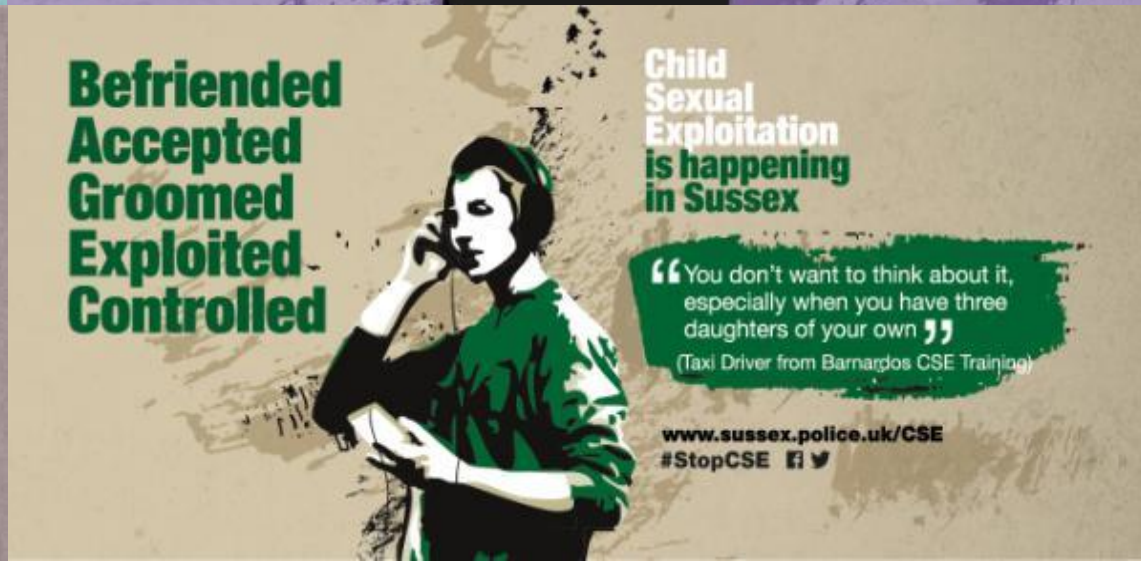
Brighton & Hove Local Safeguarding Children Board
Annual Report 2015 / 2016

Brighton & Hove LSCB local safeguarding children board



Contents

Introduction from LSCB Chairperson

Welcome to the Brighton and Hove Local Safeguarding Children Board Annual Report for 2015/16.

As ever, this has been an incredibly busy and productive year for the Board and its partners. We welcomed a new Lead Member for Children, Young People and Skills, Councillor Tom Bewick and a new Chief Executive of the city council Geoff Raw. We also have new members from schools, including for the first time the independent sector. We are delighted too to now have a Learning & Development Officer, Dave Hunt, in post after a gap following his predecessor leaving. Dave has made such an impact in refreshing our multi agency training programme and improving its responsiveness to needs of our children.

Alongside our regular programme of audits and re-audits, we have been undertaking, at various stages, four serious case reviews one of which was completed in the year. Each of these lead from a tragedy affecting a young person so we owe it to their memory to take a long hard look at ourselves and challenge every agency to find better ways to work alone and in partnership to help prevent other young people coming to harm.

We know that, on the basis that Safeguarding is Everyone's Responsibility, we are not the only Board looking to improve the lives of our people. Therefore we have started to establish stronger links with the Safe in the City Partnership, the Safeguarding Adults Board, the Health and Wellbeing Board and the Corporate Parenting Board. In times when resources are stretched it is incumbent on us to work together so that no person or group falls through the gaps and that we ensure all receive the help and support they need when they need it.

We were delighted with the outcome of our Ofsted Review, which graded us as Good. This was an in depth and rigorous process which highlighted some real strengths but also provided us with challenges to take forward. Part of that will include improving our oversight of missing children and taking over from a separate partnership board the lead role for evaluating the effectiveness of Early Help. This will be a huge challenge, as we know the level of need in our city is high meaning that far too many children and families require the support of social workers. If we can bring that need down through harnessing and directing the great work that is already taking place, we will improve the chances of our children and young people to thrive and that must be our key aim.
I hope you find this report informative and that it reassures you of the dedication that all our members share to work together to ensure our children are properly safeguarded. We know we have lots more to do to become even better, but we can only improve if we work tirelessly together putting the child at the heart of everything.

Graham Bartlett
Independent Chair Person, Brighton & Hove LSCB

Brighton & Hove Local Safeguarding Children Board
Annual Report 2015-16 Executive Summary

This annual report outlines safeguarding activity and performance in Brighton & Hove between April 2015 and March 2016 and illustrates how we as a partnership, and individual agencies, continue to strive towards improving the lives of our children and young people. Highlights contained in the report are as follows:

Priority Area 1: Responses to specific safeguarding concerns

Child Sexual Abuse (CSA)

- As a result of LSCB quality assurance activity:
  - Social Workers now **record discussions** with health professionals as part of a Strategy Discussion in their patient management system.
  - **Multi Agency Meetings** (MAMs) are now held weekly at the MASH and attended by a health representative.
  - A **Child Sexual Abuse Pathway** has been revised between health and social work in conjunction with Sussex Police which now takes account of the issue of historical allegations not directly concerning the subject child.
- This year saw the development of the **Forensic Paediatric Child Sexual Abuse service** for children up until their 14th birthday.
- Professionals have been provided with a reminder, via **a LSCB CSA Resource Pack**, of the likely signs and indicators of CSA, local and national contacts to call for advice and a reminder of how to refer concerns about a child or young person.
- A **CSA & Harmful Sexual Behaviours Conference**, which examined a number of issues around Child Sexual Abuse, was attended by over 150 professionals from across the partnership.

Child Sexual Exploitation (CSE)

- The LSCB, along with Sussex Police & Children's Services, have been participating in the **See Me, Hear Me Project**.
- The LSCB has proactively recommended a tour of **Chelsea's Choice** (a play aimed at raising awareness of CSE) to all schools in the City, and through the Educated Other than at School team (EOTAS)
- Over the year we have strengthened our scrutiny of responses to the needs of **boys and young men**.
- To ensure a robust, co-ordinated multi-agency strategic approach to tackling CSE & issues impacting other groups of vulnerable children, we have developed a **Vulnerable Children's Strategy**.
- In partnership with The Wise Project we have provided **multi-agency training** on CSE. Two sessions of the first course *Child Sexual Exploitation: Prevention & Disruption* have run, delivering awareness training to 44 professionals across the partnership. Three of the follow on sessions *Child Sexual Exploitation: Working with Young People at Risk* have been delivered with 70 professionals attending across the partnership.

Neglect

- A **Quality of Care Assessment Tool**, which aims to drive improvement in the quality of assessments, planning and the management of risk for children who are neglected, has been piloted successfully with health and social care teams.
- A **multi-agency learning review** looking into practice in relation to a long standing neglect case has been commissioned.
- As a result of a **parental substance misuse audit**, which tested whether there is a robust interagency response to the needs of children impacted by parental substance misuse that keeps children safe, all agencies have been reminded of the pre-birth conference procedures, and systems have been tightened to support adult services, working with a pregnant mother, to notify midwifery. .
- We published a **Neglect Bulletin** in February 2016 looking at the signs and risk factors around neglect and its effect on children & young people. This was circulated widely across the partnership, and helped promote our training on Child Neglect

Priority Area 2: Participation & Engagement

- **Lay members** have continued to provide additional scrutiny and challenge over the year.
- **Quality assurance activity** has continued to ensure the views of **parents and carers are contributing to learning and practice**. The Domestic Violence & Abuse audit required auditors to assess how effectively families were involved throughout interventions, similarly the CSE audit assessed the level to which parents had been consulted and kept informed of the outcome of assessments and decisions.
- **Quality assurance activity** has also continued to seek assurances that the views of **children and young people are contributing to learning and best practice.** The Domestic Violence & Abuse audit asked if the views of the child/young person had informed the work or plan, and asked auditors to consider how the weight given to their wishes & feelings balanced with the risk factors. Likewise, the CSE audit addressed the focus on the child/young person including their involvement in decisions made in respect of them
- To support parents, carers and members of the public having an improved understanding of the values and statutory function of the LSCB partnership, to work together to keep children in Brighton & Hove safe from harm, the LSCB has continued, with Safety Net, to produce the **parent newsletter** 'Safety Rocks'. 10,000 copies are distributed to parents through primary schools, and a PDF version is now circulated to parents with children in secondary school. The LSCB **Board Briefing** continues to be hosted on the LSCB website post Board meetings.
- LSCB Safeguarding Bulletins, , Managers Briefings, SCR Briefings, Twitter, Multi-Agency Training, Board Briefing's and the LSCB website are vehicles by which the Participation & Engagement has sought to support the **improved understanding of staff and managers** of the function of the LSCB.
- This year has seen **greater involvement of staff and managers** in multi-agency quality assurance activity. Staff and managers have also informed learning and improvement via their active participation and contribution to serious case and learning reviews.

Priority Area 3: Service Responses

An Early Help Conference, held in December 2015, was an opportunity to assess how well the system is working and how the LSCB and LA are demonstrably 'dedicated to early help'.

- To support the Board to build a better understanding of the effectiveness of early help assessments and interventions (to ensure that children and young people with additional needs receive timely responses and that emerging difficulties are addressed at an early stage), an extensive **multi-agency audit** of early help took place. This comprised of three parts; an analysis of early help data set; a shallow dive of cases referred to the Early Help engagement team; and a multi-agency audit of 10 cases, involving ten agencies

- Auditors concluded that 58% of cases that had been referred to the MASH, and subsequently passed on to the Early Help Hub Engagement Team (EHHET), could have been made directly to the EHHET.

- The in depth multi-agency audit found evidence of strong multi-agency working, very child focused practice, and evidence that the voice of the young person has informed the work undertaken. For the majority of children and families, their outcomes have improved as a result of multi-agency early help, and in the majority of cases there was regular case supervision and management oversight of the case.

Priority Area 4: Accountability

- The annual **LSCB Performance & Effectiveness Survey** had encouraging results. Two notable areas of improvement from last year's survey included a clearer definition of the purpose of the LSCB and more robust reviewing of progress against the work plan.

- A **LSCB Development Day** took place in June 2015 where the LSCB Business Plan for 2016-19 was drafted. Partners reviewed all the activity over the past year including feedback from the Ofsted Review, an overview of the outcomes and impact of quality assurance activity, and findings from the serious case review and learning reviews undertaken over the past three years. Five key outcomes through partnership were agreed.

- Board & subcommittee structures have been kept under continuous review.

- There has been increased scrutiny of subcommittee work plans at Leadership, with **Lay Members** providing additional challenge on progress.

- Annual scrutiny of single agency audit activity, progress against action plans from single and multi-agency audit activity, and the continuous review of LSCB core and thematic data has been undertaken by the **Monitoring & Evaluation Subcommittee**.

- Continued scrutiny of **progress against learning** and serious case review action plans has been undertaken by the Case Review Subcommittee.

Additional discharge of functions:

The LSCB undertook, completed, published, and learned from a **Serious Case Review**. We have continued to act upon the learning and implemented the changes required in frontline practice to improve outcomes for our children.

This year saw an **Ofsted Inspection** of the Local Authority and a Review of the LSCB. Ofsted judged the arrangements we have in place to evaluate the effectiveness of what is done by the local authority and Board partners to safeguard and promote the welfare of children as **good**. This year we have been working hard to take forward the recommendations made to us.

In October 2015 the LSCB team were joined by a new **Learning & Development Officer** who has revolutionised our multi-agency training programme. Whilst still early days, we have seen a re-fresh our core training offers and the development of some new specialist courses

The past twelve months have seen continuing developments for our partners. Some agencies have been subject to national restructuring and others have restructured locally in response to changing needs and economic pressures. Our partner agencies have worked hard to improve outcomes for children and young people and are able to evidence this. Please see Appendix 1 for our partners reports.

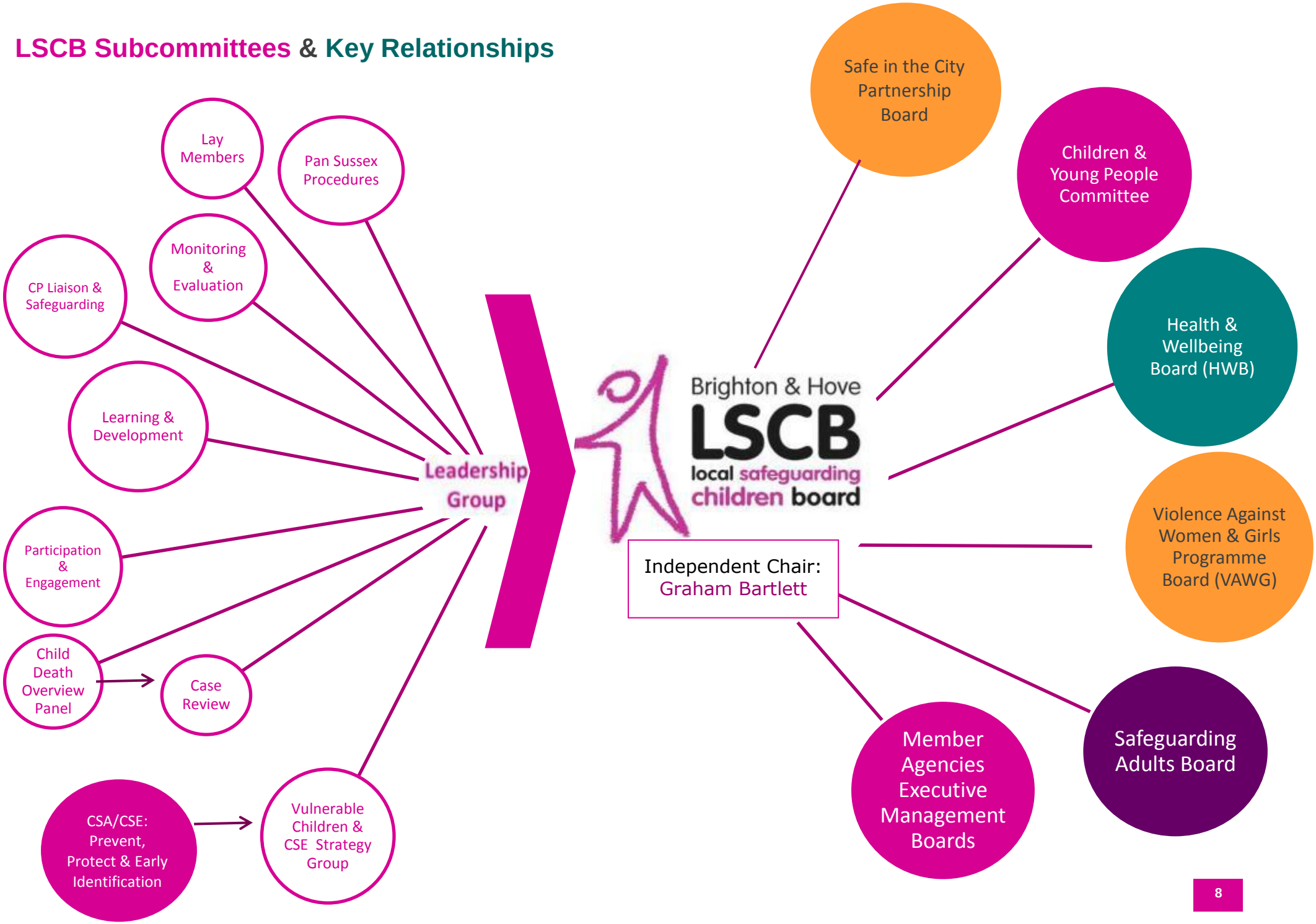
Summary of Achievements

- We have developed information sharing guidance to support professionals to understand responsibilities for legal and good information sharing. Developed following Case Reviews commissioned by the Board
- We have improved our understanding of the effectiveness of early help assessments and interventions.
- We have increased our efforts to capture the voice of children, young people, families and practitioners in our quality assurance activity
- We have raised the profile of the LSCB with practitioners by continuing to produce LSCB newsletters and safeguarding bulletins and having a presence with our new LSCB Values banner at practitioner events and remaining prominent on Twitter.
- We have made huge progress on our multi-agency training programme
- We have developed our Case Review Subcommittee to ensure learning is shared from Critical Learning Reviews undertaken by the Youth Offending Service.
- We produced a Child Sexual Exploitation multi-agency resource pack and distributed it across the safeguarding network
- We have worked hard to develop a more effective multi-agency dataset which, whilst still a work in progress, is used to routinely scrutinise operational partners' performance, and challenge and audit where necessary
- We have (although there is always more to do) worked collaboratively with other strategic boards to address areas of common and interlinked issues and concerns.
- We facilitated a number of discussions as a result of the learning from our case reviews. This has included talking to Midwifery services about the need for booking forms to collect information from both expectant parents; with Sussex Police about their approach in cases of possible non-accidental injury, and with other partners about the notification of possible non-accidental injury to the Police out of hours. We have asked all agencies how their data reports provide an overview of performance and provide information about overdue safeguarding tasks, and challenged partners whose staff are co-located about their information sharing and recording processes.

Summary of Challenges

- We still need to collate & analyse information from missing return interviews and further develop and embed the partnership response to children who are suffering, or at risk of, sexual exploitation and / or 'going missing.'
- We will continue to look to improve links with the corporate parenting panel and better understand why thresholds for care or accommodation are reached.
- We want to work more closely with the Designated Persons Network to further strengthen the flow of information between the Board and the city's schools.
- We want to strengthen links & work better, , with local communities and raise awareness of the importance of safeguarding for everybody across the city
- We want to further promote the emotional health and wellbeing of children and young people, and ensure they have access to effective mental health services
- We need to improve scrutiny of the LSCB budget via the Leadership Group
- A particular challenge for the LSCB has been engaging with sectors containing a number of relatively independent agencies (e.g. General Practitioners)
- We will never give up our aim to continuously promote the 'voice of the child' in the work of the LSCB and Partners

LSCB Subcommittees & Key Relationships



Review of Finances

All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be well organised and effective. In principle, members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on one or more partner agencies. Locally, the City Council has contributed around 70% of funding.

No uplifts in funds were requested by the Board in 2015 - 16.

It is a requirement for LSCBs to undertake reviews of serious cases in certain circumstances (please see page 12). These reviews, whilst absolutely necessary because they highlight weakness, and strengths, in the safeguarding and child protection system, are costly and impact on the financial health of the Board. The LSCB spent **£65,799** on SCRs and Learning Reviews in 2015-16.

It is important to note that the LSCB budget does not represent the true costs of the Board's business and development work and some 'hidden' costs are subsumed within the City Council and other partners' budgets. Therefore it is estimated that:

- **£113,162** was spent by the LSCB on salaries and on-costs (e.g. national insurance and superannuation) for the LSCB Business Manager, Senior Administration Officer & Learning & Development Officer.
- **£18,880** was spent on the LSCB multi-agency child protection training programme for frontline practitioners.
- **£2,310** was spent on LSCB communications.

Core Funding Contributions

Funded By :	**£**
Brighton & Hove City Council	155,410
Contribution. from NHS Brighton & Hove CCG	43,780
Kent Surrey & Sussex Community Rehabilitation Company	5,572
The Police and Crime Commissioner for Sussex	12,338
Cafcass	550
Total Funding	**217,650**

The full financial breakdown, including contributions from by East Sussex Fire & Rescue Service, the NSPCC and income from our CSA Conference, plus the budget forecast for 2016 -17, can be read in Appendix 2

Our Activity: Monitoring & Evaluation

The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through coordinating, but also by evaluation to drive continuous improvement. Under Working Together to Safeguard Children (2015) LSCBs must quality assure practice, including through joint audits of case files involving practitioners, to identify lessons to be learned. The Monitoring & Evaluation Subcommittee support the Brighton & Hove Learning & Improvement Framework to strengthen and promote a learning culture across partner agencies.

The main focus of the subcommittee's work, in its five meetings in 2015-16, has been continuing to oversee a programme of multi-agency audits consolidating the LSCB's Quality Assurance Framework (QAF), including dissemination of findings from audits and tracking action plans, and scrutinising aspects of practice highlighted by the Management Information report.

Quality Assurance Framework

The LSCB Quality Assurance Framework (QAF) underpins the multi-agency audit programme. In 2015/16, efforts were made to improve feedback from service users and from practitioners, with a stronger focus on outcomes.

Summaries of findings from audits have been shared with staff in briefings and a tracking system is in place to track all actions from LSCB audits and learning reviews.

Multi-agency Audits:

Three multi-agency audits were undertaken in 2015-16:

- Network Meetings & Core Group Audit,
- Parental Substance Misuse Audit (see page 22)
- and an extensive multi-agency audit of early help (see page 28)

Single Agency Audits:

All agencies were requested to provide their audit schedules for 2015/16 and 2016/17. Where summaries were not returned the agencies have been challenged by the LSCB Chairperson.

The past year has seen continued progress in embedding the quality assurance framework, with improvements in audit process, dissemination of findings, tracking actions, and evidence of changes in practice as a result of audits. The commitment of all members of the group to conducting regular audits is to be commended.
Helen Davies, Independent Chair, Monitoring & Evaluation Subcommittee.

Monitoring & Evaluation's Areas of Concern

An area of concern to the subcommittee and the LSCB has been the continued high number of children subject to repeat child protection plans in Brighton & Hove.

Another area of concern identified in management information is the high number of referrals and repeat referrals to Children's Services. The introduction of a MASH and Early Help Hub in September 2014 was intended to address some of the issues that had been identified as contributing to the high numbers. It took some time for accessible data about the workings of MASH to be available, but more recently the subcommittee has been scrutinising this data and will continue to do so, alongside the routine MASH audits.

In 2015-16, it was decided that the LSCB management information report would be presented to the LSCB at six monthly intervals.

Network Meetings & Core Group Audit

The focus of this multi-agency audit was to examine the effectiveness of multi-agency working through Network Meetings1 & Core Groups2. It explored the areas of enquiry raised by members of the Monitoring & Evaluation Subcommittee including; agency attendance, agency reports, agency challenge, outcomes for the child and meeting minutes.

Eighteen cases were audited. Overall, the practice was good, but 36% required improvement.

Positive findings included:

- in the majority of cases, meetings were held regularly and attendance at meeting by professionals is good
- multi-agency planning is judged to be good in the majority of cases including communication and information sharing
- the vast majority of Child Protection and Child in Need (ChiN) plans are SMART and in all but one case agencies are carrying out their agreed role

This audit included **practitioner feedback** and feedback from six parents. Reflection and feedback included:

- parents were able to engage and have input into the meeting
- meetings were an opportunity to discuss together a constructive way to support the family
- all the professionals have worked well together

The audit also focussed on **outcomes for the child**. For children subject to ChiN plans there was evidence that multi-agency working is leading to positive change for the children in three cases. For another three, contingency plans were being put in place, while for the remaining three, where parents were not engaging with the plan, they had been escalated to child protection conferences. For the children subject to a child protection plan, positive change was reported in six cases, while contingency plans were in place for the other three.

Recommendations included:

- frequency of meetings should be specified in the plan
- all actions should have a specific timeframe documented
- if practitioners are unable to attend a meeting, they should always be required to submit a report
- where appropriate, young people should be invited to attend the meeting
- minutes of the meeting should be kept simple with the focus on the child's plan
- a record of the meeting should be circulated to members within 2 weeks

[1] The Network Meeting provides an opportunity for professionals involved with a family to come together not only to share information, but also to help determine the direction of a case and the Child In Need (ChIN) Plan for a child.
[2] The Core Group is responsible for the formulation and implementation of the detailed Child Protection Plan (CPP), previously outlined at the conference.

Our Activity: Serious Case Reviews

As per *Working Together to Safeguard Children* (2015), LSCBs are required to consider whether to initiate a serious case review when a child dies (including death by suspected suicide) or is seriously injured, and abuse or neglect is known or suspected to be a factor. The main purpose of a serious case review is to learn lessons to improve the way in which agencies and professionals work both individually and collectively to safeguard and promote the welfare of children**.**

One Serious Case Review was published in 2015-16. Two Serious Case Reviews and one Learning Review have been initiated and findings are pending as at 31 March 2016.

Baby Liam: During the first seven weeks of his life Liam was injured on at least two occasions and experienced fractured ribs, a fractured femur and bilateral skull fractures. His Father was a care leaver from another area with history of volatile behaviours & substance misuse.

You can read the full review and the Board response and a short summary of the findings here.

Learning from the Baby Liam SCR has now been included in the sessions of our multi-agency training programme on lessons from local and national SCRs.

Finding 1: **Care leavers** who are, or who become **parents**, need to be supported and their **children's** safeguarding needs

Finding 2: A full & detailed **history** on fathers, partners (male and female) & other significant adults (male and female) in the family should be sought when **gathering information**. It is also important to share this information about **pregnant women** and their **partners** with **Midwifery** and **Health Visiting** teams so as to enable **effective risk assessment**.

Finding 3: Where cases are held on **duty**, responses to children may be limited / task orientated with a lack of understanding of case history, analysis of risk and ownership of outcomes.

Baby Liam SCR

Finding 4: During **case transfers** there needs to be **easily accessible** case history information to **assess risk.**

Finding 5: **Data systems** need to support frontline managers in their daily management of tasks - including providing alerts for overdue work

Finding 6: **Leaving Care Grants (LCGs)** need oversight to ensure they enable **positive outcomes** for **care leavers**

Finding 7: Unplanned/ casual / **corridor conversations** which impact on decision making need to be **recorded**

Finding 8: All possible non accidental injuries need to be referred to the police.

Our Activity: Learning Reviews

In Brighton & Hove, Learning Reviews take place when, after an initial review of the case, it is decided that there are lessons to be learnt, but the threshold for a SCR is not met. The Learning Review consists of professionals from each agency involved with the child or family meeting together to share information, identify good practice and missed opportunities. Learning which might help to prevent similar events in the future is identified.

Ben

From the age of 11 Ben was reported to be self-harming. These reports of self-harming continued to be raised during the two years prior to an episode where he attempted to hang himself. Following the hanging incident Ben was left with life changing brain injuries and sadly Ben died in 2015.

Some of the findings from this learning review were shared with Brighton & Hove CCG and Public Health Commissioners:

- Many professionals view self-harm as not uncommon, seeing it as a single type of behaviour rather than occurring along a spectrum, which makes it less likely they will notice escalation and identify high risk, potentially life threatening, behaviour.
- There is inadequate choice in emotional wellbeing support and mental health service provision to meet the preferences of many young people, leaving them with the option of attending, or not, the available medically-focused option.

The review also prompted the Board to consider:

- Is there a common organisational deafness that minimises the chances of really hearing what teenagers are saying when they tell us concerns about their friends?

This learning was fed into existing workstreams underway across the partnership, such as the Emotional Health & Wellbeing (EHWB) steering group and the re-commissioning of mental health and emotional wellbeing services. Read below for more about this work from the Commissioner for Children, Young People and Public Health Schools Programme and the Commissioning Manager, Children's Mental Health & Wellbeing.

Child J

Child J was found hanging in the family home shortly after his 18th birthday. J had received services from children's social work, mental health services, drug services and youth services two years prior to his untimely death.

Following a review of Child J's journey through the safeguarding system the LSCB wanted assurance that Child and Adolescent Mental Health Services (CAMHS) can be appropriately accessed where there is a **dual diagnosis of mental health & substance misuse,** and that safeguarding procedures work.

Ofsted Review

An Ofsted review took place from 14 April– 8 May 2015 which judged the arrangements the LSCB have in place to evaluate the effectiveness of what is done by the local authority and Board partners to safeguard and promote the welfare of children as **good**. Ofsted recognised the journey the LSCB has been on over the past two years and described a "rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner agencies". At the time 29% (17) of LSCBs were judged as good overall, 49% (28) as requiring improvement and 22% (13) as inadequate.

The good quality LSCB annual report reflects the board's learning and self-evaluative ethos

The LSCB is an active and influential participant in informing and planning services for children and young people

Findings: Governance

….transparent, learning-focused multi-agency LSCB

- constitution and compact underpins the new arrangements
- Board identifies & shares cross-cutting intelligence & knowledge about particularly vulnerable groups of children (radicalisation & CSE)
- constructive relationships with other key strategic boards
- multi-agency section 11 challenge event rigorously tested compliance of partner agencies with core safeguarding policies

Findings: SCRs & CDOP

- targeted and achievable action plans.
- implementation of action plans is closely monitored
- learning from reviews is appropriately cascaded to the workforce
- Child Death Overview Panel is effective in scrutinising serious incident notifications & has strong links with Case Review Subcommittee

Serious case reviews commissioned in accordance with statutory criteria & thresholds applied correctly

…rigorous approach to evaluating the effectiveness of safeguarding arrangements in all of its partner agencies

Findings: Quality Assurance

- tenacious efforts to develop a multi-agency dataset
- audit findings & recommendations systematically & comprehensively disseminated across partnership
- intelligence from audits, serious case reviews & learning reviews used effectively to inform content of specialist multi-agency training programmes
- good Quality Assurance Framework supported by a complementary Learning Improvement Framework
- audit recommendations rigorously pursued & repeat audits scheduled

How we have responded to recommendations & shortfalls:

LSCB to collate & analyse information from missing return interviews

The National charity, Missing People has been commissioned by East Sussex County Council, West Sussex County Council and Brighton & Hove City Council to provide a Return Home Interview (RHI) Service and a 1-1 Support Service to children across Sussex from 1 April 2016 until 31 March 2019. Return Home Interviews aim to find out why young people went missing, what happened to them while they were away, and what support they need to keep them safe and prevent them going missing again

LSCB to improve links with the corporate parenting panel and better understand why thresholds for care or accommodation are reached

Our Business Plan 2016-19 now has an objective for the LSCB to be sighted on the work of other strategic Boards in the City, including the Corporate Parenting Board. In 2015 Children's Services undertook, via their Support Through Care team, an audit which focused on children in care and care leavers who become parents, and considered whether support and safeguarding issues were being appropriately addressed. The LSCB requested the Corporate Parenting Board be made aware of the findings from this work.

LSCB to build better understanding of the effectiveness of early help assessments and interventions

The LSCB Monitoring & Evaluation Subcommittee undertook a Shallow Dive. This was to test whether professionals, who make a Contact to MASH which does not meet the threshold for Social Work Intervention understand the thresholds, and to assess whether the child's emerging needs are appropriately met elsewhere when Contacts made to MASH do not meet the threshold for Social Work intervention (Early Help Hub and MASH Initial Review, April 2015). In addition to this we also carried out a multi-agency audit of the early help provided in a sample of Contacts (with the service) which resulted in early help intervention.

Business Plan to provide focus on children looked after living outside the Local Authority

Looked after children are, in most cases, no longer within the child protection system because they have been made safe. Where there remain child protection concerns, for example through CSE or radicalisation, we of course scrutinise the services they receive for example through the Vulnerable Children& CSE Strategy Group. Oversight and scrutiny of how Looked After Children are served is through the Corporate Parenting Panel. Ofsted judged performance of the Local Authority around Looked After Children as being good, observing that the thresholds for children to become looked after are appropriate and consistently applied

LSCB to continue to scrutinise and influence the reduction of the high number of repeat referrals and child protection

Monitoring & Evaluation have, throughout the year, continued to scrutinise the high number of repeat referrals and repeat plans via consideration of the Management Information Report and a multi-agency audit. Consideration of the issue has also been tabled for discussion at all three Board meetings throughout the year.

LSCB Development Day & LSCB Business Plan 2016-19

The LSCB held a Board Development Day in June 2015 where the LSCB Business Plan for 2016-19 was drafted. Partners reviewed all the activity over the past year, including feedback from the Ofsted Review, overview of the outcomes and impact of quality assurance activity, and findings from the serious case review and learning reviews undertaken over the past three years. Feedback from the annual LSCB Performance & Effectiveness Survey was also provided, you can read more on this on page 29. Five key outcomes through partnership were agreed

Priority Area 1: Child Sexual Abuse (CSA)

Paediatric Sexual Abuse Referral Centre (SARC)

Throughout the year the Board has been keen to hear updates on the implementation of the Paediatric Sexual Abuse Referral Centre (SARC) which was launched on 1 April 2015. From this date, the Brighton & Hove team has provided a Forensic Paediatric Child Sexual Abuse service every day of the week for children up until their 14th birthday. Issues regarding facilities and the sustainability of the staffing rota have been addressed by the SARC Board, and guidance has been produced for Police Officers and Social Workers on arranging medical examinations for possible Child Sexual Abuse.

Of the 2,868 single assessments completed in 2015-16, **161 (5.6%)** identified sexual abuse as a factor at the end of the assessment compared to 5.1% in 2014-15

Of the 392 children subject of a Child Protection Plan as of 31 March 2016, **13 (3.3%)** had Child Sexual Abuse recorded as a category of abuse compared to 5.8% (18 children) at 31 March 2015.

Multi-Agency Quality Assurance Activity

As a result of a multi-agency audit in 2014 an action plan has been progressed in 2015 and the following changes in practice have been made:

- Now social workers record discussions with health professionals as part of a Strategy Discussion in their patient management system.
- The MASH now has a health partner co-located in the hub to help facilitate the involvement of appropriate doctors and other medical professionals in all strategy discussions.
- A Child Sexual Abuse Pathway has been revised between health and social work in conjunction with Sussex Police which now takes account of the issue of historical allegations not directly concerning the subject child.

Communications

A CSA Multi-Agency Resource pack was produced to help prevent children and young people being subjected to CSA. This resource pack provides information and guidance for people who may encounter children or young people at risk of, or having experienced, CSA, including:

- A description of the likely signs and indicators of CSA
- Useful local and national contacts to call for advice
- A simple referral diagram showing how to refer concerns about a child or young person.

Training

During Safeguarding the City Fortnight a session was held on the purpose and function of the Sussex Children's (Sexual Abuse Referral Centre). Attendees commented on having learnt more about the entire SARC processes from referral to medical and beyond.

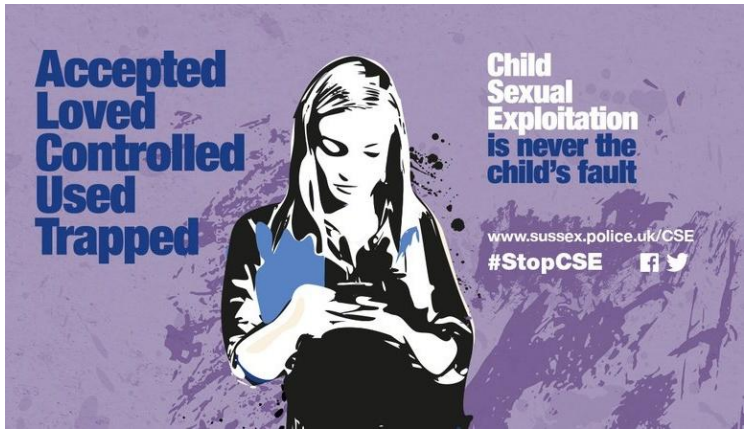
The Claremont Unit also ran a very popular session on Children & Young People who Display Harmful Sexual Behaviours, and this was repeated in the LSCB training programme in the spring

CSA & Harmful Sexual Behaviours Conference

Our Child Sexual Abuse & Harmful Sexual Behaviours conference on 22 May 2015 was attended by over 150 professionals from across the partnership. This day examined a number of issues around Child Sexual Abuse. You can view the materials from the day here. Issues discussed in presentations and workshops included:

Multi-agency investigation of CSA
Complexities of the legal issues
Procedures for CSA medicals
Barriers to communicating with under 5s to get evidence about sexual abuse
Developmentally Appropriate Interviewing
Post Abuse Therapy
Harmful Sexual Behaviours

Priority Area 1: Child Sexual Exploitation (CSE)



Ofsted Review

Ofsted noted there was an effective child sexual exploitation strategy in place, and achievable plans to improve identification of children at risk of CSE at earlier stages. They commented that the newly established CSE Prevent & Early Identification Subcommittee is well positioned to progress this, and reported that the LSCB thoroughly evaluates intelligence & cross-cutting themes regarding particular groups of vulnerable children through the Vulnerable Children & CSE Strategy Group.

The Wise Project

The WiSE Project is a service for 13-25 year olds who are experiencing sexual exploitation or are at risk of 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.

THE WiSE PROJECT
Working to prevent the sexual exploitation of children and young people

See Me, Hear Me Project (SMHM)

The University of Sussex was commissioned by the Office of the Children's Commissioner (OCC) to support the implementation & evaluation of the OCC's 'See Me, Hear Me' Framework for safeguarding children at risk of sexual exploitation in three English local authority sites.

The LSCB, along with Sussex Police & Children's Services, was invited to participate in the project towards the end of 2014.

The See Me, Hear Me Framework is a research-informed, multi-agency service model, designed to support professionals to make visible the experience of those children facing sexual exploitation, and to facilitate the creation of the relationships necessary for safeguarding to be made effective in each individual case.

The project aims to:

- *support* the implementation of the 'See Me, Hear Me' Framework
- *evaluate* the efficacy of the service model developed and the impact it achieves for children; and
- *recommend* ways in which the diffusion of the approach more widely might be achieved effectively across similar local authority areas, and in respect to safeguarding practice in general.

Chelsea's Choice

Brighton & Hove City Council have commissioned a not for profit social enterprise, AlterEgo Creative Solutions, to tour schools in Brighton & Hove with their highly innovative and acclaimed production 'Chelsea's Choice'. The play highlights the very serious and emotional issue of child sexual exploitation by telling the story of a group of three students who discover the diary of a girl called Chelsea.
The 40 minute production and post-show Q&A raise awareness of:

- Healthy Relationships
- Safe Internet Use
- Risky Behaviour
- The Grooming Process
- Child Sexual Exploitation
- Where young people can go for help & advice

Performances were supported by specialist social workers and police officers, to ensure that children are in receipt of appropriate supports and services afterwards. Materials were produced for all year groups for use in PSHE lessons and tutor time to ensure all students had the opportunity to learn more about grooming, sexual exploitation, e-safety and healthy relationships. In April 2015 the LSCB Independent Chairperson wrote to all schools in the city to recommend the play and encourage them to invest in a tour of the show.

Training

The WISE Project deliver our CSE training, which is split into two sessions: Preventing & Disrupting the Sexual Exploitation of Children & Young People and Child Sexual Exploitation: Working with Young People at Risk. This comprehensive training package, also supported by presentations from Sussex Police, covers recognition and awareness leading into how systems are put in place to disrupt this type of activity. This training has also been updated to consider and integrate the "See Me, Hear Me" principals, thus making sure that the voice of the young person or child is heard.

Multi-Agency Quality Assurance Activity

As reported in last year's Annual Report an audit looked in depth at six cases of young people at risk of CSE and this year we have, via the Vulnerable Children & CSE Strategy Group, been progressing the recommendations:

- looking at the need for a more robust response to the needs of boys and young men
- proactively identifying young people at risk of CSE through the regular review of child protection & child in need plans
- looking at ways to adapt support services for young people so that they are assertive, flexible and accessible
- continuing to raise awareness of CSE across the partnership

Next year the Monitoring & Evaluation Sub Committee will undertake another CSE audit to further test the effectiveness of multi-agency working with children who are being sexually exploited, or at risk or being sexual exploited. In response to the issues raised at the CSA/CSE Prevent, Protect & Early Identification Subcommittee, the audit will also assess whether the needs of children and young people with learning disabilities are being appropriately addressed.

CSA/CSE Prevent, Protect & Early Identification Subcommittee.

In January 2016 the *CSE: Prevent & Early Identification* and *CSE: Protect & Pursue* subcommittees merged into a single CSA/CSE Prevent, Protect & Early Identification subcommittee. The intention was to avoid duplication and make the meetings more streamlined and efficient.

This is a multi-agency meeting with the main aim of preventing, identifying early and disrupting the sexual exploitation of children.

There is a strong focus on:

- the driving factors behind CSE
- ensuring that Police operations and disruption of perpetrators is maintained
- learning from operations are captured to strategically manage the risk of CSE within the city
- ensuring that male and female victims are considered with equal measure
- ensuring that children with disabilities including learning disabilities are factored into the work of the subcommittee

Areas for improvement include:

- a focus on the needs/concerns of LGBT youth
- ensuring suitable membership
- striking an equal balance between prevent/early identification and protect/pursue

In January 2016 Dr Michelle Lefevre, Department of Social Work and Social Care, University of Sussex observed our first joint meeting, (as part of the work on the See Me, Hear Me Framework described above). Her reflections helped participants to consider the strengths and challenges in how the SMHM principals are being embedded within services.

A year on: Vulnerable Children & CSE Strategic Group

Throughout the year we have considered:

- The management of perpetrators
- Responses to the Rotherham Inquiry
- The private fostering annual report
- Progress on the implementation of the Sussex Paediatric SARC
- Changes to Modern Slavery legislation
- Scrutinised Police Strategic Needs Assessment on CSE & Benchmarking - identifying hotspots for the whole of Sussex providing each Divisional area with specific locations where CSE was being perpetrated.

Vulnerable Children Strategy

One of the group's first tasks was the development of an overarching vulnerable children strategy. The strategy aims to ensure a robust, co-ordinated multi-agency strategic approach to tackling CSE & issues impacting other groups of vulnerable children via five key objectives;

1. **Strategic Commitment** Across all Agencies
2. **Identification** - Improve Awareness, Understanding & Recognition
3. **Prevention** – Communication
4. **Protection** - Improve Effectiveness of Interventions
5. **Disruption -** Improve the Prosecution of Perpetrators

Missing & CSE Peer Review: Update on Action Plan

Brighton & Hove is a member of the South East Sector Led Improvement Programme, who have developed their own Peer Challenge process to support local authorities passionate about improvement. In 2014 Children's Services launched their new Missing Children Policy and Guidance, which provided a framework for those working with children and young people who are missing from home, care or education.

Main strengths were identified as:

- Children Services moved fast and far on this work over 12 months
- MASH set up is good and the joint leadership with Sussex Police was noted as good practice
- All involved have a good understanding of the links between Missing Children and children at risk of sexual exploitation (CSE)
- Missing from education protocols were well understood.

Areas for improvement

- Return interviews –process needed clarifying to avoid patchy practical application
- The number, membership and structure of the range of strategic and operational groups needed review and where possible rationalisation
- Work around CSE needed further development, in particular looking at how young men are affected locally
- Links with partners such as health and housing needed strengthening to create holistic solutions

Priority Area 1: Neglect & Emotional Harm

Domestic Violence & Abuse, Parental Mental Health & Substance Misuse

- A Lead Practitioner from Brighton & Hove City Council has been appointed to lead on the issue of Neglect, raising its profile and identifying best practice.
- A multi-agency learning review commissioned by the LSCB on a long standing neglect case continues. There will be an update on its findings in next year's annual report.
- The Named Nurse for Sussex Community Foundation Trust is the Board lead for the LSCB on Neglect.

Of the 2,868 **single assessments** completed in 2015-16, **520 (18%)** identified neglect as a factor at the end of the assessment, up from 416 (15%) in 2014-15

Of the 392 children subject of a **Child Protection Plan** as of 31 March 2016, **120 (30.6%)** had neglect recorded as a category of abuse compared to 95 children (30.7%) as at 31st March 2015

Quality of Care Assessment Tool

The Quality of Care Assessment Tool aims to drive improvement in the quality of assessments, planning and the management of risk for children who are neglected. This year the tool has been piloted across health and social care services. The Lead Practitioner will now be responsible for rolling this out across social work pods

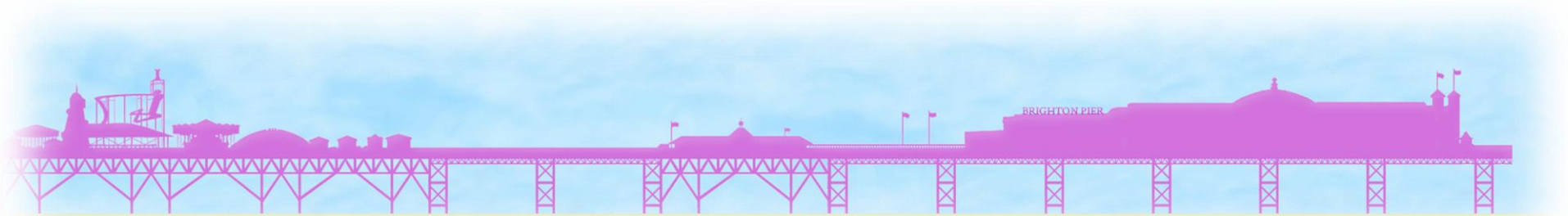
The LSCB will want to ensure the Quality of Care Tool is evaluated and is effective in better supporting practitioners to measure progress and monitor the impact of interventions. We will want to see that the quality of assessments in neglect cases is sound, taking account of family history and considering the impact of neglect on the child.

Training

The LSCB Learning & Development Officer has worked with the Board Neglect Lead and Lead Practitioner to devise a Neglect training package, which supports use of the Quality of Care Tool. This has been delivered to social care staff.

This training aims to:

- Explore and broaden participants' understanding of child neglect
- Introduce participants to the benefits of taking a systems approach to improving professional practice
- Provide an opportunity to explore local multi-agency responses to child neglect through scenarios and discussion
- Help practitioners identify individual learning about child neglect and multi-agency working
- Look at aspects of the system which help and hinder good practice



Multi-Agency Quality Assurance Activity

There is evidence of parental substance misuse in 57% of serious case reviews (of serious or fatal child abuse)[3]. Serious Case Reviews highlight that professionals often focus on the issues faced by parents who misuse substances without considering the impact on their children.

Parental Substance Misuse Audit

The LSCB Monitoring & Evaluation Subcommittee agreed to undertake a Deep Dive of parental substance misuse (under Priority 1: Neglect) to test whether there is a robust interagency response to the needs of children impacted by parental substance misuse in Brighton & Hove, and if this keeps children safe.

It looked in depth at six cases involving children aged under 5 years living with parents who misuse substances, and the support they receive from agencies.

Positive findings included:

- overall, good early recognition of the risks to the child and concerns are acted upon in a timely way in all cases. Strengths particularly noted in the Midwifery Service
- there are good quality multi-agency assessments which consider all relevant historical information
- in all cases, an enhanced health visiting service was delivered
- in all cases, the child's plan specifically addresses the impact of parental substance misuse including the risks and needs of the child
- in all cases, the interventions with parents provided by adult substance misuse services are child focused
- in all cases, there is evidence of good partnership working

Recommendations included:

- adult services to be reminded that if they are working with a pregnant mother, they should always let the midwifery service know
- all agencies are to be reminded of the pre-birth conference procedures
- GPs should ensure that the information about parental substance misuse is included on the child's record, and that parent and child records are linked

Only one parent responded to the request for feedback so her input has not been included in the report. In 2016/17 a similar audit will be undertaken focusing on parental substance misuse and its impact on older children, which will include seeking the children's views of the services they and their parents receive.

As a result of this multi-agency activity:

- All agencies were reminded of the Pre-birth Conference procedures set out in Section 5.3 of the Pan Sussex Child Protection & Safeguarding Procedures - The pre-birth conference should be held at least 3 months before the estimated delivery date to allow planning and support for the pregnancy and the birth of the baby to be put in place.
- Information about parent's substance misuse is now included on the child's record & the mother and baby records are linked.

[3] DCSF (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005.

Priority Area 2: Participation & Engagement

LSCBs are responsible for "communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so". *(Regulation 5 of the Local Safeguarding Children Boards Regulations 2006)*

The Participation & Engagement subcommittee of the LSCB has continued to meet throughout the year, leading on the implementation and evaluation of our communication strategy.

Evaluation of effectiveness of communications

A survey for partner agencies on LSCB Communications was circulated across the partnership. The aim of this was to help the Participation & Engagement subcommittee evaluate their activity against their limited budget and capacity. Results from this survey will be available in next year's annual report.

Measurable communication targets

The group have established that setting "targets" for our communications is problematic; we believe it is better to frame these as "objectives", and look more closely at what we need to evaluate. This year our agendas have been focused to help facilitate this and ensure actions incorporate who and how a participation and/or engagement activity will be done as well as how it will be evaluated.

Lay Members

Our five lay members have coordinated the following inter-related activity to ensure our Learning & Improvement Framework has been effectively implemented by:

- Being a member of a standing LSCB subcommittee & feeding back subcommittee activity to fellow lay members to support subcommittee interaction
- Making challenges to subcommittees about progress against their workplans
- Attending on a rotational basis the Leadership Group & LSCB Meeting

Next year we will be holding a Lay Member Conference for Lay Members across the South East Region to further explore the role and function of the lay member.

Child friendly annual report

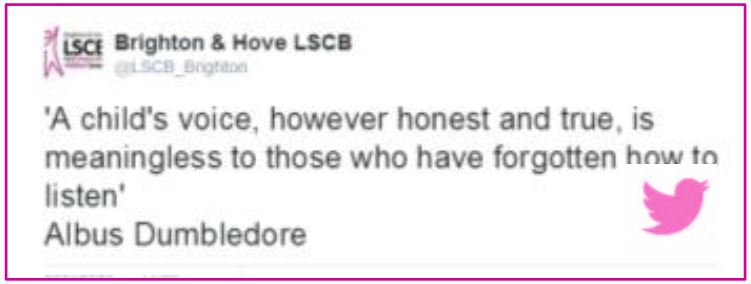
Some members of Participation & Engagement were keen to progress a child friendly annual report. However, not all members were of the view that this would be read by our target audience. Instead we were looking to develop a video clip, however due to resource capacity of the LSCB Business Team this was not progressed during the year

Twitter

We have been sharing news and links about good safeguarding practice on twitter since January 2014, and we believe that we are now one of the most followed Local Safeguarding Children Boards on twitter with nearly 1200 followers as of 31 March 2016. On average we gain 1-2 followers per day, and during 2015-16 our tweets earned 278,606 impressions, with 1280 retweets and 811 likes.

Our most popular tweet, inspired by JK Rowling's Harry Potter books, is pinned to our profile page and embodies the importance of listening to children & young people, one of the key values of our Board. This has achieved 69 retweets and 50 likes and has been viewed over 10,000 times

#YourLSCB Communication Materials



Board Briefings have been consistently produced after each main board meeting to summarise discussions held. These can be read at www.brightonandhovelscb.org.uk/board-briefings

Safety Rocks our joint newsletter for parents continues to be produced in association with Safety Net each term. An editorial team, including parent volunteers and LSCB Lay Members, meet each term to plan the content and consider how to get more feedback from parents. This year we included articles about online safety, healthy eating & body image, bullying, a parent's tips on "Morning Mayhem" for Child Safety Week, a child's story on moving to secondary school to talk about managing anxiety and an article to answer a question from a parent's on how to talk about upsetting subjects such as the refugee crisis. You can read previous editions at www.brightonandhovelscb.org.uk/parents/safety-rocks-newsletters

LSCB Bulletins continue to explore particular areas of concern in more depth. In June 2016 we published our Self Harm Bulletin to help professions recognise this and respond appropriately. This included an update on local work to deal with this concerning issue and signposts to national support. We continue to distribute our **Latest LSCB News** emails and over 200 people signed up to our newsletter via our website during 2015-16.

Staff Briefings, aimed at professionals working with children and families in Brighton & Hove continue to be circulated following quality assurance activity. Next year will see a review of the usefulness of this resource by professionals. These can be read at www.brightonandhovelscb.org.uk/manager-briefings

Case Review Briefings summarise what local case reviews have shown about the child protection system in Brighton & Hove. These can be read at www.brightonandhovelscb.org.uk/serious-case-reviews Our new format for these briefings, which asks professionals to reflect upon questions posed by the findings, has been adopted by other Safeguarding Boards as a way of sharing this important learning.

LSCB Website continues to be updated to ensure that it is in line with current legislation and guidance. All of our latest posts can be read on the LSCB website. Highlights include a series of "Day in the Life" articles for World Social Work Day, our Safeguarding Blogs from the Learning Together Fortnight, material from Safety Net's Online Safety event and information on Listening to Children and Young People. During 2015-16 our website had an average of 70 visitors per day. Our most popular pages contain information on our training and serious case reviews, although the top page visited, aside from our homepage, was a post on the changes to Working Together 2015 which had over 6200 views in that year.

In October 2015 we changed supplier for the Pan Sussex Child Protection & Safeguarding Procedures website. The new site is easier to navigate, and it gives the three LSCBs across the county access to update this at any time, allowing our procedures to be more responsive and remain more current than was possible under our previous contract.

> The Board has made meaningful progress with effective and innovative initiatives to improve the engagement of children, young people and their families and also to increase public understanding of the Board's work. **Ofsted Review**

Initiatives supported during the year

Child Safety Week is run every year by the Child Accident Prevention Trust. To support the 2015 campaign on "Tea Time Terrors" we promoted this in our newsletters for professionals as well as being a main feature in the Summer edition of Safety Rocks.

Safer Internet Day took place in February 2015. We shared online safety messages on our website, twitter and newsletters. Board Member Tracey Bowers wrote about the activities undertaken at Herford Junior school to promote internet safety for the Safety Rocks Newsletter, and we also took part in Safety Net's Online Safety City Event. In September 2015 we invited the Safer Internet Centre to hold their E-Safety Live workshops for professionals. These were attended by around 100 practitioners from across agencies, who were provided with an overview of the latest online safety information, from emerging trends and technologies to new resources and sources of support, as well as legal and law enforcement changes.

Community Works **Spring Conference** took place in June 2015, and the theme this year was safeguarding. Graham Bartlett spoke at this event and we had a stall with LSCB newsletters and a special briefing for the community & voluntary sector on the role of the LSCB.

National Safeguarding Day, organised by the National Council for Voluntary Youth Services (NCVYS), urge organisations to **stop** what they are doing, **look** at their safeguarding practices and **listen** to young people. The campaign's principles underpin everything we do at Brighton & Hove LSCB, and we encouraged our partners to make the time to focus on safeguarding on this day, 29 February 2016, by pledging to review their safeguarding policy and/or practice, run safeguarding sessions with young people, or offer space on their website for free advice, guidance or signposting on safeguarding.

Sussex Police CSE Campaign raised awareness of what CSE is to the public and targeted audiences, so that they would be able to spot the signs of CSE. Communications based on intelligence and extensive customer insight formed the foundations of the communications strategy. All work was developed with support of the Local Children Safeguarding Boards across Sussex. This campaign was rolled out in three phases between January and May 2016.

Involving Children & Young People

Learning Together to Safeguard the City
During the Learning Together to Safeguard the City Fortnight we invited young people to participate in two of the learning events.

Why do Young People choose not to access Mental Health services? took the format of a Q&A session and young people were invited to put questions to Commissioners and Mangers of mental health services in Brighton & Hove. You can read a summary of the discussion here.

Consent Based work with Adolescents was a workshop run by the Youth Offending Service, RUOK, and health, with young people. This looked at various issues that face professionals when working with adolescents around whether to share information with a parent, especially when adolescents talk about activities such as shoplifting, the recreational use of alcohol, experimenting with drugs, or becoming sexually active.

Quality Assurance Activity
To get a full picture of what is really happening, it is important to capture the experience of children and parents/carers, and the experience of frontline staff and managers. It is important to know how parents, carers and children feel treated by the professionals and agencies they interact with.

Staff and frontline managers will often know about the quality and impact of their own services, and those of partner agencies they work with.

It is important to have a constant feedback loop from the frontline to keep senior management and those with governance responsibilities 'reality based'; not just in terms of what is or is not working, but to assist with ideas for improvement so that changes can be made systematically.

Priority Area 3: Service Responses

The LSCB's influence was instrumental in the formation of the Multi-Agency Safeguarding Hub (MASH), the Early Help Hub, and the Threshold Document.

The MASH is a co-located multi-agency team consisting of social work staff, police, and staff from Early Help, Housing, Education, Youth Offending and a Health.

The Early Help Hub is a team of officers from a range of council services. It offers a new route for enquiry and referral, and supports professionals to target, coordinate and provide early help interventions to families that need additional support.

The Threshold Document, produced alongside the launch of MASH and the Early Help Hub, provides guidance for professionals and services users to help them:

- Identify and assess levels of individual need
- Clarify the circumstances in which a child might need referring to the Early Help Hub, the MASH, or another specific agency, to address their individual needs

Initial Review of early help arrangements

Our year started with an update from the Executive Director of Children's Services providing the Board with an update on the first three months of the Early Help Hub and Multi-agency Safeguarding Hub. The initial review was an early test of the impact and effectiveness of both the MASH and the EHH. This provided a close view on how the two systems were operating together to ensure referrals are made correctly, and looked at how cases are passed between the two hubs to provide an appropriate & proportionate response. You can read the findings of this initial review here

Performance Data

Working Together 2015 specifically outlines a responsibility for LSCBs to 'use data' to 'assess the effectiveness of the help being provided to children and families, including early help'. With this in mind, the Board has been routinely presented with progress reports on MASH and Early Help. Alongside the quality assurance activity mentioned above there was a thematic look at an Early Help dataset to support the Boards understanding of the story behind statistics.

Early Help Conference: How well we are doing and how do we move forward together?

An Early Help Conference was held in December 2015. This was an opportunity to assess how well the system was working and how the LSCB and LA are demonstrably 'dedicated to early help'. It considered if the city's early help systems are understood and used consistently by all agencies working with children, young people and their families. At the end of the session ideas for how to move forward as a city were discussed and agreed. This has remained a key area of continued focus for the LSCB over the year and beyond.

Referrals & Thresholds: Multi-Agency Audit of Early Help

An extensive multi-agency audit of early help comprised three elements:

- analysis of early help data set
- shallow dive of cases referred to the Early Help engagement team
- multi-agency audit of 10 cases, involving ten agencies

This was to support the Board to build a better understanding of the effectiveness of early help assessments and interventions to ensure that children and young people with additional needs receive timely responses and that emerging difficulties are addressed at an early stage.

The shallow dive looked at 114 cases that had been referred to the MASH and subsequently passed on to the Early Help Hub Engagement Team (EHHET).

The auditors concluded that 58% could have been made directly to the EHHET, so recommendations will be made to the LSCB in June 2016 in order to facilitate fewer contacts to the MASH.

The audit also found that the EHHET was mainly working at the right level with vulnerable children or those with high to complex needs.

It also concluded that the practice of the EHHET was at least ‘good’ in 57% cases in the shallow dive.

The in depth multi-agency audit focused primarily on adolescents and found many positives:

- strong multi-agency working
- very child focused practice, with evidence that the voice of the young person has informed the work undertaken
- for the majority of children and families, their outcomes have improved as a result of multi-agency early help
- in the majority of cases, there is regular case supervision and management oversight of the case

Key areas for development:

- addressing confusion reported by parents about who is doing what and which service is involved
- ensuring that the nominated lead professional is fulfilling their role

In this audit, seven parents provided detailed feedback to a student social worker. Overall, they found the team around the family approach helpful. Two expressed frustration at services no longer being available: a youth worker and a youth crime prevention officer.

Priority Area 4: Accountability

Annual LSCB Performance & Effectiveness Survey

In 2015 the LSCB undertook its annual performance and effectiveness survey to gauge how members rate the efficacy of the Board.

Chairing Arrangements & Board Structure

- Two notable areas of improvement from last year's survey included a clearer definition of the purpose of the LSCB, and more robust reviewing of progress against the work plan.
- 70% Strongly Agreed & 30% Agreed that the Chair provides decisive leadership & keeps the partnership focused on key tasks
- 60% Strongly Agree, 30% Agree & 10% Neither Agree nor Disagree, that the LSCB has a clear set of strategic aims and objectives in relation to safeguarding.

Membership & Representation

- Last time just under half of respondents said the LSCB subcommittee membership was stable & active with good partner representation. This year 100% either strongly agreed or agreed with the statement.
- A new question was added this year asking if all Board Members & Advisors pay due respect to confidentiality & data protection with regards to Board business. 80% either strongly agreed or agreed, 10% neither agree nor disagreed & 10% didn't know.

Roles & Responsibilities

- Last time 59% agreed there were clear lines between the LSCB business & professional practice, 80% now strongly agree or agree with the statement.
- 70% either Strongly Agree or Agree, 20% Neither Agree nor Disagree, & 10% Don't Know if frontline professionals have a clear understanding of roles & responsibilities for safeguarding
- 90% either Strongly Agree or Agree, & 10% Neither Agree nor Disagree, that Board decisions are clearly understood in terms of what will be done, by whom & by when.

Infrastructure to Support the Operation of the LSCB

- Last time 88% of respondents reported that the LSCB business support team responded to queries efficiently and appropriately. This year this increased to 100%.
- 80% Strongly Agree or Agree, & 20% Don't Know, if there is sufficient business support for the LSCB to function effectively
- 100% Strongly Agree or Agree that reports provided to the Board are well written with clear recommendations for action.

Subcommittees

All Terms of Reference have been reviewed, and membership and representation changes have been made as appropriate, to ensure that our subcommittees continue to be diverse, stable and active. Lay members have continued as standing members of the Monitoring & Evaluation subcommittee, Case Review subcommittee, Learning & Development subcommittee and the Participation & Engagement subcommittee

Our Activity: Learning & Development

The multi-agency annual training programme ensures training content is carefully designed to deliver specialist courses that complement learning priorities in Business Plan and the Learning & Improvement Framework **Ofsted Review, 2015**

Working together 2015 states that an LSCB "has a responsibility to develop policies and procedures in relation to the 'training of persons who work with children or in services affecting the safety and welfare of children…to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children'.

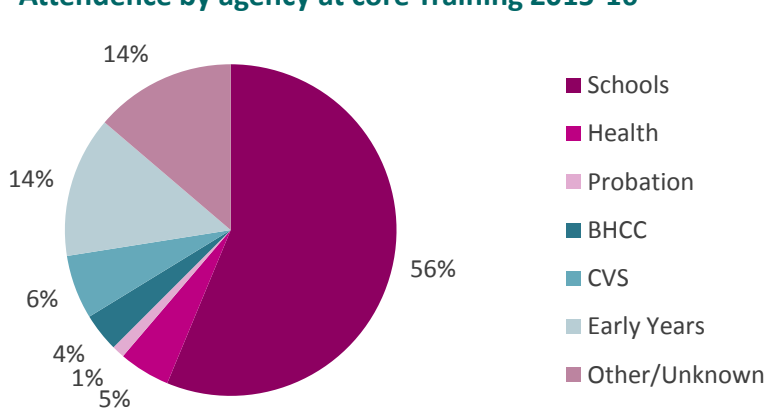
Learning & Development Subcommittee

The last twelve months have been busy, the Learning & Development subcommittee have continued to monitor and evaluate training delivery, in line with the LSCB Learning & Development Strategy, reporting to the main LSCB regularly on progress and developments within the multi-agency training programme. Attendance at the subcommittee has maintained a good representation from the majority of Board partner's agencies. The group has also benefited from the attendance of a Lay Member. A new Learning & Development Officer, who has significantly progressed all training work streams, has been in post since October 2015.

Multi-Agency Training Attendance

Between 31 March 2015 and 1s April 2016 the LSCB multi- agency training was attended by 421 practitioners. There were 81 who attended the core training courses and another 399 who attended the more specialised courses.

Core Child Protection Courses	No of courses	Attendance
Developing a Core Understanding	1	24
Assessment, Referral and Investigation	1	33
Child Protection Conferences and Core Groups	1	24
Total	**3**	**81**



It should be noted that there was a limited training programme being presented due to a vacancy, which was advertised in May 2015 with the new Learning & Development Officer taking up post in the autumn. Core training is now being presented on a continuous cycle of six sessions per year.

Specialist Child Protection Courses	No of courses	Attendance
Domestic Abuse & Violence	8	91
Child Sexual Exploitation: Prevention and Disruption (Day 1)	2	44
Child Sexual Exploitation: Working with Young People at Risk (Day 2)	3	70
MAPPA – Multi Agency Public Protection Arrangements	2	28
Safeguarding Children with Disabilities	1	18
Neglect Training	2	44
Children & Young People who Display Harmful Sexual Behaviours	1	28
Serious Case Review Briefings – Baby Liam	3	76
Total	**22**	**399**

There have been various courses run since the beginning of the 2016-17 training cycle which have been well attended. The figures for these will be reflected in next year's report.

A priority over the past year has been to focus on the three core safeguarding training days. These have been reviewed, re-written where needed and added to, so that they are more interactive and reinforce the voice of the service user, by including them in person or via recorded interviews.

A specialised course concentrating on 'Hidden children' has been progressing over the year. This looks at safeguarding children and young people who are privately fostered, home educated, or from travelling families, as well as looking at the issues relating to immigration and migrant families. The four subjects made a full days training which was well received on its first presentation.

The new Learning & Development Officer has been able to re-establish and build a network of contacts within the partner agencies. This has benefitted both the LSCB and those other agencies, as we have been able to create and deliver a safeguarding awareness package to a larger number of staff, in particular to those who do not necessarily need to attend the three day core training, but do have a need to have a good level of awareness of the multi-agency safeguarding processes. This has led to those agencies providing their specialist knowledge into the LSCB delivery, with consideration being given to working with our neighbouring LSCB colleagues to deliver some training on a joint level.

This year the LSCB commissioned the delivery of an external "Train the Trainers" course. This was taken up by eleven staff, who all obtained their qualification. This enables the LSCB to provide the varied programme required and also means that the training pool is equipped to a consistent and recognised level of training skills. The LSCB training pool has increased in number to 36 practitioners & manager, all from agencies spanning the LSCB Partnership. The appointment of the LSCB Learning & Development Officer has meant that the support available for the trainers within the LSCB pool has been re-established.

Learning points from the Baby Liam Serious Case Review, and other national SCRs, have been assessed and incorporated into the training material where appropriate. We held three lunchtime seminars to share the learning from the Baby Liam SCR, which were well attended and received, and participants fed back that it was particularly beneficial to have these sessions facilitated by those involved in the Review.

The programme has been, and continues to be, expanded with important additions to progress the LSCB Business Plan or as a result of learning from case reviews including developing a session to raise awareness of child sexual abuse, and a full day training on Enabling & Supporting Compliance: Working with Disguised Compliance & Forceful Counter Argument in Safeguarding. This year we are also working with partners to revise and update our training on the impact of parental substance misuse, working with parents who have a learning disability, and working with families where mental health is an issue.

For more information on our training please visit www.brightonandhovelscb.org.uk/events

Learning Together to Safeguard the City

Thursday 26th November – Thursday 10th December 2015

Brighton & Hove LSCB local safeguarding children board

Safe in the city
Brighton & Hove Community Safety Partnership

Brighton & Hove SAB Safeguarding Adults Board

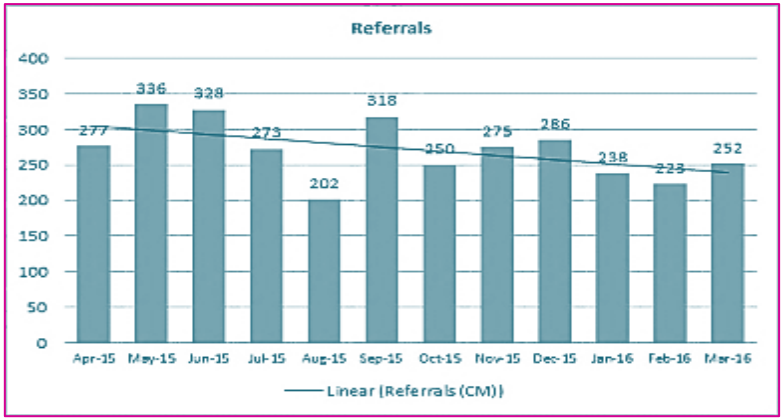
The **Learning Together to Safeguard the City** series of learning events were run over a period of two weeks beginning on the 26 November 2015, and culminated at the finale event on the 10 December 2015. It was delivered in partnership between the Safeguarding Adults Board, the Local Safeguarding Children Board and the Safe in the City Partnership Board, as well as Brighton & Hove City Council, other statutory partners including Sussex Police and Health, and charities and community groups. It brought together work around Safeguarding Children, Safeguarding Vulnerable Adults, and the wider campaign around the 16 Days of Action against Domestic and Sexual Violence alongside other forms of Violence against Women and Girls.
In total 643 people registered to attend an event, which included:

- **Why do Young People choose not to access Mental Health services**
- **LGBT Domestic Abuse, increasing awareness & Understanding**
- **Safe at Home: The role of Housing Providers in Supporting Domestic Abuse**
- **Children & young People who display Harmful Sexual Behaviours**
- **Introduction to Sussex Police SIU**
- **An Introduction to Modern Slavery**
- **The Children's SARC: How we can help**
- **Male Rape Matters**
- **Learning from Domestic Homicide Reviews**
- **LSCB Learning reviews – implications for practice**
- **Violence Against Women and Girls in the BME Community**
- **WRAP: Workshop to raise awareness of Prevent**
- **Consent Based work with adolescents and their families**
- **Historic Allegations**
- **Vulnerable Migrants**
- **MASH: current referral process**
- **Q & A with Brighton's Caldicott Guardians**
- **Working together with Parents with a Learning Disability**

I think that it [fortnight] covered everything that I needed at the time and hope that something like this runs every year

You can view the presentations from the fortnight here or read our Everybody's Responsibility Blogs where key people from across the partnership wrote about what safeguarding means to them

Our Activity: Performance Data



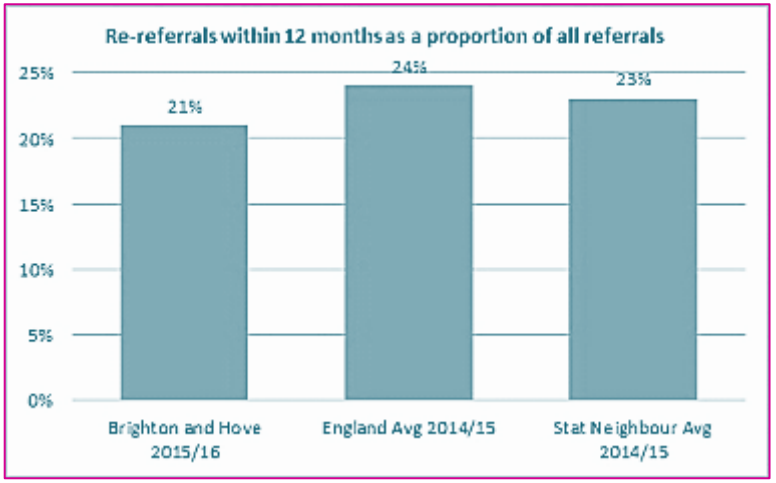
Referrals

There were **3,249 referrals** during the year ending 31st March 2016, a **significant decrease** from 7,283 during the year ending 31st March 2015

27.4% of referrals were from the Police (26.4% nationally), 18.5% were from schools (15.4% nationally), and 16.5% were from Health Services (14.9% nationally).

Re-referrals

The **re-referral** rate was **21%** for the year ending 31st March 2016, down from 32% last year. This is below the 2014/15 national average (24%) and statistical neighbour average (23%).



, On average 30% of referrals received by the MASH every month are re-directed to the Early Help Hub for support, although indications are that this figure is now decreasing. On average 30% of referrals received by the MASH move through to Social Work assessment, and this figure remains consistent.

This indicator has been affected by the change in definition of a referral to bring our reporting in line with other Local Authorities who have MASH's, and to avoid double counting. This was discussed at length at a Board meeting before being accepted as a new approach.

Brighton & Hove has a statistically high referral rate and this has increased over the past year with more recent signs of declining.

The high level of referrals should be considered in light of where the city lies in relation to deprivation, ranked 66th out of 324 local authorities in England. There are marked differences in levels of deprivation between Brighton & Hove and the rest of the South East.

It is recognised that the overall increase in referrals to Children's Social Work is a picture that has been echoed nationally.

- A number of factors are considered to be contributing to the increased demand upon the service, namely the impact of benefit reforms, the withdrawal of legal aid in respect of contact dispute and mediation, and increased awareness of Child Sexual Exploitation and potential radicalisation of young people for example.
- The impact of the Early Help Hub on reducing need and therefore re-referrals to the MASH in the longer term is currently under review with the LSCB.

Single Assessments

Of the **2,868 single assessments** completed during the year ending 31 March 2016, 1,400 (**49%**) were completed within 45 working days, down from 53% last year and below the 2014/15 national average of 81.5% and statistical neighbour average of 82.1%.

The average duration for a Single Assessment completed in December has decreased from 62.2 working days in April 2015 to 42.9 working days in March 2016

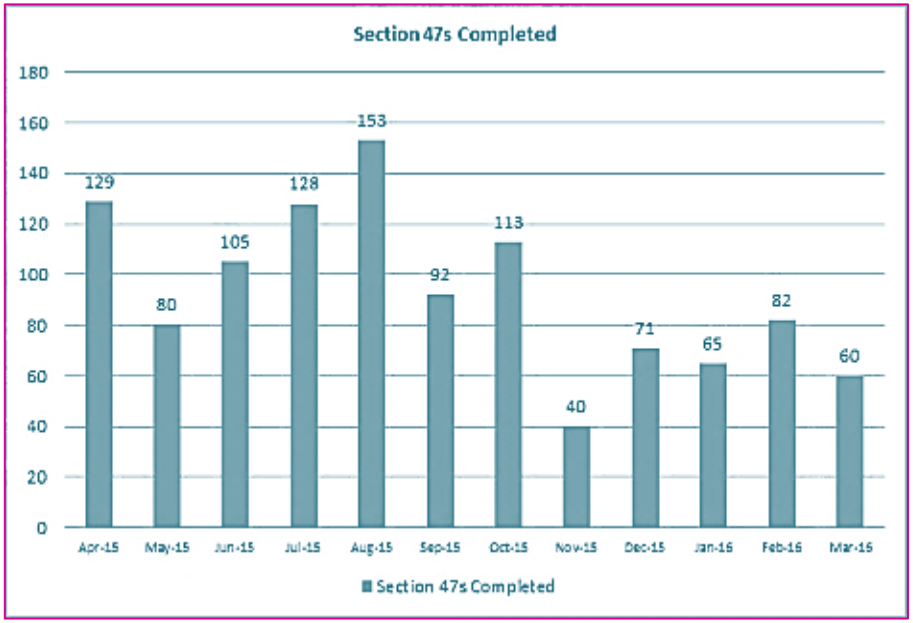
The high referral rate to MASH in Spring 2015 resulted in a high conversion rate to assessment as increased levels of need were identified.

The high level of single assessments resulted in a proportion of the single assessments being delayed as the level of higher risk cases increased. This was reflected in increasing numbers of children becoming subject to Child Protection Plans in the same period.

In October 2015 the Social Work service reconfigured into 16 Pods who are now responsible for overseeing a safeguarding response from start to finish. There are early signs that this system change has contributed to improved service delivery in terms of the timeliness of completed Single Assessments. The overall percentage of those assessments completed within 45 days is anticipated to increase further.

Section 47 Enquiries

- There were **1,118 section 47s** completed during the year ending 31 March 2016 compared to 832 during the previous 12 months.
- Of the section 47s completed in the last 12 months, 461 **(41.2%)** had an outcome of **No Further Action.**
- On average 44% of s.47's end in No Further Action within the South East benchmarking region. This suggests that Brighton & Hove are broadly in line with other Local Authorities in terms of conversion rates of s.47's to Conference. Brighton & Hove continues to initiate a high number of s.47 enquiries - this is believed to correlate with increasing numbers of children being made subject to child protection plans over the last year.
- With the introduction of the Social Work Pod system in October 2015 there are a number of new Social Work Managers overseeing s.47 enquiries and there is a need to ensure that thresholds are consistently applied across the management group.



Child in Need

As at 31 March 2016 there were 2,039 cases open to Children's Social Work. This represents **4%** of the 0-17 population. Nationally, 3.4% of the 0-17 population were a Child In Need as at 31 March 2016.

Child Protection Plans

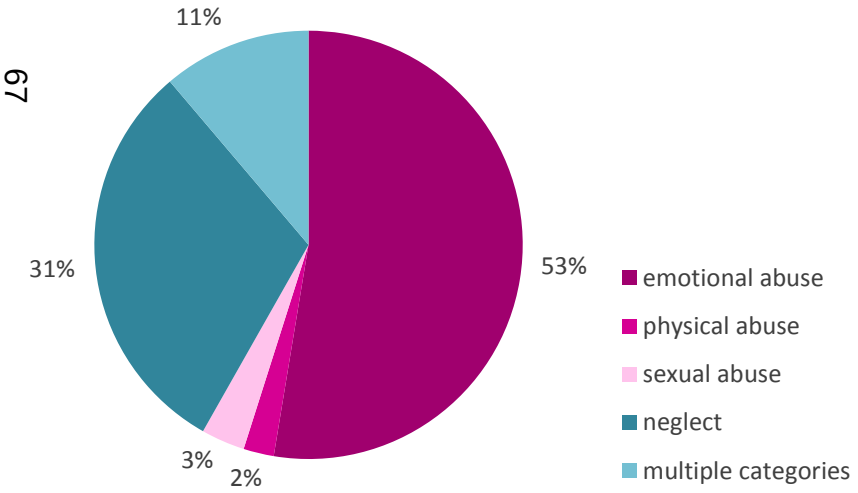
There were **392** children subject of a Child Protection Plan at 31 March 2016, up from 309 last year. This represents **0.77%** of the 0-17 population.

Nationally, 0.43% of the 0-17 population were subject of a Child Protection Plan as at 31 March 2015.

One in four children (25.7 per cent) who were subject of a Child Protection Plan in March 2016 **were not White UK/British**. 21% of children aged under 18 in Brighton and Hove were not White British at the time of the 2011 census.

Age of child on CP plan	Brighton & Hove	National Average
Unborn	2.8%	2.1%
Under 1	12.7%	10.5%
1-4 years	24.2%	28.5%
5-9 years	28.8%	29.7%
10-15 years	29.5%	26.1%
16 & over	2%	3.1%

Children subject to a Child Protection Plan at March 2016 by category of abuse



2.6% of children subject of a child protection plan had a category of **emotional abuse**, up from 49.8% at March 2015 and above the national average of 36.3%. The increase of children within this category is likely to be representative of the prevalence of domestic abuse as an underlying cause, which is a reoccurring theme in the cases where children become subject to a child protection plan for a second or subsequent time

30.6% had a category of **neglect**, below the national average of 44.5%.

The percentage of children with **multiple categories** has fallen from 12.9%at March 2015 to 11.2% March 2016, but remains above the national average.

Whilst the overall rate of children subject to a child protection plan remains high, there continues to be a gradual decrease in the numbers of children becoming the subject of a child protection plan, combined with an increase in plans coming to an end. It would be hoped that any reduction in numbers of children would be a gradual process, as large differences would lead to concerns over changes in thresholds. The decrease does coincide with the restructure of the social work teams, so potentially this could be an indicator that the new model of practice is showing an impact on evaluation and management of risk.

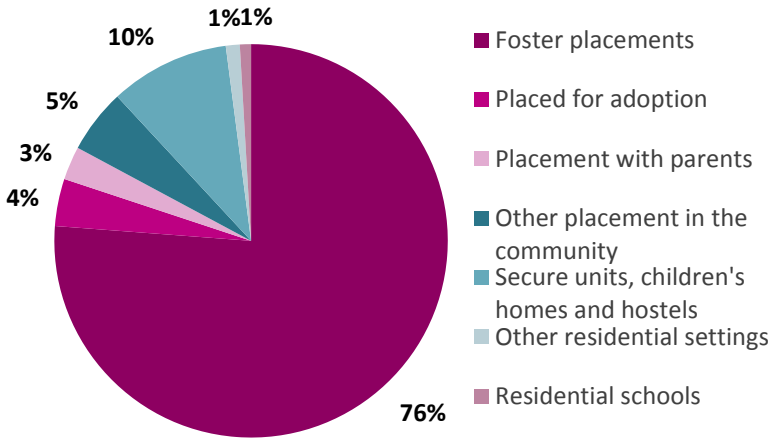
Ongoing audit activity indicates that thresholds for considering this cohort of children to be at risk of/suffering actual harm, are appropriate.

Children in Care

At 31 March 2016 there were **437** children looked after by the Local Authority., includings 34 Unaccompanied Asylum Seeking Children. The number of children looked after, excluding UASC, has fallen from 462 in March 2015 to 403 in March 2016.

The number of children looked after represents **0.86%** of the 0-17 population compared to 0.6% nationally.

Children in Care by Placement Type



A number of children continue to live outside the geographical boundaries of Brighton & Hove, (some for reasons of safety or to remain in the care of relatives/existing carers), and work continues to take place with providers to increase local placement options particularly in relation to residential care for children with specific/complex needs. 56.5% of children are placed outside of Brighton & Hove, including the 12.1% of children placed more than 20 miles and 5.3% placed outside of Sussex.

The percentage of looked after children placed within 20 miles of their home address has increased from 79% at March 2015 to 82% at March 2016.

In the year ending 31 March 2016 there were **39** children **adopted** and **41** children **ceasing to be looked after** through becoming subject of a special guardianship order (SGO). **A total of 230 children ceased to be looked after**.

The age breakdown reflects an increase in the cohort aged 10 to 15 and over 16, reflecting national and local concerns about older children at risk of family breakdown due to issues such as risk of child sexual exploitation, missing episodes, substance misuse and youth offending.

A further pressure is the ongoing increase in Unaccompanied Asylum Seeking Children. This rose from 9 at 31 March 2015 to 34 at 31 March 2016. This is the highest number of UASC's that have been the responsibility of Brighton & Hove since 2008 reflecting the growing number fleeing war and persecution. It is likely in the current political climate the numbers of UASC are likely to continue to grow.

Children's Services Care Planning Panel is chaired by the Assistant Director and continues to oversee any admissions of children/young people into the care system, and continues to provide vigorous challenge to ensure that all other alternatives, including placement with family members with support packages, have been explored before agreeing to a child/young person becoming looked after

A business care for the development of this Adolescent Service is being progressed to further develop the work of the Adolescents Pod. A clear focus of this service is to use resources creatively within a multi-agency framework to ensure that there are robust intervention packages to prevent the need for children to become looked after

Our Activity: Private Fostering

Arrangements to Raise Awareness about Private Fostering

A private fostering arrangement is one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 years (under 18, if disabled), by someone other than a parent or close relative, in their own home, with the intention that it should last for 28 days or more.

Given concerns about the level of 'hidden' private fostering, local authorities are required to raise public awareness of the requirement to notify the local authority of private fostering arrangements and therefore to reduce the number of 'unknown' private fostering arrangements.

In 2015-16 a number of initiatives were undertaken to highlight the notification arrangements to existing and potential private foster carers, voluntary and statutory agencies, and members of the public as follows:

- The Private Fostering Poster and flyer has been updated and circulated widely
- Information about Private Fostering was shared with professionals and members of the public via social media as part of Private Fostering Awareness Week (6-10 July 2015)
- A briefing to GPs about Private Fostering was issued via the CCG as part of the awareness week
- An article about Private Fostering was sent to School Governors
- Information about Private Fostering has again been included in the school admissions booklets
- Awareness about Private Fostering continues to be raised with schools via the Education Safeguarding Officer and questions about private fostering have been added in readiness for the next school safeguarding audit..
- The BHCC Private Fostering webpage was refreshed in June 2015
- Training about Private Fostering was refreshed and will be delivered by the PF Monitor and Social Worker as part of a one day LSCB programme called ' Hidden Children & Young People: Working with Invisible Families' commencing June 2016.
- BHCC continue to attend the Private Fostering Special Interest Group organised by CoramBAAF Adoption & Fostering Academy.
- PF Monitor continues to raise awareness about Private Fostering with Guardianship Agencies to ensure that the Local Authority is notified of any under 16 year olds living with host families for more than 28 days

The Brighton & Hove Ofsted Single Inspection Framework took place during 14 April – 8 May 2015. As part of the inspection, a report on children known to the local authority who are currently being privately fostered was submitted, and a sample of cases open to Private Fostering were examined by Inspectors. In addition the Deputy Lead Inspector met with the Private Fostering Monitor and the MASH Team Manager to discuss the cases, performance and other activity. The findings were positive overall and are published in the Ofsted report, June 2015 as follows;

> Effective work identifies children living in private fostering arrangements. They and their carers are assessed by social workers to ensure arrangements are safe and needs are identified. This is mainly due to increased awareness of local language schools that arrange for children from abroad to live with local host families under private fostering arrangements. Appropriate support to privately fostered children is in place in almost all cases, although not all children are visited as regularly as they should be.

Private Fostering arrangements during the year	2012-13	2013-14	2014-15	2015-16
	17	34	45	43

Monitoring Compliance with Duties and Functions

The number of privately fostered children is constantly changing as new arrangements are referred and children move on - sometimes back to their parents - or when they reach 16 years (or 18 years if disabled).

Private Fostering activity has decreased from 45 to 43 in 2015/16.

At the start of the year (1 April 2015) there were 15 children reported as living in private fostering arrangements. During the year, 30 new notifications were received and 28 were confirmed as being private fostering within the definition.

All new notifications received an initial visit, with 93% taking place within 7 working days (regulation 4)[4]. The percentage of cases where visits to children were carried out within the timescales required by Regulation 8 of the Private Fostering legislation (which is at least 6 weekly in the first year) is 83% which is better than the England average of 67% (DfE: 2014-15).

All of these children in the 28 new private fostering arrangements confirmed during 2015-16 were aged 10 to 16. .,3 of these children were born in the UK and 25 children were born overseas.

Twenty eight arrangements ended during the year, leaving a total of 15 children in Private Fostering arrangements at 31 March 2016.

Reason why the Arrangement Ended: (Using data fields proposed by Ofsted, Jan 14)	Number
Overseas child returned voluntarily to country of origin	6
Overseas child returned to country of origin via Home Office intervention	0
UK born returned to parents	0
Became 'looked after child'	0
Educational/sporting/vocational opportunity ended	0
Child turned 16 (or 18 if disabled)	13
Moved to another private fosterer	6
Other	3
Total	**28**

70

[4] Note: The DfE no longer require the local authority to submit data on Private Fostering visits therefore the last data published on this was for 2014-15. For Reg 4 visits the national average was 80%.

Our Activity: Management Allegations of Adults Working with Children

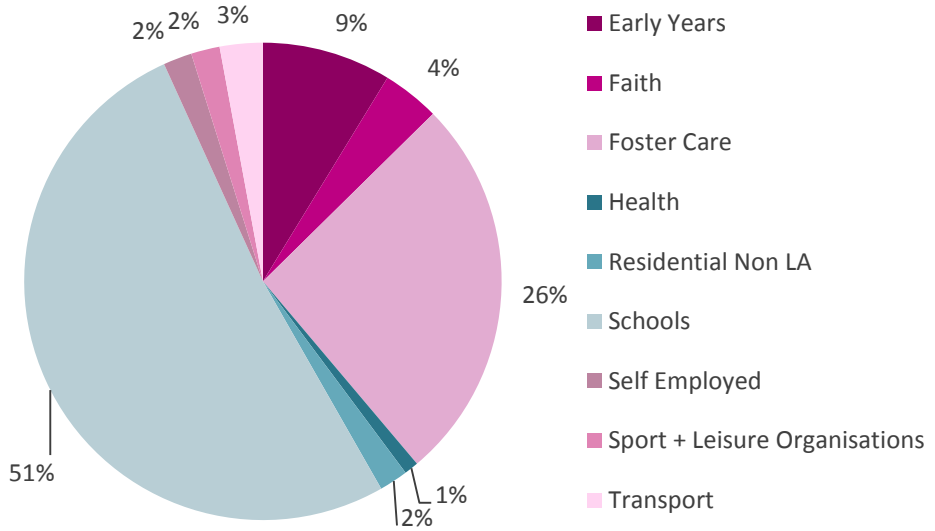
The management of allegations should been seen in the wider context of safer employment practices, which has three essential elements:

- Safer recruitment & selection practices
- Safer working practices
- Management of allegations or concerns

The Local Authority Designated Officer (LADO) has overall responsibility for the management of allegations of Abuse against Adults who work with Children. The LADO provides advice and guidance, liaises with the Police, Social Care Teams, regulatory bodies such as Ofsted, and other organisations as needed to ensure a, fair and thorough process for both child and adult. Their aim is to provide a more consistent and appropriate scrutiny across diverse workforces and voluntary bodies, to contribute to a greater level of safeguarding for children, and natural justice to staff; and to enable appropriate referrals being made for barring decisions, and to build a safer workforce by removing practitioners who are likely to present a risk. The structure of the process was designed to bring independent advice to decision making.

Overall the total number of referrals (including suitability) for 2015-16 is 260. This represents an increase of 21 from last year with a similar increase from the previous year. Referrals to LADO's across the South East Network have continued to rise.

Allegations by sector 2015-16



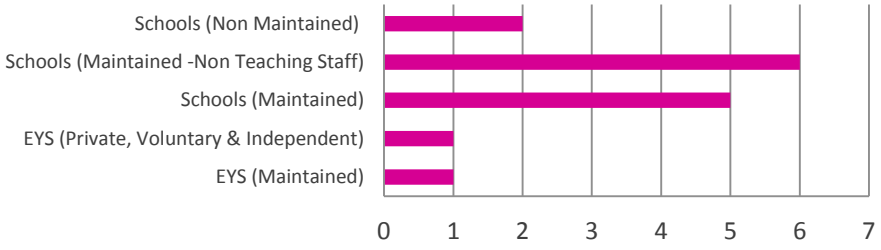
Referrals regarding all schools staff increased from 104 during 2014-15 to 134 in 2015-16. This is made up of 53 'allegations' and 81 'suitability'. This is a decrease in the number of 'allegations' by 8 and an increase of 38 in respect of 'suitability'. The proportion of referrals regarding concerns about school staff professional conduct and suitability suggests schools increasing safeguarding awareness and appropriately referring and seeking advice and guidance from the LADO when concerns about individuals arise.

A more worrying trend is the lack of referrals regarding Voluntary Organisations. There is only one regarding the 'suitability' of an individual due to a criminal investigation in their private life that was unsubstantiated. Since the LADO first reported to the LSCB in 2012, the referrals involving Voluntary Organisations has steadily declined from 13% in 2012, 7% in2013, 4.5% in 2014 to 2.9% in 2015. This appears disproportionate to the increase in safeguarding referrals across all other agencies in the city. While the LADO continues to attend the EYS Network Meetings across the city and has input into Headteacher and Designated Safeguarding Leads training, the same cannot be said for voluntary organisations and suggests the LADO needs to raise the profile within this sector.

Physical Restraint

The DfE issued non statutory guidance on 23 August 2011 on the *Use of Reasonable Force: Advice For Head Teachers, Staff And Governing Bodies* and *Search, Screening and Confiscation*.. The key points in the guidance are that staff have a legal power to search pupils or their possessions without consent (prohibited items) and to use force; that lawful use of this power will provide a defence in any related criminal or legal action; and that suspension should not be an automatic response when accused of using excessive force.

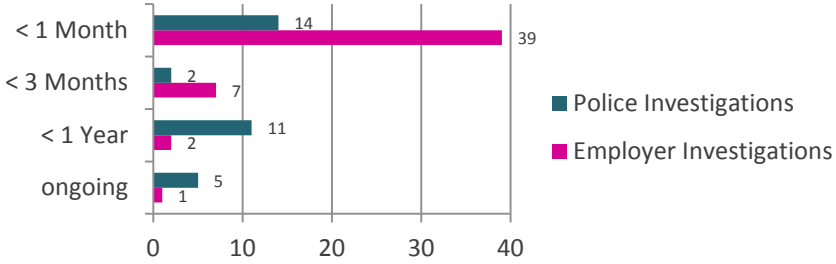
Allegations against teaching staff involving the use of restraint saw a significant increase and indicated a worrying trend in the previous year, so it is reassuring that referrals regarding the use of restraint this year have significantly decresed by 50% from a total of 30 in 2014-15. This is reflected in the combined maintained schools total, for both teaching & non-teaching staff, for this year reducing from 23 to 11. Of these cases 8 involved specialist SEN provision, and all but one were deemed malicious, unfounded or unsubstantiated. The substantiated case led to disciplinary procedures and the employer ceasing to use the employee's services, evidencing a robust stance regarding professional misconduct with regard to safeguarding.

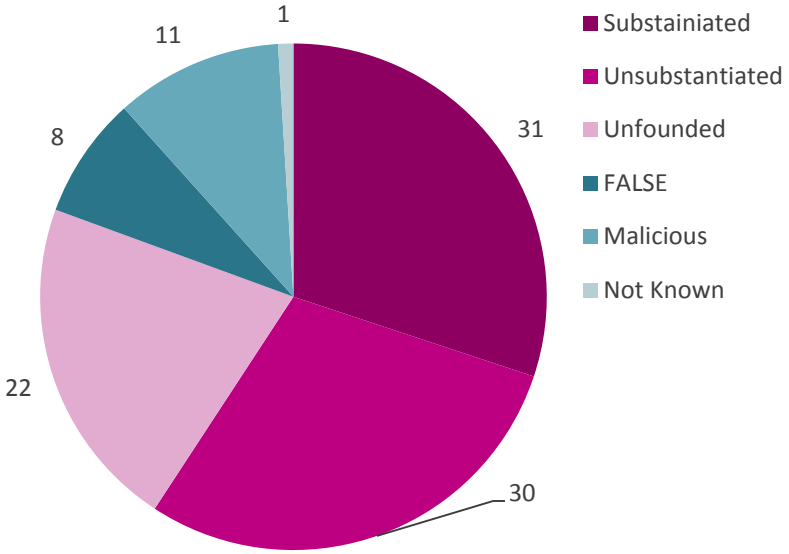


Timescales – At Point of Conclusion

The start date for counting will be the date the allegation was referred to the LADO, Children's Social Work Service or the Police. The conclusion date is the point at which there is no further action to be taken by the employer, Children's Social Work Service, the Police or Courts regarding the allegation.

There were 49 internal investigations by the employer; and 32 Police investigations. There are 5 ongoing police cases ranging from June '15 to March '16; 4 of these cases are with the Crown Prosecution Service awaiting a charging decision. CPS turnaround is currently around 12 weeks. The LADO has concern that those police cases taking more than 3 months to complete has risen from last year.





Allegation Outcomes

The significant proportion of substantiated, unsubstantiated and unfounded allegations, vs false and malicious, indicate that referrals to the LADO continue to be made appropriately.

The actions taken by Early Years, Schools and Foster Carer organisations reflect these as being the three highest employer sectors involving regulated activity with children. This is equally reflected in the relative numbers of referrals made to the DBS and Ofsted. The LADO believes they have strong relationships with these organisations and a close working relationship with the Education Safeguarding Officer. This work reflects the significance of LADO advice involving the wider issues of safer recruitment, and practice guidance, offered to employers and evidence in the LADO quality assurance survey.

Of the 45 individuals 'suspended', only 8 of these were in response to allegations, the remainder involved disciplinary procedures. Of these 8 suspended individuals , 3 were reinstated, 1 resigned, 2 ceased to use their services, 1 dismissed, and 1 case is ongoing.

There has been only 3 instances of a pupil exclusion regarding an allegation against staff deemed to be either 'False' or 'Malicious' in a maintained school. These figures remain very low.

Substantiated: allegation is supported or established by identifiable evidence or proof
Unsubstantiated: not the same as a false allegation. It simply means that there is insufficient identifiable evidence to prove or disprove the allegation.
Unfounded: no evidence or proper basis which supports the allegation being made. This might indicate that the person making the allegation misinterpreted the incident or was mistaken about what they saw, or were not aware of all the circumstances.
False: a false allegation may be made by a pupil following an altercation with a teacher or a parent who is in dispute with a school. However there is sufficient evidence to disprove the allegation
Malicious: clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.

Our activity: Child Death Overview Panel (CDOP)

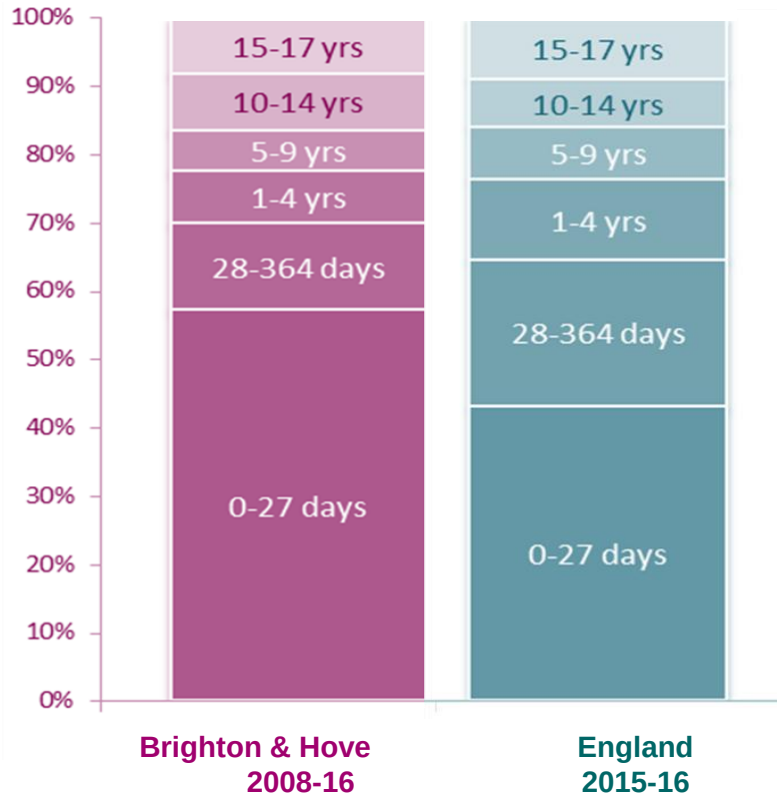
All deaths notified to CDOP from 1 April 2008 to 31 March 2016	
01/04/2008 - 31/03/2009	16
01/04/2009 - 31/03/2010	20
01/04/2010 - 31/03/2011	11
01/04/2011 - 31/03/2012	21
01/04/2012 - 31/03/2013	18
01/04/2013 - 31/03/2014	16
01/04/2014 - 31/03/2015	16
01/04/2015 - 31/03/2016	15
Total	**133**

The Child Death Overview Panel (CDOP) is the inter-agency forum that meets every two months to review the deaths of all children normally resident in Brighton & Hove. The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced. If this is this case the Panel must decide what, if any, actions could be taken to prevent such deaths in future.

Between April 2015 and March 2016 the CDOP was notified of **15 deaths** of children who were resident in Brighton & Hove which is an decrease in numbers of deaths since last year.

The CDOP met 5 times during 2015-16 to discuss child deaths in Brighton & Hove and a further 2 times for the neonatal panels. The CDOP has reviewed 17 cases from Brighton & Hove during 2015/16. There will always be a delay between the date of a child's death and the CDOP review being held. Of the reviews completed in 2015/16, 9 (53%) were completed within six months.

Age profile of deaths notified to CDOP



Over the 8-year period April 2008 – March 2016 CDOP were notified of 133 deaths. On average, 17 deaths per year are notified to CDOP for Brighton & Hove. During this time around 3 in 5 deaths (57%) notified for Brighton and Hove were for babies aged under 28 days compared to 2 in 5 (41%) for East Sussex, which is similar to England (43%). Brighton & Hove had a significantly lower rate of deaths in babies aged 28-364 days, compared to the 2015/16 England rate however there is no statistical difference when the confidence interval is taken into account. There are no significant differences in the rates of deaths for the other age groups

Local Developments, Challenges and Achievements

The CDOP set itself a number of challenges with regards to improving its functioning. These included improving data collection regarding ethnicity for the CDOP process and developing the CDOP database to ensure that data could be extracted easily to inform the annual report and other learning. Both of these have been put in motion and recording of ethnicity in the last annual DfE data return was significantly improved. The data base has been adapted and it will make it easier in the future to provide more detailed data reports.

Collating learning on deaths resulting from self-harm and suicide across Brighton & Hove and East Sussex to inform future preventative work. This is being taken forward by Public Health via the existing Suicide Prevention Group(s) for each LSCB.

CDOP Recommendations to Brighton & Hove LSCB 2015-16

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

- The LSCB asks agencies to review the guidance that is given to parents and young people about ensuring personal safety if taking drugs or alcohol. In particular, whether the risks of physical harm are identified and whether advice is given about ensuring that a friend who has not taken drugs is present and can provide support. This review to include looking at the guidance on "talk to Frank".

- The LSCB should ask BSUHT and the CCG (NHS England) to consider how to share the learning from this case about how to improve communication between agencies around end of life care planning for children with life limiting conditions where there is a Do Not Attempt Resuscitation (DNAR) agreement in place.

Progress on Recommendations from 2014-15

The LSCB were asked to seek re-assurance from Brighton & Sussex University Hospital Trust (BSUH) that their services were operating in accordance with NICE guidance on Feverish Illness in Children (2013) and that this is being monitored. The LSCB has since been assured, via the Brighton & Hove Clinical Commissioning Group and NHS England Area Team, that BSUH are operating in accordance with the NICE guidelines and that all staff have been reminded of the importance of listening to parents when they report that their children are acutely unwell and are encouraged to bring the child back for further assessment if the child's health does not improve or deteriorates.

There LSCB were recommended to request regular updates from the Brighton & Hove Clinical Commissioning Group on the implementation of the Action Plan relating to communication difficulties between community services, local hospital and tertiary centre until all the recommendations are achieved. The CCG has raised this matter via NHS England and through the designated network. Health providers have also been asked to alert the CCG to any new cases where communication is an issue, and as far as is known, there have been no new cases in the last 18 months.

National Developments

The DfE published the Wood Review of the Role and Functions of Local Safeguarding Children Boards, together with the government's response on 26 May 2016. The review found that the gathering and analysis of data on child deaths is incomplete and inconsistent, leading to a gap in knowledge. It suggests that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. It suggests greater regionalisation with consideration being given to establishing a national-regional model for CDOPs. The Government says that evidence suggests that over 80% of child deaths have medical or public health causation and that only 4% of child deaths relate to safeguarding. Therefore, it intends to transfer national oversight of CDOPs from the Department for Education to the Department of Health, whilst ensuring that the focus on distilling and embedding learning is maintained within the necessary child protection agencies.

Violence against Women and Girls Forum (VAWG)

The VAWG Forum aims to raise awareness of VAWG crime types and enable practitioners to stay up to date with local, regional and national policies that impact on the sector. Its role includes:

- **Networking** - providing mutual support and encouragement and developing a strong and effective partnership;
- **Sharing** effective practice and good news stories;
- **Working together** to overcome barriers to local delivery;
- Keeping up to date with, and helping to **inform**, Brighton & Hove, Sussex and national policy in relation to VAWG and related themes
- Providing strategy **advice**, **feedback** and **support** to the VAWG Programme Board, as well as influencing and lobbying for VAWG and wider policy developments.

The Forum's role in relation to the LSCB is to ensure that domestic violence and abuse, rape, sexual violence & abuse and harmful practices remain a priority. This includes:

- Contributing to the development & evaluation of safeguarding children policies, procedures & practices
- Promoting greater awareness of the impact of violence and abuse issues, developments and services, and disseminating information, policies and procedures to LSCB members
- Participating in LSCB meetings & development days, and supporting other LSCB activities and committees
- Identifing gaps in service provision and training needs for members of both forums
- Promoting effective communication between the LSCB and members of the Forum
- The VAWG Forum Chair also attends the Safeguarding Adults Board providing a link between adult and child safeguarding issues and these forms of violence and abuse.

Domestic violence and abuse

It is estimated that 7,639 women and girls aged 16-59, and 3,868 men and boys experienced domestic violence and abuse in the last year in our city

In making these estimates, it is important to note that while both women and men experience incidents of inter-personal violence, women are considerably more likely to experience repeated and severe forms of violence.

Of the 449 cases heard at the Multi-Agency Risk Assessment Conference (MARAC) in the year, there were 431 children associated with these cases.

Domestic abuse is a factor in second or subsequent episodes of being on a Child Protection Plan.

Locally, in July 2016, of 385 children subject of a child protection plan, 45% had parental domestic violence recorded as a factor.

A report produced for the LSCB noted that there have been 109 children in the last year who have become subject of a child protection plan for the second and subsequent time, with 25 going back on plans in less than a year. A high percentage of these were where the mothers had reported ending an abusive relationship who then resumed the relation with their abuser.

What difference has the VAWG Forum / Members made to Safeguarding Children?

- Ensured that the safety of children and young people is recognised.
- Provided specialist support to children and young people affected by VAWG.
- Raised awareness of 'The Portal' Service (www.theportal.org.uk) and how people can access support
- Raised awareness of services providing support to specific communities, such as survivors from BME communities or those who identify as LGB or T, boys and men.
- Raised awareness of services providing support to perpetrators of domestic violence.
- Raised awareness of preventative / early help interventions
- Provided an opportunity for professionals and survivors to have their say as to what is required to make Brighton & Hove a fair city in their support of women and children affected by violence and abuse
- Provided a forum for information sharing and sharing of good practice for professionals.

Brighton & Hove City Council: Families, Children & Learning

What have we done

In October 2015 a **relationship-based model of practice** was introduced and a Team Around the Relationship structure developed, which places the social worker's relationship with a family at the heart of a network of relationships supporting reflective practice. Children's social work services were redesigned into small teams, or pods, to support families from their first assessment and to provide a consistent service for the duration of the child's social work journey. This included the development of a specialist adolescent pod working with complex adolescents at risk of CSE or coming into care.

In February 2016, the interface between **Early Help and MASH** was reviewed and a new IT system has been commissioned that will enable progress of cases to be tracked and monitored and allow for more effective and responsive commissioning arrangements within Early Help. This will be online from September 2016.

In August 2015, the Children's Social Work Quality assurance Framework (QAF) was revised. Social workers are now required to quality assure their own case work in order to learn; critically analyse their own practice; and identify solutions. Other revisions to the QAF include new audit tools which focus on the child's journey (which is in line with the approach used by Ofsted) and improved systems for ensuring that intelligence from quality assurance activity informs learning & development.

There has been joint working between YOS, social work pods and police to stop young people arrested being **held in the cells** overnight.

A lot of work has been undertaken at our residential home for **children with disabilities** including mandatory Internet Safeguarding training, Radicalisation e-learning (Ofsted have praised resulting good practice), and their safeguarding policies have recently all been refreshed.

Schools are actively engaged in completing the annual safeguarding audit: This has been updated to include greater focus on Child Sexual Exploitation, Domestic Abuse, Female Genital Mutilation, The Prevent Duty, Private Fostering Arrangements and Self Harm. Information on safeguarding is shared well across our partnerships including, for schools in particular, through the Behaviour and Attendance Partnership and the Designated Safeguarding Leads Network.

Children Missing in Education are monitored through the CME Panel, which provides oversight and advice to relevant agencies to improve school attendance of individual children.

Investigations and deep dives have been completed at a number of individual schools in response to Ofsted or parental concerns around safeguarding.

The Educational Psychology Services and the Community CAMHs team have been working closely on a number of areas including a **CAMHs pilot in Secondary Schools** , leadership on various operational and strategic groups in the city e.g Early Help and Management of Risk and Multi-Agency Planning (Youth Offending Service), plus support to the Virtual School re emotional health and well-being

The Educational Psychology Service has been active in delivering Attachment aware training, attending Complex Case Panels with CCG. There has been enhanced joint working between the EPS and SEN around in Agency Placements.

Home visits to children who are **Electively Home Educated** are conducted within timescales: Checks with other agencies, including MASH where necessary, are included within these visits.

How well have we done it?

The **Ofsted Inspection** of services for children in need of help and protection, children looked after and care leavers in Brighton & Hove took place 14 April 2015 – 8 May 2015. This rated the service overall as Requires Improvement, with good ratings achieved for children looked after and achieving permanence; and leadership management and governance. Children who need help and protection were rated as Requires Improvement. Ofsted recognised that children are kept safe, that the service knows itself well and that improvement plans are appropriate.

The quality assurance framework was assessed by Ofsted as being well established, with learning routinely identified and disseminated from a range of sources. Compliance with the completion of audits by social workers and their managers has increased each quarter during 2015-16 and by Q4 this was 98% .

There has been an improvement in the percentage of regular audits (of social work practice) graded overall as good or outstanding. In quarter 4 (2015-16), sixty-eight percent of cases in the audit were judged overall to be good or better and the use of relationships to affect change was identified as a particular strength Social workers have reported that the Team Around the Relationship 'is helping us to think differently about cases' and to feel contained.

100% of maintained **schools** (including the academies and free school) submitted a safeguarding audit for the academic year 2014-2015 and that is looking the same for 15/16. 48 schools were given 1:1 feedback on their audit through a follow up meeting.

The Behaviour and Attendance Partnership and the Designated Safeguarding Lead Network meetings are dynamic and productive, with positive outcomes for student welfare.

Initial visits to families for new Elective Home Education referrals, and follow up visits are completed within timescales. Children with less than 30% attendance are discussed at the CME Panel

The EPS Attachment training positively was evaluated and there has been better linking and data sharing over cases and challenge/support to settings around meeting needs of children and young people. EP presence at meetings has enabled the voice of education, SEN and applicability of decision makings to help safeguard CYP

There has been positive evaluation from schools on the Mental Health Pilot and this is going to be rolled out to other schools

What difference did it make?

Audit findings show that in the vast majority of social work cases (Q4: 86%) there is a good understanding of the child's experience; that direct work is being undertaken and there is strong evidence that the use of relationship based practice is having a positive effect on outcomes for children.

The new Early Help IT system will enable the service to better understand how targeted teams and universal services work together and record Early Help interventions, allowing more effective monitoring to inform commissioning arrangements.

The safeguarding audit with schools is increasingly becoming a vehicle for change, as opposed to monitoring. This is in part due to the feedback visits being provided. These will be planned differently for the coming year to ensure that 100% of schools receive one.

Feedback from parents about the service they have received from their social worker during is positive overall with parents saying that they felt that the work they did with the social worker was successful.

Drove Road continue to promote good relationships with staff and young people so they feel safe to talk to us and tell us about things that might be bothering them. There is evidence that highlights the good relationship between staff and the young person and staff knowing the procedure they need to follow. Also work continues on completing very detailed body maps for the young people, liaising with schools, parents and social workers.

The Behaviour and Attendance Partnership and the Designated Safeguarding Lead Network meetings allow for genuine and organic networking and sharing of practice between agencies, in addition to planned input around particular themes or issues.

The findings from investigations and deep dives in schools are shared across the Designated Safeguarding Lead Network, so that any learning can be widespread.

School staff have a better understanding of need e.g. Autistic Spectrum Condition (ASC) and are therefore more able to meet needs of CYP in schools

CAMHS Pilot has enabled school staff to have greater confidence in discussing Mental Health and needs of CYP being met in a more timely way

EPs knowledge and discussion has helped other professionals see the situation through a different lens/understand the needs of the CYP

Neglect

- The Principal Social Worker has identified a **Lead Practitioner** to focus on the issue of Neglect, raising its profile within the FCL directorate and identifying best practice.
- The **Quality of Care Assessment Tool** has been piloted and the Lead Practitioner will be responsible for rolling this out across social work pods
- A **learning review** was commissioned by FCL on a long standing neglect case – this has subsequently turned into an LSCB multi-agency learning review given the multitude of issues identified
- The Education Safeguarding Officer and Designated Persons network maintains links between **schools and the MASH** and social work pods, ensuring effective communication across services around Neglect.
- Child neglect features within the **school safeguarding audit,** and it is a part of the mandatory single agency **training**: *Leading and Managing Safeguarding in Schools including Managing Allegations against Staff*, which all Headteachers and Designated Safeguarding Leads must complete: this in turn is disseminated to all school based staff on an annual basis
- **‘Signs of safety’** training from Claremont looking at neglect has been adapted for disabled children and there is planning joint training with paediatricians/Children’s Disability Service around neglect

Child Sexual Abuse

- A joint agency **CSA pathway** is in place which focuses on supporting the child and their family
- **Therapeutic support** from Clermont is available for all children referred into the paediatric Sexual Assault Referral Centre
- **Training** on child sexual abuse, sexual abuse and child protection and sexual violence and abuse – the impact of rape and sexual assault, are part of the core training programme available to FCL staff
- Child Sexual Abuse features within the **school safeguarding audit**, and the Education Safeguarding Officer and Designated Persons network maintains links between schools and the MASH and social work pods, ensuring effective communication across services around CSA.
- Child Sexual Abuse features within the mandatory single agency **training**: *Leading and Managing Safeguarding in Schools including Managing Allegations against Staff*, which all Headteachers and Designated Safeguarding Leads must complete: this in turn is disseminated to all school based staff on an annual basis.

Child Sexual Exploitation

- Senior operational management oversight on high risk CSE cases provided by co-chairing arrangements of **Red Op Kite** MaCSE meetings
- Development of Kite team into specialist **Adolescent Pod** dealing with high risk adolescents within the city, including those at high risk of CSE.
- **Schools Safeguarding Audit** Tool highlights CSE as a priority area. The Education Safeguarding Officer and Designated Persons network maintains links between schools and the MASH and social work pods, ensuring effective communication across services around CSA.
- Increased funding to WiSE to provide independent service for children at risk of CSE
- Engagement with Office of Children's Commissioner and Sussex University in a research programme into the efficacy of the **See Me Hear Me framework** as a model for working with children impacted by CSE.
- Child Sexual Exploitation features within the mandatory single agency **training**: *Leading and Managing Safeguarding in Schools including Managing Allegations against Staff*, which all Headteachers and Designated Safeguarding Leads must complete: this in turn is disseminated to all school based staff on an annual basis
- CSE is a **standing item** on the Behaviour and Attendance Partnership and Designated Safeguarding Lead Network meetings.
- **Chelsea's Choice**, a Theatre in Education production aimed at highlighting CSE with young people, was successfully delivered to all secondary schools for the second year running.
- Relationship based training focussed on tackling child sexual exploitation in **Children's Disability Service**
- Updated **residential safeguarding policy** at Tudor House to incorporate CSE, Radicalisation and Female genital mutilation.
- All Drove Road staff have undertaken CSE e-learning and SCO's and PM's have attended the one day training course.

Voluntary & Community Sector

Brighton & Hove has a vibrant, active and diverse Voluntary & Community Sector (VCS). The last Taking Account Survey 2014 by Community Works showed that there are at least 2300 CVS organisations & groups in the city of which 11% (253) define their main activity as working with children & young people.

These groups are often engaging and supporting the most vulnerable, marginalised and disadvantaged children, young people and families. For example; young carers, LGBTU young people, BME young people and their families, children and young people with special needs and disabilities and gypsy and traveller families. The sector also offers specialist support in relation to families affected by domestic violence, bullying, emotional well-being and mental health, substance misuse, sexual abuse and exploitation.

Brighton & Hove has a well-established VCS infrastructure organisation – Community Works, which provides a mechanism for bringing together the voice and concerns of the Third sector, including the Children and Young People's Network of organisations.

Safeguarding support to the VCS sector in 2015 - 6

- Safeguarding training and support services are provided by local organisation Safety Net. Between March 2015 and April 2016 500 workers and volunteers from the community and voluntary sector attended an introduction to safeguarding and child protection course. A further 2305 people from the CVS attended other safeguarding related courses provided by Safety Net.
- Community Works and Safety Net ran a number of safeguarding focussed events during the year including a safeguarding conference in June 2015 to update and get feedback from CVS groups on safeguarding developments and gaps in knowledge identified by the Section 11 audits.
- An online safety conference took place in February 2016 with presentations around the benefits and risks of the online world and asking the question: How could we make Brighton & Hove the online safety capital of the UK?
- The safeguarding quality assurance scheme Simple Quality Protects (SQP) is co-ordinated by Safety Net . 14 organisations achieved their award during the last year.

Sexual abuse and sexual exploitation

Local VCS organisations, WiSE, Survivors' Network and Amaze undertook partnership work around preventing child sexual exploitation of young people with learning difficulties. The project planned and delivered a series of sessions on healthy relationships for pupils at the Cedar Centre special school intended to reduce their vulnerability to sexual exploitation. The specialist organisation Amaze participated by helping the workers from WISE and Survivors' Network to adapt their approach to work with young people with learning difficulties. One of their interns (a disabled young woman) helped plan and deliver the sessions with support and supervision.

Safety Net ran a project funded by Comic Relief for young survivors and young people aged 13-19 at risk of sexual violence and/or exploitation. 106 young people, 88 girls and 28 boys, took part in the project which worked mainly from referrals from secondary schools. The project provided a combination of non -therapeutic 1:1, small group work and residentials, with a focus on active and creative activities concentrating on building emotional resilience, safe risk taking & personal safety.

An independent evaluation of the project by Sussex University concluded that, "*All young people reported positive and beneficial changes to their feelings, attitudes, and self-concept as a result of their participation. The reported changes included being more confident, feeling better about themselves, valuing their friends more, and being more tolerant of others. They also reported greater understanding of their feelings, greater ability to identify to risks, and greater ability to problem solve and keep themselves safe*".

Safety Net was also involved in a partnership piece of work with the BHCC Standards and Achievement Team to produce a curriculum pack for primary schools, called 'Feeling Good, Feeling Safe' which provides prevention education around building skills for emotional literacy, resilience, body awareness, safe touch, safe networks and problem-solving. The pack is being rolled out to schools across the city.

Neglect

Brighton Oasis Project (BOP) provides services for adults with substance misuse problems which impact on their ability to care for their children. This year for the first time they delivered the POCAR programme (parenting our children, addressing risk) to men; with 44 men and 73 women being referred to the programme by Children's Social Care this year.

The crèche opened 4 days a week to enable parents and carers to access treatment and support - throughout the year the crèche cared for 72 children from birth onwards

In February BOP held a Safeguarding Event identifying how their support contributes to improved outcomes for children in the city. 3 mothers who have engaged with POCAR spoke about the programme and identified how the support they had received was helping them.

The BOP therapeutic service for children affected by substance misuse in the family worked with 72 different children, 32 of those children completed therapy in the year. A newly funded project will aim to improve outcomes for under 2's. Staff were trained to deliver the 'Mellow Parenting' programme and the first cohort of vulnerable mothers assessed

Holiday activities were provided for children and young people who are affected by substance misuses. BOP also held its first residential weekend for 7 children.

The Young Women's Alcohol Project worked with Young Women aged 14-15 who were to experiencing problems with alcohol.

The Young Carer's Project secured a section in the council's school Safeguarding Audit to ask about recognition of young carers and engaged support with young carers. This should improve communication & identification of young carers by schools, and the Education Safeguarding Officer is promoting provision, support and referral pathways to schools and will communicate any school support needs. Support from the Young Carers project is now routinely included on CIN and CP support plans.

Daybreak provides family group conferencing (FGC's) for families in Brighton & Hove who are involved with Children's Social Care to support them to come together to work out solutions to a variety of problems and safety concerns.

Service providers are also able to share their concerns and other relevant information with the family who are then left in private to discuss the way forward and establish a mutually agreed safe, detailed and protective plan. FGC also encourage the 'voice of the child' to be heard and acknowledges their views and wishes.

- Daybreak accepted 158 FGC referrals from April 2015 to March 2016
- 241 children were referred and 74% of those children went on to have an initial FGC.
- Of the 177 children who had a meeting, 75% (132) children were on a Child Safeguarding Plan at the time of their initial meeting.
- Of the 110 meetings that were convened 100% produced a safe family plan that addressed the concerns raised by Children's Services, and was agreed by the children's social worker.
- 660 family members attended a FGC, with the average number of attendees being 6. Out of 131 feedback responses from service users, 99% were positive about the experience "*we will all make sure that M and E are safe and well looked after working together I find the family group conference very helpful*"
- 163 referrers and other professionals attended the meetings. Out of 55 feedback responses from professionals, 98% were positive about the experience:

'It felt like a really useful tool, in relation to working with a family that are normally more concentrated on undermining each other, than working together. To have a meeting that was focused purely on the children, and to ask for the family to work without professional intervention felt very positive and empowering'

Brighton & Hove Clinical Commissioning Group

What have we done?

As a Statutory Board Member the CCG has worked closely with the LSCB throughout the past year. The CCG employ and host the Designated Professionals: Doctor and Nurse for the Brighton & Hove System, and the the Named GP supporting primary care.

CCG Executive, designated and named professionals support the work of the LSCB by chairing the Case Review, Learning & Development, and Child Sexual Exploitation subcommittees. and in addition sit on numerous subcommittees, providing clinical expertise, substantial training and advice.
CCG staff work closely with local authority, public health and CCG commissioners to ensure learning from case reviews influences strategic commissioning plans and the monitoring of existing provider contracts

To support new integrated ways of working we have provided leadership and pump primed funding to pilot a nurse working across BSUH, SPFT and SCFT in the MASH which led to a shared sustainable model of on-going support funded jointly between BHCCG, SCFT, SPFT, and BSUH. The liaison nurse and administrator is in post supporting the MASH and improving the information supplied from health agencies

This year we have increased the capacity of the Designated Safeguarding Adult practitioner with specific focus on supporting primary care in recognising and contributing to the safeguarding agenda, including a focus on supporting victims of domestic violence specifically where children are in the family. This professional also sits on the Channel panel and will be joined by the Designated Nurse/Doctor for Safeguarding. We have recently facilitated representatives from CAMHS to sit on the Chanel Panel which adds a mental health dimension.

The Designated Doctor supports Named Professionals and provider clinicians in perplexing and medically-unexplained cases and provides Children's Social Care with advice in cases of fabricated and induced illness. We have advised the provider Trusts and CCG on the planned medically unexplained symptoms/chronic pain pathway.

The Designated Nurse has led on the development of the FGM pathways and guidance, and the Designated Doctor is leading on the multi-agency response to FGM cases involving children.

How well did we do it?

The Designated Doctor provided clinical and safeguarding expertise in the commissioning & development of the Sussex Paediatric SARC.

Contributed to the development and introduction of the NHS pan Sussex assurance tool for monitoring provider compliance against safeguarding matrix

What difference did it make?

There is strategic leadership in place for named professionals, and safeguarding leads of independent health providers.

MASH has the support of a dedicated healthcare professional in early decision making.

Learning from LSCB case reviews and other programs such as Transforming Care (Winterbourne) has influenced the CCG commissioning of services for children and young people. For example a new pathway of care for supporting those traumatised by sexual and domestic violence, leading to a review of services to support the pathway from childhood for individuals with learning disabilities, and a review of CAMHS services.

Child Sexual Abuse

- The CCG sit on **Pan Sussex Strategic Board**. The Designated Doctor is the board lead for CSA and sits on the Sussex SARC board.
- The CCG safeguarding **training** includes ensuring all commissioning staff have an introduction to what is child sexual abuse and how to refer.
- Commissions a **therapeutic pathway** for victims requiring specialist support.
- As Commissioners we **monitor** providers of NHS services adherence to Pan Sussex policies.
- We continue to work with National Health Service England (NHSE) supporting the development and commissioning through them of the **Paediatric SARC** and the Designated professionals have identified and raised significant concerns about the processes and investigation of cases of CSA and FGM.

Child Sexual Exploitation

- Strategic lead for named professionals ensured independent providers are aware of the issues.
- Designated Doctor chairs the new merged LSCB CSE subcommittee.
- The Designated Nurse and Doctor provide supervision for all named professionals across the Brighton and Hove NHS providers and support the Health Advisor Group (HAG) and meet with independent providers where awareness raising and discussion of this issue takes place.

Neglect

- The Designated Professionals and Head of safeguarding have been key in ensuring Neglect is raised at appropriate strategic levels, which included referring a case to the SCR panel and lead to a learning review being commissioned.
- The Designated Nurse has supported the LSCB to plan a training programme on Neglect in association with Social Care Institute of Excellence
- Information on Neglect has been raised with independent providers

NHS England

NHS England South (South East) remains committed to safeguarding vulnerable children across the South East. As such we are actively involved in the delivery of the national safeguarding agenda and the implementation of the NHS England Safeguarding Vulnerable People in the NHS - Assurance and Accountability Framework. We continue to work collaboratively with key partners and remain active members of the National Safeguarding Steering Group and National CSE and FGM Sub Groups. We offer professional support in line with our safeguarding governance arrangements.

During 2015/16 we committed financial resources across the south east to support progress against the four national safeguarding priorities:

- Looked After Children (LAC)
- Mental Capacity Act and Deprivation of Liberty (MCA/DOLs)
- Female Genital Mutilation (FGM)
- Child Sexual Exploitation (CSE)

Additionally we invested further monies to support the development of the Named GP for Children role.

We have provided whole system leadership and gained assurance that NHS organisations who commission health care across the south east are working to safeguard children at risk of abuse or neglect. We continue to inform the long term national safeguarding strategy.

We have identified our priorities for 2016/17 and will continue to work collaboratively to drive improved outcomes for vulnerable children across the south east.

Sussex Community NHS Foundation Trust

What have we done?

This year SCFT has continued to strive to improve their systems such as training, supervision and governance arrangements in order to support practitioners to safeguard children whilst also developing new initiatives such as Health practitioner in the Multi Agency Safeguarding Hub (MASH) and Children's Sexual Assault Referral Centre (CSARC).

Improved organisational communication was achieved in relation to "What to do if you suspect a child is being abused" by the development of an SCFT leaflet which was included in every employees wage packet .

The Annual Safeguarding Children Report 2015-2016 which provides both assurance and evidence to the Board that the Trust is fulfilling its statutory responsibilities to safeguard children, and summarises achievements and challenges, has been approved by the Safeguarding Group and will go to the Board in the Autumn. The Three Year Safeguarding Plan 2016-2018 has been revised and has been approved by the Quality Committee.

The Section 11 Audit was completed and signed off by the Chief Nurse in March 2016. An action plan is in place to address the amber actions and is being monitored at the trust wide Safeguarding Steering group which meets regularly.

SCFT has been represented on the LSCB Board by the Chief Nurse or their delegated representative. In addition the Named Nurse and Doctor have continued to play an active role in the LSCB by attending the Board meetings as professional advisors to the Board lead, and being involved in a number of the subcommittees and short term working groups including the Monitoring & Evaluation Group, the Child Protection Liaison Group, the Learning & Development sub group and Preventing Child Sexual Exploitation

Named Professionals were part of Review Teams for Serious Case Reviews & Learning Reviews and SCFT practitioners were part of the case groups. Relevant findings to SCFT have been actioned and the learning from the reviews has been shared across Trust by incorporating relevant findings in training and discussion at team meetings.

How well did we do it?

This year there has been a strong focus on improving the training delivery, focusing both on compliance figures and also quality of the sessions . In accordance with the SCFT Safeguarding Children Training & Development Strategy & the Intercollegiate Document (RCPCH 2014) staff groups have received the appropriate level of training for their role. There has been an improvement in provision for staff to undertake safeguarding children training enabling compliance rates to increase to 100% for level 2 and 84% for level 3.

The delivery of regular safeguarding children supervision also continues to be a priority. As a consequence 98% Health Visitors and School Nurses, and 100% of Managers received supervision in the appropriate timeframe. This demonstrates a sound commitment to supervision delivery and uptake by practitioners. A Safeguarding Children Supervision re-audit was completed which demonstrates that a risk assessment model of supervision form was used in 94% of cases which is positive & demonstrates the rationale for decision making .

Single agency audits that were completed in order to assure the Board that SCFT processes are robust in relation to safeguarding children include the following:

- Single Combined Assessment of Risk Form (SCARF) and discussion in Supervision – This demonstrated that there had been a 20% increase from the previous audit of SCARFs being discussed by the Health Visitor with their manager in supervision
- NICE PH50 Domestic Violence & Abuse: How to respond effectively ? – Baseline data collected and action plan in place to increase use of leaflets, posters and training.
- CSARC audit to ensure that children who may have been sexually assaulted are screened appropriately for sexually transmitted diseases

SCFT hosted, managed and developed the MASH Specialist Nurse and Administrator posts, funded for a year by Brighton & Hove CCG. Within a six month period 1458 referrals were MASHed with health information which equates to approximately 3,000 per annum.

The sharing of SCARFs from Police to Health Practitioners has dramatically increased since the MASH Specialist Nurse has been in post, from Health Visitors and School Nurses only receiving 12 SCARFs in a 3 month period prior to the post being in place increasing to 198 being shared in a comparable three month period.

The Named Doctor is Sussex Children's SARC (CSARC) Clinical Lead and had developed the new service delivery model from April 2015 which aims to provide a welcoming child centred service to meet the specific health needs of children who have been sexually assaulted. It undertakes forensic medicals and historic cases in response to referrals from police or social workers, and provides follow up support, advice and referrals to sexual health and contraception services and or the children's independent sexual violence advisor (CISVA) as needed.

What difference did it make?

The Section 11 audit has evidenced that Sussex Community Foundation Trust continues to have safe and effective arrangements in place to safeguard and promote the welfare of children .

An increased number of staff have received good quality safeguarding children training which has been positively evaluated at the appropriate level in accordance with the Safeguarding Children Training and Development Strategy.

There is a high level of effective multiagency working through case reviews and multiagency sub groups which has resulted in changes to practice.

Improved sharing of information between health and social care: Health practitioners have reported via an audit that they feel more confident sharing information securely with the MASH health practitioner, and that they had more involvement in MASH decision making since the Specialist Nurse has been in post

Sharing of SCARFs in a timely way enables sharing of information between social care and health in the interest of the safety of the child and their family, helps the practitioner plan work with the family, and also ensures SCFT staff safety

Neglect

The Named Nurse is a lead for the LSCB on Neglect. Work undertaken by the SCFT Safeguarding Team includes:

- Supporting Social Care to pilot the Quality of Care Tool
- Working with Social Care for Excellence (SCIE) on their pilot training in Neglect
- Supporting the LSCB Trainer by helping to devise the current Neglect training package and co-facilitating the training day with social care

SCFT have also made a commitment to a neglect learning review with the Named Nurse being part of the review group and clinicians involved in the case group.

Health Visitors and School Nurses offer an enhanced service to support families where child neglect is an issue .

Within SCFT cases of child neglect are discussed within regular safeguarding supervision, and as an adhoc consultation, to enable practitioners to review the cases objectively, have clear outcome focused plans for the children, and to prevent drift.

Child Sexual Abuse

- The Named Doctor is Sussex Children's SARC Clinical Lead and has developed the new service delivery model from April 2015 which aims to provide a welcoming child centred service to meet the specific health needs of children who have been sexually assaulted. It undertakes forensic medicals and historic cases in response to referrals from police or social workers and provides follow up support, advice and referrals to sexual health and contraception services and / or the children's independent sexual violence advisor (CISVA) as needed. The service is available daily between 9am-5pm for referrals and Doctors are available from 10am-4pm for examinations, strategy meetings and advice.

- Training has been delivered by the CSARC operational lead, specialist nurse and CISVA to the West Sussex, East Sussex and Brighton & Hove police and social work teams and Brighton & Hove School Nurses and Health Visitors. This has received positive feedback and has enabled some useful discussion about management of cases. This has aimed to increase understanding and use of the CSARC service to improve the experience for the children who attend.

- SCFT Named professional and MASH Specialist Nurse give advice and support to practitioners working with Child Sexual Abuse cases .

87

Child Sexual Exploitation

- SCFT Named Professionals involved in the multiagency Strategic Child Sexual Exploitation groups

- Clinical Staff from the Looked After Children Health Team and Contraceptive and Sexual Health Team attend the operational multiagency groups to share relevant information and co-ordinate care plans.

- All children and young people who are identified as being at risk of child sexual exploitation by Op Kite are flagged on SCFT health record system

- Awareness of Child Sexual Exploitation has been incorporated into all SCFT safeguarding children training programs level 2 & 3 for year 2015/2016.

Sussex Partnership NHS Foundation Trust

What have we done?

We have provided safeguarding training for all clinical staff in the Trust at level three and have developed training specifically for CAMHS staff and for adult mental health staff in line with the intercollegiate document.

The Named Nurse has attended meetings when possible and has participated in the multi-agency review of the recent SCR and also submitted a section 11 report and attended the section 11 report challenge event.

We also arrange and attend 'safeguarding link practioner' meetings across all of our areas.

In the Trust, we have reviewed our safeguarding policy and continue to have regular Trust wide safeguarding meetings in order to share information about safeguarding across Kent, Sussex and Hampshire.

We have changed the culture and the paperwork in the agency to ensure that safeguarding issues are raised and discussed at all team meetings and also raised and discussed in supervision

We have highlighted the role of the Named Nurses and Drs in being able to support staff with complex safeguarding issues. We have supported staff in escalating issues with partner agencies when necessary

How well did we do it?

The training has received positive feedback consistently and it is noticeable that more referrals are being made, and copied into the Named Nurse, as staff as they become more aware of their responsibilities with regard to safeguarding. Over 90% of CAMHS staff have up to date training and the number of adult mental health staff trained has risen by 50% in the past year.

The Trust safeguarding meeting functions well and is well attended. Safeguarding issues are discussed regularly in supervision and team meetings.

What difference did it make?

As above, more referrals being made appropriately, people reporting feeling more confident in their knowledge of safeguarding issues and how to manage them.

People are more aware that safeguarding is their business, whatever area of the Trust they work in.

Neglect

Raised awareness of the issue through training and dissemination of information.

The issue is highlighted in our safeguarding policy and discussed in our safeguarding meetings.

Child Sexual Abuse

We have provided training around CSA and disseminated information from partner agencies and also via our safeguarding meetings. The issue is highlighted in our safeguarding policy.

In our level three training for CAMHS staff, we have had a specialist session on CSA and have used SCRs where CSA has been an issue in the 'Learning from SCRs' part of our training programme.

Child Sexual Exploitation

We have included detailed information on CSE in our training package, including showing NHS England videos to demonstrate the issue of CSE.

In our level three training for CAMHS staff, we have had a specialist session on CSE and have used SCRs where CSE has been an issue in the 'Learning from SCRs' part of our training programme.

The Named Nurse has also been part of the SCR panel for the WS case review regarding CSE and has shared information appropriately to enhance our understanding and consider issues that we need to address as a service

Brighton & Sussex University Hospitals Trust

What have we done?

BSUH continues to ensure that arrangements are in place to meet the Section 11 of the Children Act 2004 (HMSO 2004) requirements. External monitoring of these arrangements is a responsibility of the LSCB (Local Safeguarding Children Board), Ofsted and the Care Quality Commission (CQC), and the CCG who meet with the Trust on a regular basis to discuss quality and service issues.

As a Statutory Board Member, BSUH has worked closely with the LSCB throughout the past year contributing to the Board and the subcommittees with 80 - 100% representation.

Learning

BSUH has been involved with the Brighton & Hove SCR, and learning this and national SCRs has been incorporated into the safeguarding action plan including;

1. Improving the maternity information gathering documentation relating to fathers.
2. Ensuring all staff are aware of how to access safeguarding advice and support throughout the day.
3. Continuing to make urgent referrals (in and out of hours) to local social services of serious life threatening injuries.

Team work

- BSUH has been part of the Health steering group working with the MASH health representative and contributed to the funding of the post.
- The paediatricians have worked hard to maintain a quality child protection medical service, providing detailed reports and opinions on possible non accidental injuries.
- The named nurse has been part of the working party developing the FGM risk assessment forms & part of the mandatory reporting to the Government for scoping exercise.
- BSUH has worked closely with RISE and the CCG by having a Health Independent Domestic Violence Advisor (IDVA) working in A&E, Maternity and sexual health, who takes referrals relating to victims of domestic abuse.
- The safeguarding nurse continues to support MARAC by attending and providing relevant information about hospital attendances.
- The specialist safeguarding liaison nurse was appointed in Sept 2015 and has continued to provide a quality risk assessment of all the discharge summaries for children attending the hospital and to provide timely communication with community health services & professionals linked to the child & family.

Training

- Over 130 training sessions were undertaken by the safeguarding team to enable the single agency training across the 7000 members of staff in BSUH
- New quarterly safeguarding raising awareness sessions have been introduced which are well attended and evaluated and cover a multitude of topics with speakers from all agencies.
- The online training has been introduced linked to ‘e learning for health’, which the Named Doctor helped to design.
- The safeguarding team continue to contribute towards the LSCB training pool.

Communication

- The monthly safeguarding newsletter is circulated for staff to raise awareness and to be used as a discussion prompt. The newsletter is circulated at the monthly nursing meeting.
- The BSUH web page has been updated giving links to many online services and training opportunities
- A wider staff audience has been reached directly via the monthly nursing meetings
- CP-IS is being introduced by means of smart cards so that staff in key areas can access the national spine to check if children have a CP plan. This will eventually replace the local flagging system currently in place

How well did we do it?

Having a Health representative as part of the MASH has promoted communication and sharing of information, and enabled improved multi-agency working & decision making. BSUH referrals to the MASH are usually well documented and result in a high proportion of assessments being undertaken (40-60%). Serious Case Reviews highlight that babies are very vulnerable to abuse & as such the maternity service continues to refer a high number of women and families with complex needs.

Having taken part in the LSCB Multi-Agency Audit about substance misuse it was pleasing to note that there is good early recognition of the risks to the child and concerns are acted upon in a timely way in all cases. Strengths were particularly noted in Midwifery where there is evidence of good risk assessment when mothers book into the maternity service.

In all cases where maternal substance misuse is identified by Midwifery, a referral is made to the 'One Stop' Clinic which is a specialist service for women who use alcohol and / or street drugs and certain prescribed drugs, at any time during pregnancy.

An audit of FGM recognition and referral showed that there was a good process for asking women about FGM but a need for co-ordinated documentation and pathway which helped inform the Pan Sussex risk assessments and flowchart.

The Named Doctor has completed an audit looking at imaging in children with suspected non-accidental injury.

What difference did it make?

The IDVA service in A&E/Maternity and sexual health clinic has resulted in increased referrals relating to domestic abuse.

The number of safeguarding referrals from the hospital and midwifery which convert to actual assessments is relatively high suggesting that staff are aware of the thresholds and vulnerable people.

The daily ward rounds continue to ensure staff are supported to assist families with safeguarding issues. Staff listen to the voice of the child by helping to co-ordinate safeguarding aspects of care, attending strategy meetings and case conferences.

The B&H commissioner secured some funding to improve the service of mental health support for children in B&H with long term health issues linked with BSUH, as well as more funding to improve the in-patient service of mental health support for children in B&H with self harm which has proved to be very successful.

Child Sexual Abuse & Exploitation

The Lampard report prompted BSUH to formulate an action plan & highlight the issues about CSE and sexual abuse.

We have raised awareness of Operation Kite in Sussex to staff across the Trust and highlight in our training the factors that make children more vulnerable to exploitation. The monthly newsletter raised awareness of CSE & child sexual abuse throughout the year

Information about professionals involved with young people discussed at Operation Kite is filed in their medical notes to alert practitioners of the need to share information.

The WISE risk assessment tool is available, and the Sexual health clinic has a specific risk assessment tool.

As in the previous year there are ongoing links to the B&H SARC with staff being aware of the need to recognise and refer.

The Named Nurse is a member of the LSCB vulnerable children group and the Prevent and Protect group which informs the Trust response to this issue.

The Goddard enquiry into sexual abuse started and BSUH has responded to the directive to keep patient notes which may be required for the inquiry.

Neglect

The Named Nurse took part on the SCIE neglect training programme and has used that information to update the training packs for staff.

The monthly newsletter has raised awareness of Neglect

Information related to Neglect informs part of both level 1 & 2 training sessions and a neglect case discussion is used for level 3 training.

The Trust has a nurse for homeless people who helps liaise with housing as this may have an impact on Neglect.

South East Coast Ambulance Service

South East Coast Ambulance Service NHS Foundation Trust is committed to promoting and safeguarding the welfare of all vulnerable people; recognising that everybody has the right to be protected from harm, exploitation and neglect within the context of the law and personal civil liberties. During 2015/16 the Trust has worked hard to implement the changes the Care Act introduced. Referral rates have risen again over the year with overall activity across the whole Trust increasing by 22% from 2014/15..

3 Key Achievements in 2015-16

- Increasing rates of safeguarding training to 90% across the Trust.
- Implementing a Trust-wide on-line reporting process for concerns. This has improved the quality and quantity of referrals being submitted.
- Improved Domestic Abuse awareness and training across the Trust with an extended Domestic Abuse pilot.

3 Key Challenges in 2015-16

- Capacity within the safeguarding team with staff being seconded into posts and the increasing workload resulting from increased reporting activity.
- Loss of the Domestic Abuse practitioner when the external pilot funding ended in December 2015 meaning that it was not possible to continue and expand on the work undertaken.
- Implementation of the Care Act within the Trust.

Future Plans 2016 -2017

The improved data gathering will be used to better understand reporting patterns within the Trust. We will also be piloting using this information within the appraisal process at a practitioner level, so that staff will be able to benchmark their activity within their own teams/station areas which will, in turn, help the Trust identify possible learning needs for a specific area or areas of good practice which could be shared across the whole organisation.

Sussex Police

What have we done?

The new Safeguarding Investigation Unit (SIU) continues to develop. The SIU has brought together trained detectives, with expertise and experience in investigating child abuse, together with other specialist roles, such as dedicated Sexual Offence Liaison Officers (SOLOS), missing person co-ordinators, and domestic abuse case workers. This approach ensures we can deliver effective and timely investigations as well as providing appropriate support to victims. The Complex Abuse Investigation Unit has now been introduced, providing specialist support to the SIU at Brighton by assuming responsibility for some complex and large scale investigations. This allows the SIU to focus on local child protection investigations.

How well did we do it?

The introduction of the new Safeguarding Investigating Unit in October 2015 was based upon the principle of a larger investigation team of Omni competent officers who would be dealing with Serious Sexual Offences, high Risk Domestic abuse, and child and adult safeguarding.

As would be expected there have been some initial teething problems around the training requirements that such an undertaking requires and the training program continues to roll out. There was a multi-agency training held for Brighton SIU in April 2016 where some of the issues around multi-agency working were addressed with partners. Inputs included Unexpected Child Deaths, Paediatric SARC, Stalking and MASH principles and procedures. The training program continues to address the specialist training that is required by SIU officers.

What difference did it make?

The development of the SIU is still in progress, including the introduction of new audit measures which will assist in quantifying the improvements the SIU has achieved.

One advantage of the new SIU system is that we are more consistently able to allocate and investigate those investigations with the most intensive safeguarding elements e.g. CSE, which historically sat with CID if this was not considered to be intra familial.

The establishment of the MASH has continued to be embedded into our day to day business and we have responded to feedback from partners by increasing the consistency of staff at the MASH.

Neglect

The police have continued to respond to referrals of neglect and contribute to joint investigations.

The local MASH has assisted us in better information sharing and early intervention in neglect and other safeguarding issues.

Child Sexual Abuse

The police have continued to respond to all allegations of sexual abuse whether made by children concerning current abuse, or adults reporting earlier abuse, and have emphasised that any victim making an allegation will be listened to, and where appropriate a criminal investigation initiated.

The continuing development of the SIU is providing additional resilience to investigate this sensitive area of child abuse.

Child Sexual Exploitation

The SIU DI and Missing persons / CSE team have continued to engage in the Red Op Kite meetings which identify and oversee the risk management of the most high risk cases. Also they have been involved in the quarterly reviews of Amber and Green cases that feed into that meeting cycle.

This year we have further developed an internal intelligence meeting cycle in which all CSE related intelligence is examined and tasked out to identify and target the most concerning perpetrators of CSE via the weekly tasking meeting held on the division.

Two separate Op Pipeline – CSE - trials have been held this year. Whilst both were unsuccessful at court, they were each underpinned and enabled by significant safeguarding and disruption successes and demonstrate an increased understanding of the local CSE picture.

A further example of this developing understanding of our CSE problem locally is Op Crossroad. This involved the sexual exploitation of several young boys linked to Dukes Mound. Again whilst no prosecutions were forthcoming there were significant safeguarding and disruption objectives met.

The DCI from the SIU is Co-Chair of the LSCB's CSE/CSA Prevent, Protect & Early Identification Subcommittee

CSE Communication Campaign

This campaign was rolled out in three phases between January and May 2016. The overall aim of the Pan Sussex CSE campaign was to raise awareness of what CSE is to the public and targeted audiences, so that they would be able to spot the signs of CSE. By offering specific guidance and support to these audiences, they will know how to report CSE and ultimately support the reduction of this type of crime.

Effective communications based on intelligence and extensive customer insight formed the foundations of the communications strategy. All work was developed with support of the Local Children Safeguarding Boards.

The campaign made use of outdoor media in high risk locations; Audience-specific posters in schools, GP surgeries, health clinics and libraries; Social media campaign on Facebook, Twitter, LinkedIn and Instagram *#StopCSE,* and web pages tailored for each audience on sussex.police.uk/cse

The police sought engagement with children via CSE school information packs and in Tag (a magazine by students, for students). They worked with children to produce 'Scarlett's Story' – a YouTube video about CSE.

Work was also done to engage with taxi drivers to encourage reporting, including distribution of 2000 air fresheners, and engagement with hotel staff via social media and forums.

National Probation Service

What have we done?

The National Probation Service is now into its third year of operation and continue to consolidate and build on our learning & experience to ensure continuous improvement in our Safeguarding practice.

During 2015/16 our staff have undertaken mandatory Safeguarding training. All staff have completed Civil Service Learning provided through our comprehensive E-learning safeguarding and domestic abuse courses. In addition all front line operational staff, including team managers have attended or are scheduled to attend class based safeguarding training.

Training and Development is consolidated with the use of reflective supervision in management one to one meetings with staff as well as reviews of safeguarding performance in quarterly appraisals. An appraisal objective for every operational member of staff is to attend at least one safeguarding training event a year. The culture of our organisation is to create a working environment where staff feel confident in raising and discussing any safeguarding concerns with colleagues and managers.

As in previous years, we continue to prioritise NPS staff attendance at Child Protection Conferences and reviews and fully participate as required in Child protection Plan core groups and professionals meetings. Additionally we ensure the welfare of the child remains paramount when exercising our duties as the Responsible Authority within Mapp arrangements and is at the heart of all our sentence and risk management planning.

Nationally NPS have reduced the involvement of our middle managers with regard to engagement in MARAC. NPS Sussex however have continued our commitments to local arrangements to assist in reducing the potential of harm to children as a result of domestic violence and abuse.

We continue to significantly invest resources in supporting the work of partner agencies in the Prevent strategy to safeguard children from harm and abuse from exposure to extremist views. This is alongside our commitment to timely information exchanges with our partner agencies concerning individuals who come into contact with our service or who are under our direct supervision.

We continue to purchase services from the KSS Community Rehabilitation Company in the delivery of specific programmes with our offenders. In addition to these we commission other services from a range of providers to address service user needs with regard to substance misuse, mental health difficulties, housing and other areas that can impact negatively on the wellbeing and safety of children.

How well did we do it?

During 2015/16 we have made good progress in bedding in our new systems and processes. Our notifications from Court in relation to offender appearances and sentencing are robust and resilient.

We continue to work hard in producing good quality risk assessments, risk management plans and sentence plans. Our multi agency work with regards to Mappa and domestic abuse continue to work effectively.

Considerable investment has been made in updated training of our front line staff and feedback has been positive. We are making good progress in creating working environments where professional curiosity and discussion are encouraged and supported.

Offender cases where there are safeguarding concerns are regularly reviewed and good practice examples and learning points are shared with staff through our usual communication channels and good practice discussions.

NPS continues its senior management involvement with LSCB . We have demonstrated our commitment to the strategic management of CSE incidents and statutory services and responses as the Head of Sussex NPS has chaired the LSCB Vulnerable Children and CSE Strategic Management Board throughout 2015 /16.

What difference did it make?

Public protection is at the core of the work of the National Probation Service and our safeguarding role is at the front and centre of our practice. We are confident that the activity outlined in this review has made a positive contribution to safeguarding in the city.

Child Sexual Exploitation

Child Sexual Exploitation continues to be a high priority for the National Probation Service in our Safeguarding work.

All front line operational staff have now been trained in raising their awareness and identifying potential concerns with regard to CSE, not only in terms of direct work with convicted offenders of CSE, but also with our service users who have been or continue to be at risk of becoming involved in CSE and also the victims of CSE through our Victim Contact Scheme statutory duties.

We have ensured our Probation Officers are aware of the fact that CSE is one of the numerous MOs in child sexual abuse cases, and therefore remain cognisant that these cases should managed primarily as a CSA case, particularly when considering the impact upon the victims.

We continue to work closely with our partner agencies in exchanging information in connection with any individuals or groups that raise potential concerns in relation to CSE. This ranges from first point of contact with our Court Duty staff through to custodial and community offender management.

Alongside the investment in training of our staff, we remain vigilant to the need for continuous professional development and learning from partner agency experience in this area of safeguarding.

Child Sexual Abuse

During 2015/16 the National Probation Service has undertaken the supervision of adult offenders sentenced to less than 12 months custody. This has brought us into contact with an even larger group of service users. All are subject to comprehensive risk assessments using a range of assessment tools that assist in identifying concerns in relation to child sexual abuse.

In addition to risk assessment and management, many offenders will be subject to home visit checks where the circumstances of the offender and their immediate family and other close relationships can be observed, early signs of potential abuse identified and action taken.

Neglect

We work closely with our service users who are parents or carers to offer support and advice in parenting and relationships. Many of our service users experience substance misuse addictions, mental health difficulties and are perpetrators of domestic violence.

We are aware that such criminogenic factors can contribute to the neglect of children in the home. As outlined in this review, we comprehensively assess service users with regard to safeguarding concerns and provide and commission a wide range of services to tackle these crimoinoenic needs.

The welfare of children when working with parents or carers is our highest priority and is supported with regular information exchange and practice discussions with colleagues from partner agencies.

We have established systems and processes to identify concerns with regard to neglect that escalates to management for further oversight, review and response.

National Probation Service

Kent Surrey & Sussex Community Rehabilitation Company

What have we done?

Over this last year KSS CRC has been embedding its operating model to ensure its three core functions, Assessment, Rehabilitation and Resettlement support the service users' journey from court to rehabilitation. The Senior Management Team has been consolidated with Suki Binning appointed as the Chief Executive. Heads of Service roles have now been established with Debbie Piggott taking over as KSS CRC Safeguarding Lead. A Child Sexual Exploitation Champion, Jane Port, has also been appointed to support staff and organisational development in this area.

The main aim of KSS CRC is to reduce reoffending and thereby protect the public. Recognising that safeguarding of children and adults is an important aspect to public protection, KSS CRC has revised its policies so that it now brings together all the key documents that fall within the safeguarding of children and adults under one set of overarching principles. In addition, to support clarity and best practice we have added, extremism, modern slavery, sex working, gangs, child sexual exploitation and trafficking (CSE) and female genital mutilation (FGM) as key strands to the policy.

KSS CRC has also revised its Continuous Professional Development & Supervision policy which applies to all staff across the organisation. Whilst this policy has been developed to ensure all staff are supervised appropriately and their professional development is reviewed, it also clearly outlines an expected regular review of safeguarding practice to ensure that every staff member reflects on the quality of their practice, receives appropriate support and attends the required training.

KSS CRC have developed a Quality Assurance Audit and Performance Strategy which outlines the purpose, principles, strategies and key deliverables for quality assurance, which will include audits focused on safeguarding practice for both children and adults.

There have been three external inspections carried out by HM Inspectorate of Probation over the year. We received excellent feedback from the Ministry of Justice following our inaugural annual service review with them in July. Our operating model, use of management information and, in particular, performance improvements were highlighted as being impressive achievements.

In East Sussex we continue to work with East Sussex Children Services in the provision of our Building Better Relationships Domestic Violence Programme for perpetrators.

How well did we do it?

Our revised safeguarding policies bring together all the key documents in one safeguarding area in the eHandbook and on Intranet (our communication tool) available to all staff within KSS CRC. Managers were required to discuss the revised policies at their team meetings and also individually with staff in supervision. We continue to actively promote safeguarding training within the monthly Learning and Development Bulletin, during supervision and our poster campaign.

QA activities planned for 2016-17 include management case audit; an internal quality and impact inspection; internal operational assurance audits on risk management, enforcement, sentence planning; programmes and child safeguarding. As part of the supervision process, managers are carrying out observations of the quality of responsible officer and receptionist interactions with service users. This work as stated above has been supported by the revised Continuous Professional Development Policy.

The Safeguarding Audit sample included at least one case from each responsible officer but due to the IT issues not all proposed cases were audited. 155 cases were audited in total which represented 83.3%. Half of the sample included known safeguarding cases, the other half did not, so that the extent that issues were being identified could be assessed. The majority of cases audited were community orders where the service user was assessed as posing a medium risk of serious harm.

What difference did it make?

The updated safeguarding policies and procedures support clarity and best practice, as well as ensuring that all staff understand their roles and responsibilities with regard to safeguarding and are up to date with their practice.

We continue to encourage staff to attend local safeguarding board training which has resulted in 41 members of staff attending courses over the last year. KSS CRC provide in-house safeguarding courses with every member of staff required to complete online Educare Child Protection Training every 2 years. 166 were enrolled for the period 2015/2016. 11 safeguarding workshops were held in-house.

The results of the Safeguarding Audit will be reported to the Senior Management Team in September 2016. It will give an insight into what is happening with practice across the CRC, a measure which we have not had since KSS CRC came into existence. It will also give us a measure against the safeguarding concerns raised by the NOMS sentence planning and risk audits and the improvements put in place. Further work is needed to continue to improve our safeguarding practice.

Neglect

Whilst KSS CRC does not work directly with children we have ensured that when home visits are completed with our service users staff are aware of things to consider when the meet children within the home. In addition, the revised safeguarding policies include additional strands to expands on wider environmental factors to consider.

Child Sexual Exploitation

KSS CRC has nominated a CSE champion. This role is held by our Learning and Development Manager. The Champion attends multi agency CSE champion meetings and disseminates information/ communicates to staff via forums such as the Intranet, cascadings to operational teams via senior probation officers/middle managers.

Child Sexual Abuse

The overarching KSS CRC Safeguarding Policy is linked to separate Children and Adult Safeguarding Policies with further links to information on child sexual exploitation; female genital mutilation; gangs; trafficking; sex working; modern slavery and extremism.

The policy clearly states where responsible officers are aware that service users have care of children they should be alert to welfare and safeguarding concerns. They should consider within available information, the parenting capacity and family and environmental factors and monitor children's living conditions where necessary.

Where there is an assessed medium risk of serious harm to a child, home visits should be completed on a regular basis. There are a number of factors listed that the responsible officer must consider when doing a home visit which include:

- physical and emotional deprivation of the child or children
- lack of positive relationship with protective/nurturing adult
- physical symptoms of a child, or adult in the family home
- expressions of despair of adult or child
- contact with an unknown adult outside of the usual range of the child's social contacts

Cases where there is a high risk of serious harm including children fall under the management of the National Probation Service (NPS). The updated procedures will assist our operational staff to identify cases at risk and escalate these to the NPS if they meet our threshold.

CAFCASS

Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is to safeguard and promote the welfare of children; provide advice to the court; make provision for children to be represented; and provide information and support to children and their families. It employs over 1,500 frontline staff.

The demand upon Cafcass services grew substantially in 2015/16 with a 13% increase in care applications and an 11% increase in private law applications. The grant-in-aid provided by the Ministry of Justice was smaller than the previous year. Notwithstanding this, Cafcass has met all of its Key Performance Indicators.

The following are examples of work undertaken by Cafcass in 2014/15:

- Revision of both the Quality Assurance and Impact Framework and the Supervision Policy, which together set out the organisation's commitment to delivering outstanding services and the ways in which staff are supported to achieve this and the quality of work is monitored. The Framework integrates the impact of the work on the child into the grade descriptors so that evidence of positive impact is to be present, alongside compliance with the expectations of Cafcass and the Court, for an outstanding grade to be achieved.
- Implementation of the Equality and Diversity Strategy. This entails: a network of Diversity Ambassadors who support the development of staff understanding and skill; the holding of workshops; a themed audit on the impact of diversity training on practice.
- Extending the Child Exploitation Strategy introduced in 2014/15 to include trafficking and radicalisation as well as sexual exploitation. Key elements of the strategy include: Ambassadors (at a service area level) and Champions at a team level to have a 'finger on the pulse' of local issues and to support learning; training and research (including a study of 54 cases known to Cafcass in which radicalisation was identified as a feature).
- Working with a range of partners across family justice, children's services and the voluntary sector. Examples include Local Family Justice Boards (Cafcass chairs 12 of the 46 of these), the judiciary, the Adoption Leadership Board and the Association for Directors of Children's Services with whom Cafcass has developed the social work evidence template for use in care cases, and with whom we are developing good practice guidance for children who are accommodated by the local authority
- The development of innovations that are aimed at improving our practice and supporting family justice reform. These include: piloting the provision to our Family Court Advisers of consultations with a clinical psychologist; the extension of Family Drug and Alcohol Courts; *the supporting separated parents in dispute* helpline (a pilot across five service areas aimed at promoting out-of-court settlements of disputes where safe to do so).
- Contributing to the government review of Special Guardianship Orders, including a small piece of research that was included in the government's response to the consultation.
- A Service User Feedback Survey, which looked at the interim outcomes of children six to nine months after private law proceedings concluded. Specifically the survey looked into whether arrangements ordered by the court had sustained; how effective communication was between parents before and after court proceedings; and whether participants believed that the court order was in their child's best interests.

East Sussex Fire & Rescue Service

What have we done?

ESFRS seeks to increase safety of children and young people by carrying out our Home Safety Visits (HSV) to ensure a safe living environment, identify and refer any safeguarding issues, and work with children and young people to increase awareness to keep themselves safe.

There is ongoing access to Safeguarding Children E-learning packages which are compulsory for all staff, and completion is monitored and audited. ESFRS continues to make child safeguarding referrals as appropriate which are monitored and audited. Internal scrutiny is provided via an internal panel which meets every 6 months. We continue to work with partners both to increase ESFRS awareness of child safeguarding and to support work in this field via our Home Safety Visits which are aimed at increasing safety in the homes. ESFRS employs a Partnership and Inclusion coordinator for Brighton & Hove to attend relevant partnership meetings and build links in this area.

We are undertaking an increasing number of community safety projects in the city which are aimed at both increasing the knowledge of young people and their ability to keep themselves safe, and so have a safeguarding element. An ESFRS firefighter from Roedean fire station acted as a mentor on the ACF Young Leaders Programme aimed at developing leadership skills for young people whilst also tackling emerging threats such as radicalisation. ESFRS is currently leading the Hoarding Sub-Group drafting a Partnership Hoarding Framework for the city which will include actions for agencies when children and young people are identified in this living environment. ESFRS organised jointly with BHCC a “Safety In Action” day on 23 June for pupils to learn safety messages in a practical environment including sessions by Sussex Police and an online safety session run by Safety Net led by young people. ESFRS is currently developing a themed project on learning disability to increase our home safety visits including for families where a child has a learning disability, and developing a ‘hazard room’ where young people will be able to attend the fire station to increase safety awareness. We are working in partnership with Sussex Cricket Club Academy and the Youth Offending Team to progress our safety awareness work for young people. We also have a dedicated Schools Team who undertake lessons in schools and work with young firesetters to raise safety awareness and the team is fully trained in relation to safeguarding issues.

How well did we do it?

Children and Young Families remains a targeted group on our Care Providers Scheme. We also undertake referrals via Child Protection Plans and a Home Safety Visit is considered for all families under the Integrated Team for Families referral pathway. Domestic Violence referrals, including those where children are present receive an enhanced safety visit and offer of specialist equipment.

All Junior Officers in the City have received a briefing on Safeguarding and Modern Slavery in the new Junior Officers Handbook to consolidate knowledge in this area.

The Service is represented at a wide range of relevant Partnership meetings in the city including Prevent Board, Early Help Hub meetings, Domestic Abuse MARAC, Modern Slavery Meetings and Suicide Prevention Group.

Stats for Safeguarding children referrals: 16 Child Protection Safeguarding CTN’s were reported for this period. Following a Home Safety Visit firefighters identified children living in a Hoarding environment and a referral into the Early Help Hub was made.

What difference did it make?

ESFRS continues to make safeguarding referrals in a timely manner ensuring these are referred to the correct agency. Referrals for Home Safety Visits received under our Care Providers Scheme and those received via child protection plans continue to be prioritised.

Stats for HSV for households with children present: 12 Child Protection referrals were received.

Expenditure:

	Detail	Original Budget	Revised Budget	Actual	Forecast 2015-16	
Staffing	Training Manager	£30,900	£30,900	£14,078	£31,300	
	Business Manager	£50,000	£50,000	£49,985	£51,600	
	Admin Officer	£24,000	£24,000	£23,967	£24,600	
	Agency Cover	£0	£0	£1,165	£16,700*	*Employee costs to be allocated
	Independent Chair	£20,000	£20,000	£23,967	£20,000	
	Staff advertising	£0	£0	£400		
	Total Staffing	**£141,400**	**£141,400**	**£113,162**	**£144,200**	
Other costs	Serious Case Reviews	£10,200	£10,200	£65,799	£40,300	
	Venue Hire	£1,000	£1,000	£1,967	£1,000	
	Training	£24,740	£24,740	£17,259	£900	
	Insurance	£100	£100	£100	£100	
	Transport Costs	£200	£200	£157	£200	
	Printing	£2,000	£2,000	£2,486	£2,000	
	Office Stationery	£100	£100	£0	£100	
	Telephony	£300	£220	£479	£200	
	Computer Costs	£200	£200	£0	£200	
	Chronolater	£2,300	£2,300	£2,259	£2,300	
	Communications	£2,000	£2,000	£2,310	£2,000	
	Conferences	£1,000	£1,000	£488	£1,000	
	Hospitality	£200	£200	£290	£200	
	Child Death Review Panel	£10,000	£10,000	£10,000	£10,000	
	Monitoring & Evaluation Chair	£2,400	£2,400	£3,450	£2,600	
	Occupational Health Charge	£0	£0	£450	£0	
	DBS Checks	£0	£0	£44	£0	
	Miscellaneous	£0	£0	£1,387	£0	
	Total other costs	**£56,740**	**£56,660**	**£108,925**	**£63,100**	
	Support Service Charges	**£19,590**	**£19,590**	**£19,590**	**£30,800**	

Income:

	Funded By :	
core	Brighton & Hove City Council	£155,410
	Brighton & Hove CCG	£43,780
	Kent, Surrey & Sussex Community Rehabilitation Company	£5,572
	The Police and Crime Commissioner for Sussex	£12,338
	CAFCASS	£550
	Total partner contributions	**£196,508**
other	NSPCC LIPP Project	£21,387
	ESFRS for publicity materials	£1,855
	CSA Conference	£4,542
	Total other contributions	**£27,784**

Total LSCB Income	£245,433
Total LSCB Expenditure	£241,677
Final underspend	**-£3757**

Please note that the Board has incurred costs relating to Serious Case Reviews during 2015-16 which will not be paid out until 2016-17 when the review is completed.

Statutory Members:

Graham Bartlett, Independent Chair of LSCB

Brighton & Hove City Council (BHCC):
Pinaki Ghoshal, Director of Families, Children & Learning
Helen Gulvin, Assistant Director: Children's Safeguarding & Care
Jo Lyons (Dr), Assistant Director: Education & Skills
Peter Castleton, Head of Community Safety

Sussex Police
Jason Tingley (T/ Detective Superintendent)

National Probation Trust
Andrea Saunders, Director of Public Protection

Kent Surrey & Sussex Community Rehabilitation Company
Debbie Piggott, Resettlement Director

Youth Offending Service
Anna Gianfrancesco, Head of Service

CAFCASS
Nigel Nash, Service Manager

East Sussex Fire & Rescue Service
Andy Reynolds, Director of Prevention & Protection

Schools
Richard Chamberlin, Roedean School
Tracy Bowers, Hertford Infant School

NHS England
Carol Cassam

Brighton & Hove Clinical Commissioning Group (CCG):
Soline Jerram, Director of Clinical Quality and Primary Care
Jamie Carter (Dr), Designated Doctor
June Hopkins, Designated Nurse
Mary Flynn (Dr), Named Doctor (GP representative)

NHS Trusts
Sherree Fagge, Chief Nurse, Brighton & Sussex University Hospitals (BSUH)
Susan Marshall, Chief Nurse, Sussex Community Foundation Trust (SCFT)
Helen Greatorex, Executive Director of Nursing & Quality, Sussex Partnership Foundation Trust (SPFT)
Jane Mitchell, South East Coast Ambulance Service Safeguarding

Domestic Violence Forum
Gail Gray, Chair, Brighton & Hove Domestic Violence Forum

Community & Voluntary Sector
Terri Fletcher, Director, Safety Net

Lay Members
Andrew Melrose (Professor)
Ella Richardson
Lorna Miller-Cooper
Signe Gosman
Stephen Terry (Rev).

Advisors:

Ann White (Dr), Named Doctor, SCFT
Deb Austin, Head of Safeguarding, BHCC
Debi Fillery, Named Nurse BSUH
Eddie Hick, Child Protection and Safeguarding Manager, Sussex Police
Helen Davies, Chair LSCB Monitoring & Evaluation Subcommittee
Leonie Perera (Dr), Named Doctor, BSUH
Mia Brown, Brighton & Hove LSCB Business Manager
Natasha Watson, Managing Principal Lawyer, BHCC
Rebecca Conroy, Principal, City College
Sue Kelly, Named Nurse, SPFT
Tom Bewick (Cllr), Lead Member, BHCC Children's Services
Tom Scanlon, Director of Public Health
Yvette Queffurus, Named Nurse, SCFT

Brighton & Hove
LSCB
local safeguarding children board

Brighton & Hove LSCB
Moulsecoomb North Hub
Hodshrove Lane
Brighton
BN2 4SE
01273 292379

www.brightonandhovelscb.org
LSCB@Brighton-Hove.gov.uk

@LSCB_Brighton
#yourLSCB