosure and Barring Service in consultation with the LADO regional network, HR and the LSCB safeguarding sub-groups.

- The LADO to ensure that each agency represented by the LSCB has a Named Designated Officer to act as a conduit between its agency and the LADO.

12 CONCLUSION AND CHALLENGES FOR 2012-13

The majority of objectives in last year's business plan have been met. A new Section 11 audit was agreed and introduced, and subject to peer review in the LSCB Executive. Key audits have been completed or re-run, and findings brought to senior attention. Agencies are producing their own safeguarding annual reports. The Executive had been embedded. The LSCB has a place alongside the Health and Wellbeing Board, and 2 lay members have been appointed to the LSCB. Learning from local case management reviews, and SCRs from elsewhere, has been widely disseminated.

The Board has monitored and facilitated some key service improvements around child protection medicals and pre-birth planning. The Child Protection Liaison Group has continued to work on a multi-professional basis to learn from the management of difficult cases and improve practice. The training programme continues to be comprehensive.

Last year's report talked of understanding more the high numbers of CP Plans. It is probable that this has been largely related to case management processes and the need to improve early help, and numbers are already reducing. A major challenge in 2012-13 is for agencies outside social care to find ways of working together to extend early help, so that fewer cases below the threshold are referred to social care. CAF numbers need to increase.

As can be seen in appendix D, the business plan for 2012-13 has used headings which reflect the Munro Report and the draft new Working Together guidance: Strengthening accountabilities, creating a learning system, raising the profile/understanding of the LSCB, and sharing responsibility for early help. Amongst the key actions are the formation of an annual audit plan for

the Board, monitoring audits within member agencies, the creation of a dedicated capacity to strengthen the capacity of the Board to evaluate services, a major conference on child sexual exploitation, and to appoint 2 lay members (achieved July 2012).

Finally, within the year new government guidelines on safeguarding will be issued. These are likely to be radically smaller in size and with less prescriptive timescales. While this will allow more professional judgement about what is right in individual cases, LSCBs will need to be very vigilant to ensure that multi agency working arrangements remain strong and well-co-ordinated when there are less rules about how things should be done, and that case planning does not become more tardy when there are fewer national standards.

13 APPENDICES

A. Summary of Key Achievements and Onward Priorities
B. LSCB Budget Statement 2011-12
C. LSCB Multi-Agency Training Attendance Data 2011-12
D. LSCB 2012-13 Business Plan

Appendix A

SUMMARY OF KEY ACHIEVEMENTS AND ONWARD PRIORITIES

2011-12 Business Plan outcomes - see pages 11-12
- Robust new Sussex wide Section 11 audit tool agreed and implemented
- Thematic audit on child sexual abuse cases conducted for report in 2012-13
- Agencies reported on progress against the domestic violence audit which was re run, with some improvements seen
- Ofsted/CQC inspection reports circulated and action plan disseminated
- The high number of children on CP Plans was researched and no demographical factors were identified to justify the degree to which Brighton and Hove is an outlier: conclusion - that it is more a product of case management and improvements needed in early help
- The LSCB annual report was presented to the Children's Trust, incorporating summaries of agency safeguarding annual reports
- A major analysis of the work of the Local Authority Designated Officer was presented to the Board for the first time
- A Chief Officer led LSCB Executive is now fully embedded – see p15
- The LSCB has a formal relationship with the Health and Well-being Board
- By autumn 2012 there were formal links with the shadow Clinical Commissioning Group, which is now represented on the Executive
- The Munro and DfE proposals for safeguarding reforms were discussed and submissions made to consultations
- Two lay members were appointed to the Board in mid 2012
- An improved process is in place for the Chair to be informed of cases which might need a decision about an SCR
- Major seminars were held on SCR management, and lessons from a Local Management Review - see page 24
- A new Training and Development Strategy was introduced
- Safer recruitment practices were reported on in agency Section 11 audits
- A communication strategy was not produced due to other priorities
- The link with the Community Safety Partnership still has room for improvement
How the Board has made a difference - see pages 13-14
- The Board has monitored and supported Brighton University Hospitals NHS Trust (BSUH) to improve its capacity to undertake, and the quality of, child protection medicals which are now done at a more senior level and subject to regular peer review
- The Board regarded it as a priority to ensure there was a clearly agreed multi-agency agreement on processes around pre-birth planning. This led to a jointly agreed way forward between BSUH and the Council Children's Social Care
- The Board commissioned a Local Management Review, the findings of which were discussed in detail at the Board, were subject to multi-agency training, and to agency reports to the Board on how they has handled the

findings
- The update on the domestic violence audit was considered , and the process of police notification of DV incidents to health staff was reviewed
- The Board has increased the attention given to child sexual exploitation, with a new subgroup, a major police presentation (and a very successful conference in October 2012
- The Board began to address the low numbers of CAFs completed and the impact this has on referrals to social work, and this focus has continued in 2012-13 when a major Board conference on CAF/early help is planned for December
- The Board agreed an accountability framework to set out the guidance and LSCB expectations around the role of designated and named doctors and nurses.
- Detailed multi-agency work goes on through 9 LSCB sub-groups – with their work described in p15-22. For example, the Child Protection Liaison Group work through together challenging issues about how complex cases are handled, to identify and learn quickly from day to day practice
Learning and Development - see pages 22-25
- The audit of domestic violence case records was repeated, with some improvements for example on speed of response, early planning and decision making and more early referrals to police.
- The new Section 11 audit tool was used, patterns identified, and returns subject to chief officer peer review
- The Board began to collect information on single agency audits
- An informative Local Management Review was held with results widely disseminated and actioned. The key theme was the need for rigorous child focus when the adult is the client
- Actions were also agreed in a case which was deemed below the threshold for SCR
- New Training and Development Strategy
- 38 multi-agency events ran by the LSCB
Performance - see pages 25-30
- An increase in referrals to children's social care of 50% 2009-12. Initial and core assessments up two and three fold in the same period
- However over the year the number on CP plans dropped by 28% as a result of improved work at the Child in Need (CIN) stage and CIN plans being used more. This is still a national high outlier and the Board will have a major focus in 2012-13 of early help and extended use of CAF. There were less CAFs completed in 2011-2 than the previous year
- The percentage of children on CP plan who were also Looked After fell from 10% to 4%
Key Items from 2012-13 Business Plan - summarised from Appendix D
Governance/Accountability:
- To develop an annual programme of multi-agency audits and monitor the findings of single agency audits
- Ensuring the Board has sufficient capacity to enhance its ability to evaluate

local services
- To report on early help in the annual report
- To implement (the as yet unpublished) new Working Together guidance. This annual review points to the risks from the likely radical reduction in national guidance, and says the LSCB will need to be vigilant during the transition to the new arrangements
- To facilitate progress on the implementation of Ofsted inspection recommendations
- To ensure new NHS organisations are firmly embedded within the LSCB
Creating a Learning System:
- Continue to share lessons from SCRs and other Reviews and review methods for future reviews in line with the expected new statutory guidance
- Commission a major Sussex wide conference on Child Sexual Exploitation (completed)
- Evaluate the effectiveness of multi-agency training and monitor compliance with single agency mandatory training
Raising the profile and understanding of the LSCB:
- Appoint two lay members (Completed)
- Review the relationship between the Board and Education
- Produce an LSCB communications plan
- Strengthen links with Community Safety
Sharing responsibility for early help:
- Ensure the Board provides a focus and forum for the overview of early help
Main Challenge
In addition to dealing with the large public sector reorganisations and changes to national guidance, the main challenge for the Board is to facilitate the improvement in early help and case management, to head off the high numbers of cases which have traditionally ended with Child Protection Plans.

Appendix B

LSCB Budget Statement 2011-12

for year ended 31 March 2012

Detail	Budget	Actual
Staffing		
Training Manager (inc on-costs)	25,700	33,016
Business Manager (inc on-costs)	48,700	48,667
Admin Officer (inc on-costs)	12,100	3,588
Independent Chair	20,000	*24,841
Other Costs		
Contingency for SCR Panels	10,000	8,250
Venue Hire	2,000	1,295
Transport Costs	200	67
Printing	2,000	4,290
Office Stationery & Other	100	185
Telephone	110	223
Computer Costs	1,500	40
Communications	2,000	1,800
Conferences	2,000	1,826
Hospitality	200	38
Audit Analysis	5,000	0
Serious Case Reviews Seminar	1,000	910
Contingency **	20,950	14,840
CWDC funding for board development	18,300	*
Total LSCB Expenditure	**171,860**	**143,876**
Return of overfunding for admin post		7,984
Carry forward to 2012-13		20,000
Funded By:		
B & H City Council - Core Funding		85,010
CWDC Funding		18,300
B & H City Teaching PCT -		32,000
Surrey Sussex Probation Trust		4,000
Sussex Police		9,000
CAFCASS		550
Partner's Carry Forward		23,000
Total Funding		**171,860**

* £2100 of the CWDC funding was applied for Chair's development activity shown against the LSCB Chair line, leaving a net £16,200 available

****Contingency Breakdown**

Spend	
Safety Net - QA Products	4,550
FII Working Group	932
City Teaching PCT - Named GP	8,886
Training for court work	472
Total	**14,840**

Appendix C

LSCB TRAINING ATTENDANCE 2011-2012

Course Title	No. of courses run	CVS	EY - CEYCP	EY - P&I	Edu - LEA	Edu - Indie	ESFRS	BSUH	NHS	SCT	SPT	Police	Probation	Private Sector	Housing	Children's Social Care	Youth	Integrated Disabilities	LDS Adults - BHCC	Community Safety	BHCC - Other	Totals
Level 2																						
Developing a Core Understanding	9	19	17	46	33	2	0	0	0	8	13	0	2	0	4	16	10	1	2	1	6	180
Assessment, Referral and Investigation	6	5	9	22	29	3	0	0	0	8	10	0	7	0	0	11	1	2	1	0	5	113
Child Protection, Conference and Core Groups	5	4	14	20	22	4	0	0	0	4	5	0	2	0	1	13	2	1	1	0	1	94
Sub Total	**20**	28	40	88	84	9	0	0	0	20	28	0	11	0	5	40	13	4	4	1	12	**387**
Level 3																						
Domestic Violence and Abuse	7	7	5	2	18	0	0	7	2	10	14	0	0	1	7	34	9	3	4	0	2	125
Preventing Sexual exploitation of Children and YP	4	4	0	0	3	1	0	1	2	2	2	0	1	0	6	7	8	1	9	0	1	48
Substance Misuse and Parenting Capacity - day 1	1	5	0	1	2	0	0	1	0	0	4	0	0	0	0	5	0	0	0	0	0	18
Substance Misuse and Parenting Capacity - day 2	1	4	0	1	2	0	0	1	0	0	4	0	0	0	0	5	0	0	0	0	0	17
Working with Parents with a Learning Disability	1	2	0	0	0	0	0	0	0	4	1	0	0	1	0	5	0	1	0	0	0	14
MAPPA Training	2	1	2	0	1	0	0	0	0	0	6	0	0	0	16	7	0	0	3	0	0	36
Serious Case Review Workshop	2	5	5	0	8	0	1	1	0	21	9	4	2	0	0	28	4	2	0	0	4	94
Sub Total	**18**	28	12	4	34	1	1	11	4	37	40	4	3	2	29	91	21	7	16	0	7	**352**
		CVS	CEYCP	P&I	Edu - LEA	Edu - Indie	ESFRS	BSUH	NHS	SCT	SPT	Police	Probation	Private	Housing	Social Care	Youth	Integrated D's	LD - Adults	Community	Other	
		56	**52**	**92**	**118**	**10**	**1**	**11**	**4**	**57**	**68**	**4**	**14**	**2**	**34**	**131**	**34**	**11**	**20**	**1**	**19**	**739**
Grand Total	878 places available																					
	739 attendees																					

LSCB Training Total Attendance 2011 - 2012 = 739 / 878 (84.2%)

Brighton and Hove LSCB Business Plan 2012-13

Purpose of Brighton & Hove Local Safeguarding Children Board (LSCB):

The Brighton and Hove Local Safeguarding Children Board (LSCB) was established in 2006 under the Children Act 2004. The LSCB is the key statutory mechanism for agreeing how relevant organisations within Brighton and Hove will co-operate to safeguard and promote the welfare of children and young people and for ensuring the effectiveness of the work undertaken. The LSCB provides the strategic direction and operating framework that is needed to ensure the relevant organisations focus on their responsibilities with regard to safeguarding children and young people within the City.

Introduction to 2012-13 LSCB Business Plan:

The 2012-13 LSCB business plan is designed to reflect key objectives and actions in order to help make children and young people safer in Brighton and Hove. In doing so, this plan has taken into account the Government response to Professor Munro's review of Child Protection.

In addition, please note that, following the intended publication of revised statutory guidance (Working Together) in the autumn, the 2012-13 business plan may be subject to in-year amendment.

The business plan will be reviewed and updated as necessary by the LSCB Business Manager.

LSCB Objective 1: STRENGHTENING ACCOUNTABILITIES				
ACTION	**OUTCOME**	**LEAD**	**TIMESCALE**	**PROGRESS**
Develop an annual programme of multi-agency audits	Assurance of effective multi-agency practices across relevant organisations responsible for working with children and young people.	Monitoring & Evaluation Sub Group	October 2012	

	The programme includes case audits which gain a real sense of the quality of front line work			
Monitor the extent and findings of single agency audits	Improved scrutiny of audit activity to assess robustness and quality of practice across partner agencies.	Monitoring & Evaluation Sub Group	Report on progress to June 2012 Board	
Explore the capacity for the LSCB to have a dedicated post to enhance the Board's capacity to evaluate local services	Improved monitoring and evaluation function of the LSCB in line with Munro recommendations	LSCB Business Manager	Scoping exercise to be complete by August 2012	
Ensure the LSCB Annual Report includes the effectiveness of local early help and protective services (and that the report goes to the LA CEO and Health and Wellbeing Board)	An assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children to ensure that members are satisfied that arrangements for safeguarding children in B&H are robust.	LSCB Chair/Business Manager	Annual Report to be published in November 2012	
Ensure that requirements for the LSCB in the revised statutory guidance Working Together is disseminated and implemented where necessary.	LSCB members are aware of the new guidance in order to implement changes in compliance with revised statutory duties.	LSCB Chair	Dependent on publication of WT2012	

Work with NHS partners to ensure that shadow and new NHS organisations are firmly embedded with the LSCB and that accountabilities are clear.	Clarifications of accountability arrangements to ensure any new structures are engaged with the LSCB as necessary.	LSCB Chair	March 2013	
Ensure the Board facilitates the progress of recommendations from 2011 Ofsted reviews	Board satisfied that recommendations have been implemented	LSCB Chair/DCS	Ongoing	
LSCB Objective 2: CREATING A LEARNING SYSTEM				
ACTION	**OUTCOME**	**LEAD**	**TIMESCALES**	**PROGRESS**
Ensure the lessons from published SCRs are shared with members of Board	Partners are fully aware of learning in order that improved safeguarding and child protection processes are put in place.	SCR sub-committee	Ongoing	
Taking into account requirements from the new WT, review methods available to the Board to review cases other than through undertaking SCRs.	Efficient systems are in place to pull out learning and disseminate as quickly as possible across relevant agencies.	SCR sub-committee	September 12	
Ensure all actions from Local Management Reviews are monitored	Assurance that agencies have improved processes in place	SCR sub-committee	Ongoing	

Commission a Sussex wide conference of Sexual Exploitation	To raise awareness and share knowledge to help improve practice across partners agencies	LSCB Business Manager	October 12	
Evaluate the effectiveness of multi-agency training	Assurance that training is of sufficient standard to meet local needs and workforce requirements	Training sub group/Training Manager	December 12	
Monitor compliance of mandatory single agency training	Assurance that training is of sufficient standard to meet local needs and workforce requirements	Training sub group/Training Manager	December 12	
LSCB Objective 3 **RAISING THE PROFILE/UNDERSTANDING OF THE LSCB**				
ACTION	**OUTCOME**	**LEAD**	**TIMESCALES**	**PROGRESS**
Appoint 2 lay members in 2012	To help strengthen links with the local community in local child safety.	LSCB Chair/Business Manager	June 2012	Achieved subject to references etc May 2012
Review the effectiveness of links between the Board and 'Education' (taking into account any new requirements in WT)	Effective engagement with Education partners with the Board	LSCB Chair/Business Manager	To be agreed after new WT is published	
Produce an LSCB	Wider understanding of role	LSCB Business	March 2013	

communications plan (carry forward from 2011-12)	of the LSCB amongst members of the workforce and local community.	Manager/Proposed Communication Planning Steering Group		
Ensure good links with community safety and adult safeguarding	Strengthen partnership working to ensure there are no gaps or unnecessary overlap concerning children and young people in the City	DCS/LSCB Business Manager	December 12	
LSCB Objective 4: SHARING RESPONSIBILITY FOR EARLY HELP				
ACTION	**OUTCOME**	**LEAD**	**TIMESCALES**	**PROGRESS**
Ensure that the Board provides a focus and forum for the overview of progress on improving early help	Oversight on the effectiveness of early help in the city across the Board	LSCB Chair	Ongoing, but statement in Annual Report 2012	

[1] End Note

The chair of respective sub groups will have responsibility for ensuring actions are completed. The Head of Safeguarding and LSCB Business Manager will assist those sub groups where neither of them is acting as chair if necessary.