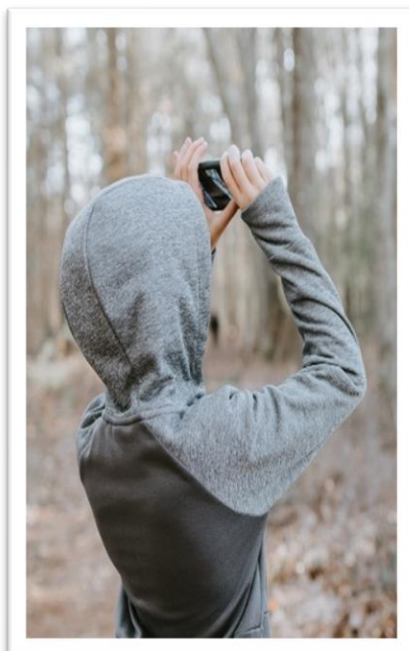
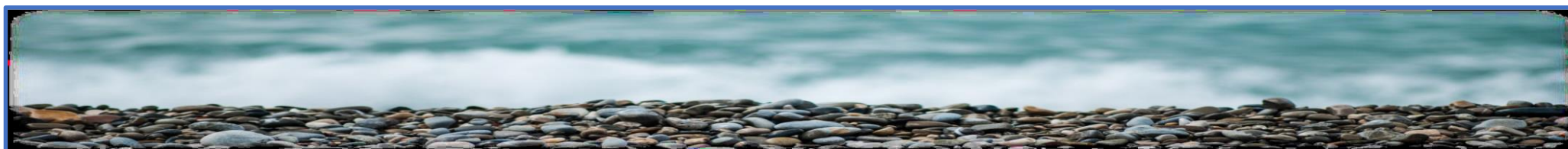


# Brighton and Hove Safeguarding Children's Partnership Annual Report 2021-22



**Safeguarding is Everyone's Responsibility**



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This annual report charts the work of our safeguarding children partnership during a year of challenges and achievements; we led the partnership whilst the country transitioned from full lockdown towards post-pandemic normality. Our partners continued supporting and protecting children, young people, and their families through another year of changes. We know disrupted education and restricted mobility impacted on the mental health and wellbeing of many. The impact of hidden harms such as domestic abuse and criminal exploitation evidenced emerging pictures of acute need and concern.

In Brighton & Hove we had rapidly adapted our practice methods to provide targeted support for families and children most in need of help and protection. Brighton & Hove City Council co-ordinated multi-agency and organisational networks to focus on meeting immediate and intermediate needs. As the government's 'roadmap' progressed we saw restrictions pulled back, with the vaccination programme being introduced in the spring of 2021 - we continued to focus on our most vulnerable families, sharing real time updates across partner agencies.

The year demonstrated the tremendous resilience of our frontline staff and our partners in the community and voluntary sector organisations. The response in Brighton and Hove demonstrated our ability to respond imaginatively in unprecedented times; we are grateful and proud for all they have achieved and continue to achieve as we move forward. Much of our core delivery moved on to virtual platforms during the height of the pandemic and this provided some positives such as greener ways of working, travel efficiencies, and online engagement. We also saw impacts in terms of social isolation and reduced understanding of the families we want to engage with. We have moved to a more hybrid way of working which acknowledges the benefits of virtual delivery but highlights the continued need for frontline delivery of services for our most vulnerable and the wider community. The continued development and future implementation of a new early help strategy will tackle disadvantage and provide opportunities to improve life chances for all our children and young people.

During 2021-22 we implemented Sir Alan Wood's recommendations from his review of multi-agency safeguarding recommendations. The Partnership is now well established including improvement subgroups; whilst the Steering Group and Partnership Board, chaired by the Independent Scrutineer, provides oversight. Safeguarding Partnerships need to demonstrate the impact of their work and provide assurance to residents. The subgroups, Steering Group and Board bring together strategic leaders and practitioners; the aim is to be a learning partnership designed to develop safeguarding services through training, reflection, evaluation, and challenge. Our vision to improve the lives of children and young people remains at the heart of what we do.



*Naomi Ellis, Director of Safeguarding & Clinical Standards, NHS Sussex*

*Naomi Ellis*



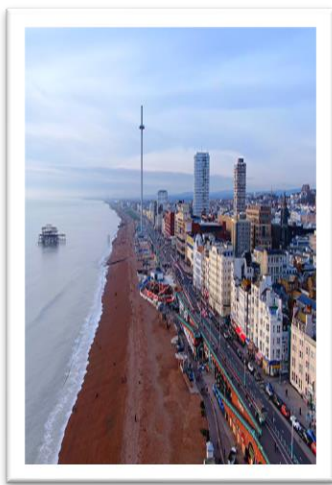
*Deb Austin, Executive Director, Families Children & Learning, Brighton & Hove City Council*

*Deborah Austin*



*Jon Hull, Detective Superintendent, Public Protection, Sussex Police*

*Jon Hull*



**Brighton and Hove** – The city population is estimated to be 291,700 in 2020. Between 2020 and 2030 the population is expected to rise by 3.9%. This projected growth is similar South East (4.1%) but slower than England (4.7%). The latest population estimates for 2020 indicated that 15% of the population are aged 0-15 years. Ethnicity estimates indicate that 21% of children and young people aged 0-15 years are from BME groups. In 2020, 19% of the city’s residents were born outside of the UK, of which 55% were born in the EU. Between 11% and 15% of the population aged over 16 is estimated to be lesbian, gay, or bisexual.

The most recent Indices of Deprivation data published in 2019 by The Department for levelling up, Housing & Communities show that the city is ranked 160 out of 317 local authority districts and ranked 211 for Education, but less favourable rankings overall in living environment (87/317) and crime (150/317). It is ranked 100 overall in terms of the proportion of the 10% of neighbourhoods with the highest levels of deprivation.

Due to Covid-19 the government decided not to publish its annual school or college level data. According to the latest Department for Education 2019 data, 67% of primary school pupils reached the expected standard of attainment, above the 65% average for England. 47% of secondary students achieved Grade 5 or above in English and maths GCSEs, compared to a 40% average for England. [brighton-and-hove-population-jsna-dec-2021.pdf](https://www.brighton-and-hove-population-jsna-dec-2021.pdf) ([bhconnected.org.uk](http://bhconnected.org.uk))

**The Brighton & Hove Safeguarding Children Partnership (BHSCP)** is independently chaired and consists of three key agencies who collectively hold statutory responsibilities for keeping children and young people safe: the Local Authority (through Families, Children and Learning), Health (through Brighton & Hove Clinical Commissioning Group) and Sussex Police.

**Objectives:** Co-ordinate local work undertaken by all agencies and individuals to safeguard and promote the welfare of children and young people  
Ensure the effectiveness of that work

**Core Values:**

- ✎ A child centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.
- ✎ Safeguarding is everyone’s responsibility: for services to be effective each citizen, practitioner and organisation should play their part.
- ✎ Promoting preventative and early help approaches for outcomes to be improved there should be timely identification of a problem; the earlier the better to secure maximum impact and greatest long term sustainability.
- ✎ Always alert to transition points: for outcomes to be improved known transition points should be planned for in advance

**Our Principles**

- ✎ To work in partnership
- ✎ To commit to genuine engagement: listening to, and acting, on what our community tells us
- ✎ To be a learning partnership
- ✎ To ensure all activity is characterised by an attitude of constructive professional curiosity and challenge
- ✎ To be flexible to respond to emerging threats and risks.

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Thank you for taking the time to read Brighton and Hove Safeguarding Children Partnership (BHSCP) Annual Report. This document should give you an open, honest view of how the Partnership works to safeguard our children and young people in Brighton and Hove. As the Independent Chair and Scrutineer of the BHSCP I have the responsibility for scrutinising this report and making sure it is accurate and provides the information you, the reader, requires. I hope that it meets your expectations, provides you with the information you need and above all gives you complete confidence in the way the Partnership strives to safeguard our children.

I want to start by thanking all the organisations, individuals and communities who have contributed towards safeguarding children and young people in Brighton and Hove.

Sometimes when we read these reports it can be easy to forget the one act of courage or kindness from a person that results in such a positive impact for a child and their family. Many of you go 'above and beyond', providing dedicated, professional input that has a positive impact on lives.

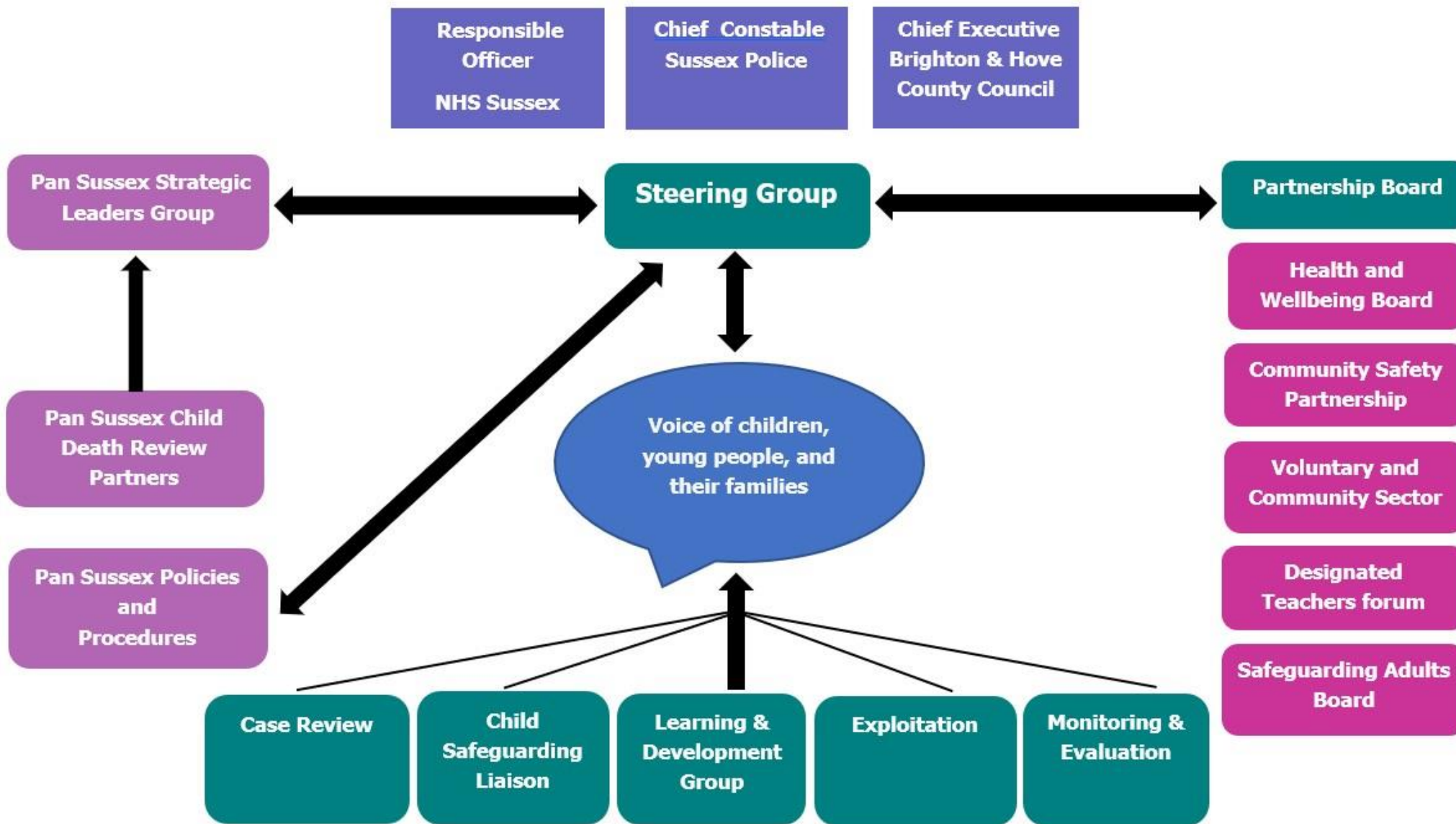
We are of course still dealing with a world that is recovering from a pandemic. This has brought challenges for us and the real impact on safeguarding continues to be assessed. Children's mental health, the impact of lock down on children and families and the stark fact that some children remained hidden from the view of those who can safeguard them are all matters that the Partnership has considered and continue to deal with. Other challenges have developed, a significant proportion of our families are coming under huge financial pressures and this in turn can lead to increased safeguarding concerns. It is important that we continue to harness the help and support that our communities have given us, so as you read this report, please remember that safeguarding is everybody's responsibility. We have learned is that we need to engage with our communities and seek their help to safeguard our children. This was a positive aspect of covid and as a Partnership we need to ensure we maintain the links we developed.

We continue to work hard to achieve in our priority areas and the Partnership is and strategic leads are updated regularly on progress in each of them. You can read about these priorities in this report. It is important to recognise that whilst these are key areas for us, we continue to address all other areas of safeguarding. B&HSCP is mature in its approach and will flex and respond to any other safeguarding threat.

I continue to scrutinise the safeguarding partnership, challenging partners to provide the best possible service to children and families. The maturity of the Partnership means that any scrutiny is always received in a positive manner. Leaders acknowledge that learning is key to improved outcomes for children and work hard to improve. B&HSCP works in a culture that seeks to continually improve. Finally, I would like to thank those who have contributed to this report. I believe this report is fair, informative, and balanced and I hope it goes some way to illustrating the work your partnership does to safeguard children in Brighton and Hove

A handwritten signature in black ink, appearing to read 'Chris Robson'. The signature is fluid and cursive.

Chris Robson, Independent Chair & Scrutineer



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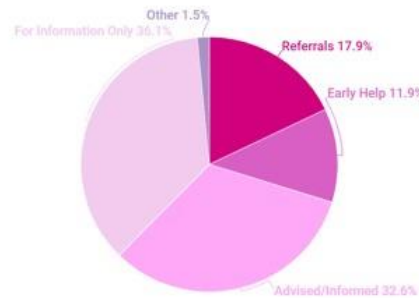
This section demonstrates some of the key statistical indicators used to guide the Partnership’s priority safeguarding areas including children missing from education, referrals to Front Door for Families (FDfF) and Community Adolescent Mental Health Services (CAMHS), and children identified as being at risk of exploitation.

**Initial Contacts, Referrals and Assessments year ending 31 March 2022**



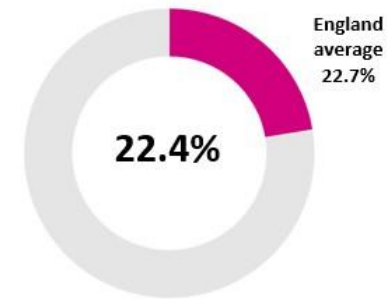
The above chart shows the number of Initial Contacts to Front Door for Families, the number of Initial Contacts that were passed to Children’s Social Care and the number of Strengthening Family Assessments completed during the year ending 31 March 2022.

**Initial Contacts to Front Door for Families by Outcome year ending 31 March 2022**



The above chart shows Initial Contacts to Front Door for Families during the year ending 31 March 2022 by outcome.

**Re-Referrals to Children’s Social Care year ending 31 March 2022**



A re-referral is where a child has been referred within 12 months of a previous referral.



**592**

Early Help Assessments completed year ending 31st March 2022



**651**

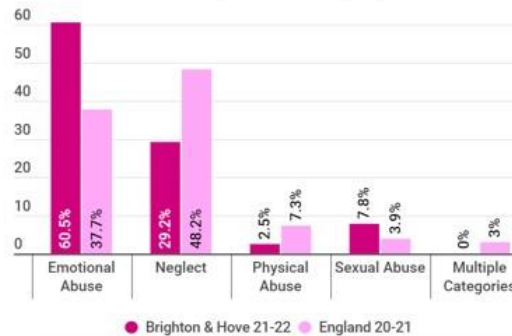
Children and young people open to Early Help Services at 31st March 2022



**281**

Children subject of a child protection plan at 31st March 2022, up from 273 at 31st March 2021

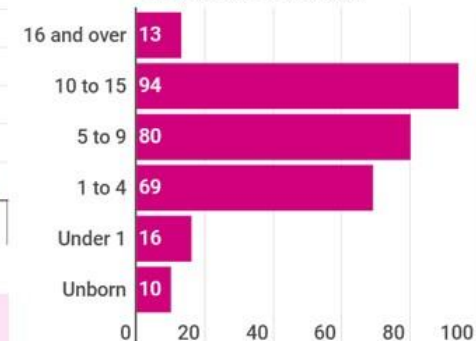
**Children Subject of a Child Protection Plan at 31 March 2022 by Initial Category of Abuse**



When a child becomes the subject of a child protection plan, the initial category of abuse is recorded.

The above chart compares the percentage of children subject of a child protection plan at 31 March 2022 by initial category of abuse with the England average at 31 March 2021.

**Children Subject of a Child Protection Plan at 31 March 2022 by Age**



## Children Missing from Education (CME)



25

Children Missing from Education under Criteria 1 and 2 between January and March 2022

**Criteria 1:** 9 pupils known to be not on roll and missing education in Brighton and Hove.

**Criteria 2:** 14 children who were reported to have come off roll from a school with an unconfirmed destination in another authority.

## Children’s Sexual Assault Referral Centre (CSARC)



83

Children Referred to CSARC during year ending 31st March 2022



58

Strategy Discussions Attended



23

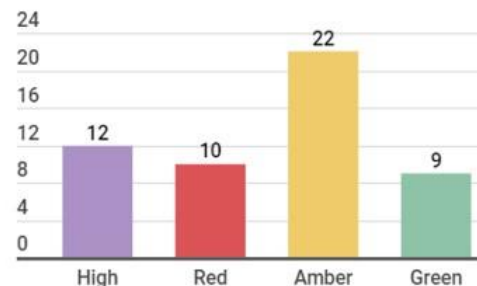
Children Seen

## Adolescent Vulnerability Risk Meeting (AVRM)



53

MACSE / MACE / AVRM Nominals at 31st March 2022



Multi-Agency Child Sexual Exploitation (MACSE) / Missing and Child Exploitation (MACE) / Adolescent Vulnerability Risk Meeting (AVRM) nominals are children who have been identified as at risk of Exploitation.

Multi-agency meetings are held regularly to review the level of risk that each child is currently exposed to. This generates a high (red), medium (amber) or low (green) risk score.

A multi-agency plan is created for each child within the process which includes; planned engagements, home-visits, and medical assessments.

High = High Risk of Harm  
 Red = High Risk  
 Amber = Medium Risk  
 Green = Low Risk

## Pupils Electively Home Educated (EHE)



423

Children educated at home at 31st March 2022, down from 437 at 31st March 2021 but up from 241 at 31st December 2019

## Child and Adolescent Mental Health Services (CAMHS)



1,997

Cases open to CAMHS at 31st March 2022, up from 1,491 at 31st March 2021 and from 1,340 at 31st March 2020



971

New referrals to CAMHS during the year ending 31st March 2022, down from 1,025 during the year ending 31st March 2021. Of these, 959 were accepted.



**Priority 1 – Partnership Engagement and Accountability**

**Lead Agency – Brighton & Hove City Council:**

**Strategic Objectives:**

- 1.1 Assure the efficacy of the new safeguarding arrangements and mechanisms for partners to be held to account for their safeguarding practice.
- 1.2 Strengthen the governance interface between the BHSCP and other key strategic forums across the city and pan Sussex.
- 1.3 Understand and provide robust and timely strategies/responses to address external factors which may impact on safeguarding Brighton & Hove.
- 1.4 Involve and consult children and young people in the process of helping them to stay safe and promote their wellbeing.
- 1.5 Engage with voluntary, charity, social enterprise (VCSE) and faith groups in training, challenge, and consultation.
- 1.6 Promote an anti-racist ethos through identification, an acknowledgement of the existence and impact of racism, and reparative work where needed to change systems and practice, thereby ensuring race equality for children, young people, and their families across the city.

**Priority 2 – Safeguarding children from violence and exploitation**

**Lead Agency – Sussex Police**

**Strategic Objectives:**

- 2.1 Develop a profile analysis for each of the elements of complex safeguarding to target interventions.
- 2.2 Organisations and agencies have the skills and knowledge to recognise and undertake high quality assessments regarding exploitation delivering interventions for children, young people, and families at all levels of need.
- 2.3 Target intervention where children and young people are deemed to be at risk of extra-familial harm.
- 2.4 Prevent the exploitation of children through raising awareness, building young people’s resilience, providing appropriate diversionary activities. and upskilling practitioners across the partnership.

**Priority 4 – Mental Health and Emotional Health and Wellbeing**

**Lead Agency – NHS Sussex**

**Strategic Objectives:**

- 4.1 Evaluate the availability and impact of services and resources on the safety of young people experiencing emotional and mental health issues.
- 4.2 Strengthen the governance interface between the BHSCP, NHS Sussex and Public Health on the local suicide prevention strategy and action plan.

**Priority 3 – Reducing Neglect**

**Lead Agency – Brighton & Hove City Council**

**Strategic Objectives:**

- 3.1 Strengthen the governance of partnership arrangements to further support a co-ordinated and multi-agency response to neglect.
- 3.2 BHSCP in partnership with the Voluntary, Community Sector to ensure role out and use of neglect tools and strategies in order to ensure early prevention and detection of neglect.
- 3.3. The Partnership is assured that an effective whole family approach to assessing neglect, as well as planning and monitoring interventions is embedded city wide across agencies and organisations.

Latest BHSCP Business Plan is available from - <https://www.bhscp.org.uk/safeguarding-partnership-documents/business-plan-and-strategies/>

Every Safeguarding Children Partnership (SCP) has a Business Plan to outline priorities and how we are going to tackle key safeguarding areas.

Our vision is that children and young people in Brighton & Hove live a life free from fear, harm, abuse, and exploitation, enabling every child in every part of the city to achieve their potential. As part of business planning, we identified four priority areas to enable this vision – these are set out above showing the lead agency for each one. It is important each priority has a different lead agency to demonstrate how we work collaboratively to safeguard the children and young people of Brighton and Hove. The current Business Plan covers April 2020-March 2023 and was written as the first plan under the new safeguarding children partnership arrangements; the priorities are delivered through Subgroup activity.

The following section provides an overview of the Business Plan and our priorities, identified challenges, and multi-agency achievements.

**Priority 1 – Partnership Engagement and Accountability** – Lead Agency – Brighton and Hove City Council.

Aims: Embed the principles of safeguarding children citywide.



**Progress made –**

- ✎ Well attended Partnership Board meetings held quarterly with Lead Partner attendance.
- ✎ Practice improvement – embedded new approach to monitoring and evaluation (M&E) work – focussing on practice to drive improvement in multi-agency working. Independent M&E Scrutineer appointed in November 2021.
- ✎ Independent Scrutiny - A Review of BHSCP Arrangements – One Year On presented to Executive Steering Group in May 2021: identified progress made with some challenges to be addressed, but overall concluded: ‘The Partnership is mature and has built on existing relationships. Partners scrutinise each other’s contributions, challenging and offering support’.
- ✎ Three new Lay Persons were appointed and inducted in 2021.
- ✎ Development starts on a new Pan-Sussex Section 11 Audit Tool - In contrast to previous audits, the Partnerships want agencies and organisations to use 2022-24 Section 11 audit as a tool for improvement rather than compliance.
- ✎ The Early Years - work started with the Virtual school to assess how Children in Care/Children previously in care, and those with a social worker are identified and supported in Early Years settings. This includes a service review (currently in progress) for council run nurseries to assess need, actions and impact.
- ✎ Over 600 families used council nurseries during the reporting period. All vulnerable families were prioritised for nursery places during Covid restrictions.

**Challenges identified –**

- ✎ Individual agencies previously reported ways in which they worked with the ‘voice of the child’ via their Section 11 Audit responses (demonstrated in BHSCP Annual Report 2020-21). We are hopeful that Section 11 returns in 2022 will continue to demonstrate this position. However, **Voice of Children and Young People** remains an active development area for the Partnership and will feature as part of our forward planning.
- ✎ Covid 19 restrictions reduced during the reporting period however the transition period continued to impact on partner agencies and delivery of business priorities.



**Priority 2 – Safeguarding Children from Violence and Exploitation** – Lead Agency

– Sussex Police

Aim: Ensure there is a clear understanding of the scale of complex and contextual safeguarding within Brighton & Hove and that the needs of children and young people affected by any form of violence, from any source, are identified and assessed effectively resulting in timely and appropriate intervention.

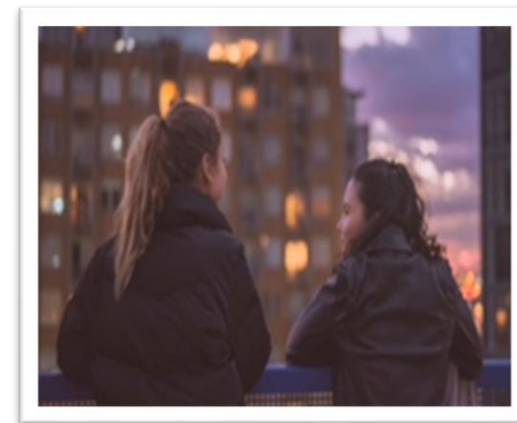
**Progress made –**

- ✎ B&H has recently sought to build upon the Adolescent Vulnerability Risk Management (AVRM) with the addition of the AVRM Escalation process whereby red AVRM cases are assessed and allocated to a Detective Inspector owner who is responsible for targeting and disrupting exploiters.

- ✎ During 2021-22, the focus of the BHSCP Exploitation Subgroup was to act as a strategic governance multi-agency group overseeing the Exploitation Action Plan as part of the Community Safety & Crime Reduction Strategy 2020-23 with a real focus on children, young people, transitional and contextual safeguarding.
- ✎ Criminal exploitation task and finish group reviewed Waltham Forest SCR (Child ‘C’) and NCSPPR **‘It was Hard to Escape’**, identifying transitional safeguarding and leadership culture as two key areas to develop. The outcome of this task and finish group informed the work of the Exploitation Subgroup and **Exploitation Action Plan** for most of the year. A short-term transitional safeguarding working group was established to review the current transitions processes for people who are being exploited and the development of action learning sets to support an improved multi-agency risk management approach.
- ✎ A mapping exercise was completed to better understand where issues related to child exploitation, drug harm and serious violent crime are discussed to reduce duplication.

## Challenges identified –

- ✎ Some progress was made to develop a performance dashboard with key indicators of exploitation. This work was overtaken by a parallel piece of work within the Sussex Violence Reduction Partnership – as a result this piece of work was paused to avoid duplication of efforts
- ✎ It was acknowledged that the identity and function of the Exploitation Subgroup had become confused. Therefore, in 2021-22 Q4 the Subgroup membership reviewed governance and purpose. It was agreed to re-focus the group as a tactical/operational group using the 4P approach identified by College of Policing to help re-engage and re-purpose the group (e.g. looking at Preparation, Prevention, Protection and Pursue).
- ✎ The key focus for 2022-23 is to continue the work to re-form the Exploitation Subgroup with a clearer identity and purpose with a greater focus on delivering task and finish pieces of work that better supports the work of the Partnership to reduce child exploitation.



## Priority 3 – Reducing Neglect – Lead Agency – Brighton and Hove City Council.

**Aim:** To ensure the needs of children and young people affected by neglect are identified and assessed effectively resulting in timely and appropriate intervention.

## Progress made –

- ✎ Multi-agency Neglect Audit completed in 2021 to evaluate the effectiveness of arrangements to safeguard children at risk of harm from neglect – key findings and recommendations discussed later in this report.
- ✎ 247 professionals attended multi-agency GCP2 training courses during 2021-22.
- ✎ Neglect Strategy reviewed in 2021-22.
- ✎ Sussex Police - The force has run a series of communication pieces and CPD aimed at improving the recognition of our first responders of the signs and indicators of neglect.

## Challenges identified –

- ✎ Despite 247 professionals completing training during 2021-22 and positive feedback post-training only 2 assessments have been recorded as completed on Eclipse (Children’s Social Care recording platform).

**Future planning** – Partnership and GCP2 Lead Practitioner to complete *deep dive* audit of cases to identify potential barriers to use of assessment tool.

**Priority 4 – Mental Health and Emotional Health and Wellbeing** – Lead Agency – Clinical Commissioning Group (NHS Sussex Integrated Care Board)

Aim: Consistently good service provision for children who need support for emotional and mental health issues.

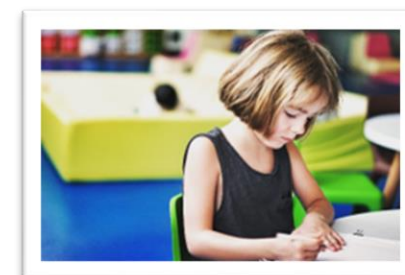
### Progress made –

- Public Health Leads met in May 2021 to scope work which needs to be undertaken to address concerns.
- Pan Sussex Self-harm Learning Network – workshops for education staff and parents on responding to children and young people who self-harm.
- E-wellbeing self-harm webpages have been created.
- Toolkit in the event of an unexpected death or suicide in the school community – Final Toolkit will be ready Sept 22 and provide schools with a holistic framework for prevention and postvention
- Self-harm guidance and flowchart for schools – provided to all statutory schools in the city – this will be sent to all independent schools during the summer term of 2022.
- Suicide prevention 'Assist' training provided free to schools this year by Grassroots, funded by Public Health and coordinated by the Schools Wellbeing Service.
- Schools Wellbeing Service added to the consent to share safety plan for CYP who have presented at hospital with self-harm – the Service now follows up with schools and provides support to ensure school response is coordinated with the Primary Mental Health Worker.
- Families Children and Learning key team working with and in schools providing support to pupils, schools, and parents.
- Schools Wellbeing Service – Primary Mental Health Worker team working with school staff in secondary and sixth form settings providing range of 1:1 and groupwork offer alongside support for parents.
- Mental Health Support Team – Providing mental health interventions for children in primary school as part of the Schools Wellbeing Service – four qualified practitioners will be joined by four new trainees in September 2022.
- Mental Health and Wellbeing became a specific focus for Early Years/council nurseries as a result of children returning to nursery after lockdowns, and children starting nursery who were born in the pandemic. Some council nursery staff participated in Emotion Coaching training which is now reflected in nursery policies. Curriculums focus on personal, emotional, and social development for children when first starting a nursery place

### Challenges identified –

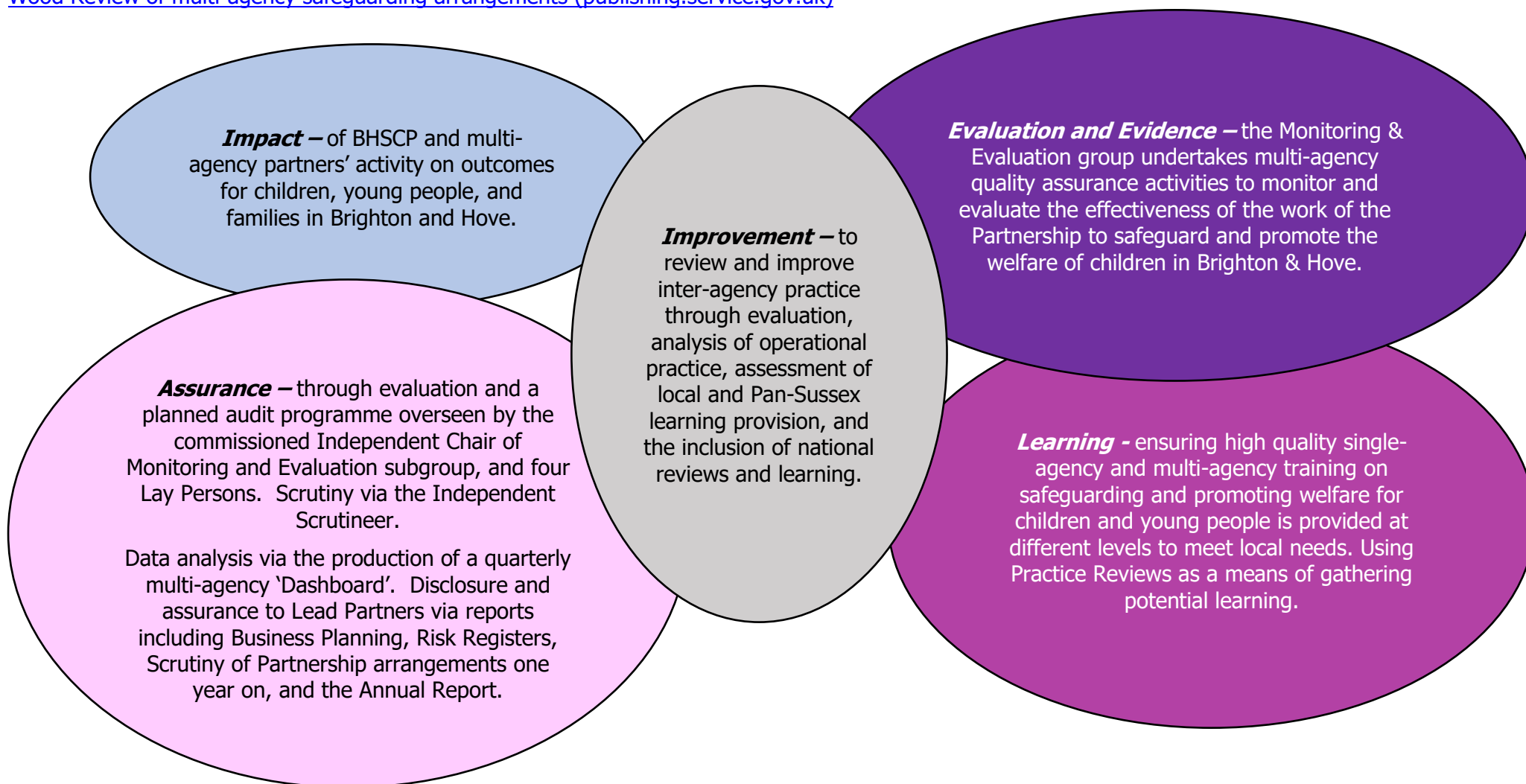
- Mental health and well-being of children and young people remains a priority area for agencies despite restrictions lifting throughout the reporting period.
- The work strands detailed above have provided some mitigation, but the Partnership and agencies will continue to monitor especially where children are not accessing school premises as electively home educated or missing from education.

**Future planning** – Pan-Sussex Elective Education Audit planned for May 2022.



The Wood Review (2021) of new multi-agency safeguarding arrangements states: 'Safeguarding partners have introduced a wide range of new measures to ensure independent scrutiny and challenge of the new arrangements. This includes peer challenge, Independent Scrutineers, commissioned external reviews, ... engaging lay members and the use of local authority scrutiny and health and wellbeing committees. We need to draw together a secure evidence base for the impact of independent challenge and scrutiny on the outcomes for children.'

[Wood Review of multi-agency safeguarding arrangements \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)



**Steering Group** – This group oversees the strategic direction and work of the Partnership as set out in the Children and Social Work Act 2017 and Working Together to Safeguard Children (2018). The Steering Group is attended by Lead Partners, agency Leads, and is Chaired by the Independent Scrutineer.

### Purpose

To ensure the BHSCP is fulfilling its statutory duty to monitor and challenge the effectiveness of the local multi-agency response to safeguarding children and young people.

To oversee strategic activity undertaken across the Partnership to safeguard and promote the welfare of the children and young people.

To analyse data and intelligence to be fully appraised of the effectiveness of help, including early help, being provided to children and their families.

**Partnership Board** – The Children and Social Work Act 2017 in conjunction with statutory guidance, Working Together to Safeguard Children 2018 requires partner agencies, to work together to safeguard children, young people, and their families effectively and to promote their emotional health and wellbeing.

The role of the Partnership Board is to bring together wider partners from across Brighton and Hove to ensure the strategic direction as set by the Steering Group and BHSCP Subgroups is taken forward and operationalised in all organisations.

The Partnership Board should ensure that all agencies and organisations have access to and an understanding of the full scope of the BHSCP's work and how they contribute to working together to safeguard children and promote their wellbeing across the city.

### Purpose

The main purpose of the Partnership Board is to:

- Operationalise the strategic aims of the Steering Group
- Raise issues put forward by Steering Group
- Engage the wider safeguarding community

The Partnership Board is attended by Lead Partners, agency Leads, wider agency representatives; and is Chaired by the Independent Scrutineer.

[Working together to safeguard children - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

**Lay Members** – Lay Members play a crucial role in the Partnership as they provide an independent voice to the decision making processes and provide a unique perspective as members of the public living in Brighton and Hove. During 2021-22 the Partnership had four very committed Lay Members supporting Subgroups and partners agencies.

**Plans for 2022-23** – The Partnership currently has vacancies for Lay Members after we said farewell and thank you to two of our four Lay Members. We are also exploring the possibility of recruiting a Young Persons' Lay Member/Advisor who would bring another voice and perspective to the Partnership.

*'I have been a lay member since September 2021 serving on the case review group (CRG). I have benefited from training to develop my knowledge and ability to provide support and challenge in the group. I have been impressed by the strength of partnership working and the eagerness that individual agencies work together to understand evidence and to learn from it. The CRG has been listening hard, alert to risks for children and working beyond institutional boundaries and organisational constraints. High profile reviews have been diligently tracked and managed so that action plans are clear and capable of being implemented. There is healthy scrutiny, support, and challenge across professions. There is focus on specific details and potential for strategic change. At all times I have observed clear determination to learn and improve outcomes for children and young people in the City.'*

(Lay Member for Case Review Group 2021 – present)

**Independent Scrutiny is detailed in Working Together to Safeguard Children 2018 where it states:**

*The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases. This independent scrutiny will be part of a wider system which includes the independent inspectorates’ single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections.*

*Whilst the decision on how best to implement a robust system of independent scrutiny is to be made locally, safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement.*

*The independent scrutineer should consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership and agree with the safeguarding partners how this will be reported.*

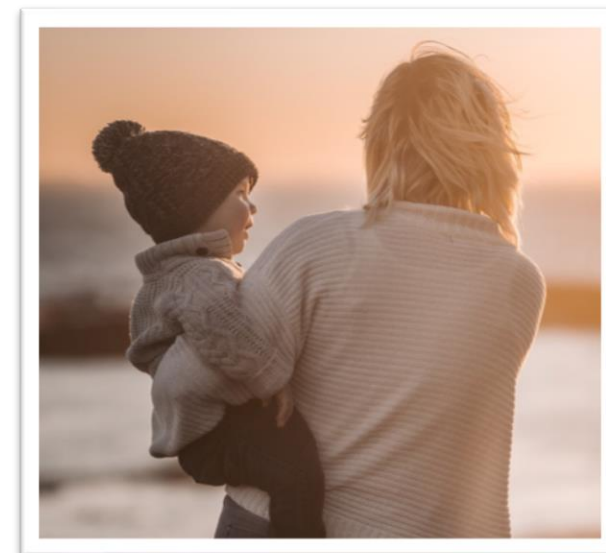
**Independent Scrutiny of BHSCP** –The Independent Scrutineer provides challenge and scrutiny of Lead Partners’ and Lead Agencies’ effectiveness as the Chair of the Steering Group and the Partnership Board.

The Scrutineer provides scrutiny and recommendations via several platforms including written reports such as ‘BHSCP Arrangements – One Year On’ towards the end of 2021 and maintaining oversight of Annual Reports and Business Planning with the Partnership Business Manager, in meetings as the Independent Chair, and as the objective voice amongst partners - for example at crucial points throughout the case review process.

The Independent Scrutineer was joined by the Independent Chair of the Monitoring and Evaluation (M&E) Subgroup in November 2021. Both act as the Partnership’s ‘critical friend’, providing constructive challenge and reflective questioning of all partners to promote continuous improvement across all agencies and organisations.

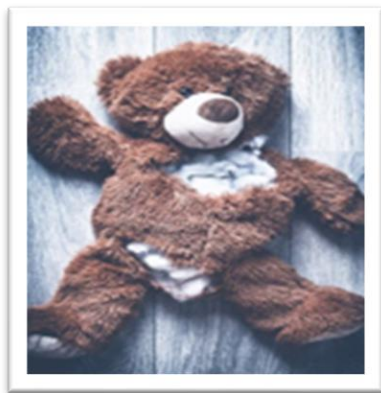
The M&E Chair has provided scrutiny of the performance mechanisms used to provide assurance to the Partnership Leads. The introduction of new processes and quality assurance mechanisms will provide early identification of and the analysis of emerging threats, reflective challenge, and the opportunity for all partners to implement practice improvement through learning.

**Recommendation for 2022-23** – Encouraging partners to capture the voice of the child in key areas of work within the Partnership and individual agencies i.e. Lay Member scrutiny.









### Reducing Neglect – Neglect Audit completed in Q4 2021 by Monitoring & Evaluation Subgroup –

The purpose of the audit was to evaluate the effectiveness of arrangements to safeguard children who are at risk of neglect with a focus on children under 4yrs. A total of 51 audits were completed by 13 agencies - the rationale for focusing on under 4s was as follows:

- Younger children are at increased risk of harm during (Covid-19) lockdown (ref: Ofsted have reported that there has been an increase in Non-Accidental Injuries (NAIs) for under 1s during lockdown).
- CDOP has highlighted the link between NAIs and other neglect issues.
- Learning from recent Safeguarding Practice Review around child sexual abuse (CSA) and links to neglect amongst younger children.

### Key findings –

- Parental mental health was recognised as a factor in 8 cases.
- Children’s Social Work found that in some cases the presenting superficial issues were being addressed without always understanding or addressing the underlying and complex reasons for neglect.
- It was also recognised that there was a need for a more in-depth assessment of the reasons behind parental issues around mental health or the mistrust of services.
- A theme highlighted by Brighton and Hove Schools (for the older siblings in the cases audited) was whether we are listening sufficiently to the voice of the child especially when the focus shifts to the parents’ issues and needs.
- There was evidence of effective joint working across agencies
- Schools in particular, reported that professional challenge was area of difficulty and that they were not fully aware of how to challenge other professionals e.g. how to seek a formally recorded professional’s meeting. Professionals were reminded of the [7.2 Professional conflict resolution | Sussex Child Protection and Safeguarding Procedures Manual](#) in the Audit Report (published July 2021)

### Recommendations –

- The application of thresholds and assessments to take into account the history and the cumulative impact of neglect.
- The underlying causes of neglect, and not just the presenting issues to be understood to ensure that interventions are effective.
- The impact of neglect and the interplay with the child’s developmental needs to be considered in assessment and planning.
- Professionals to be involved in decisions to close/‘step across’ a CiN Plan - decisions to be clearly communicated to partner agencies.
- The focus within planning and reviews to be on whether the actions completed can evidence change including an improvement in the child’s daily lived experience/child outcomes.

Working Together to Safeguard Children 2018 sets out agencies and organisations' responsibilities under Section 11 of the Children Act 2004; namely it places duties on a range of organisations, agencies, and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

BHSCP undertook their first Pan-Sussex Section 11 Audit with East and West Sussex Safeguarding Children Partnerships (SCP) in 2020. This continued a two-year cycle of activity which occurred under the previous Local Safeguarding Children Boards' (LSCBs') audit in year 1 and scrutiny of action plans in year 2 of the cycle.



Agencies and organisations across Sussex were asked to complete a self-assessment return using an audit tool which enabled them to assess their level of compliance with statutory guidance and address areas requiring development. S11 activity also provides an opportunity to identify and share good practice.

The self-assessment return was updated in 2020 to include a suite of indicators around children who are looked after (CLA), some were new (7) and some added to existing standards (6). This contributed to an overall 16% increase in the number of standards to be assessed in 2020: from 80 (in 2018) to 93 in 2020. Findings and recommendations were published and reported by individual SCP and as a Pan-Sussex working group to all three Steering Groups.

As part of the 2020-22 S11 Audit process it was agreed that we should review and redevelop the S11 process for 2022-24. Agencies were asked to report against 93 standards in 2020-22; an 86% increase since 2012 of standards/indicators which raised a question around quality versus quantity of responses. A review of the standards was agreed to: (i) support agencies and organisations to undertake a proportionate audit and (ii) enable the SCPs to focus on their energies on core safeguarding children functions.

**Plans for 2022-24** – In contrast to previous audits, the Pan-Sussex SCP want organisations to use the 2022-24 Section 11 audit as a tool for improvement rather than compliance. We want agencies, when completing the tool, to reflect on how well the standard is embedded into frontline practice, as this is often the gap, we identify in case review and audit work. The process in 2022-24 will still include Peer Challenge, and Peer Scrutiny but there will also be an opportunity for frontline practitioners to contribute by completing a Section 11 Staff Survey using an online platform. Audit tools and guidance notes will be circulated to Pan-Sussex agencies and organisations at the beginning of the autumn term 2022.

A key function of the Partnership is to reflect on systems and practice following a serious child safeguarding incident. A Local Child Safeguarding Practice Review (LCSPR) is undertaken when a child dies, or the child has been seriously harmed. The purpose of a practice review is for agencies and individuals to learn lessons to improve the way in which they work individually and collectively, to safeguard and promote the welfare of children and young people, and ultimately to deliver improved outcomes for them.

The Case Review Group (CRG) undertakes work which identifies areas for consideration to drive improvement to services delivered to local children, young people, and their families. During 2021-22 the BHSCP Case Review Group –

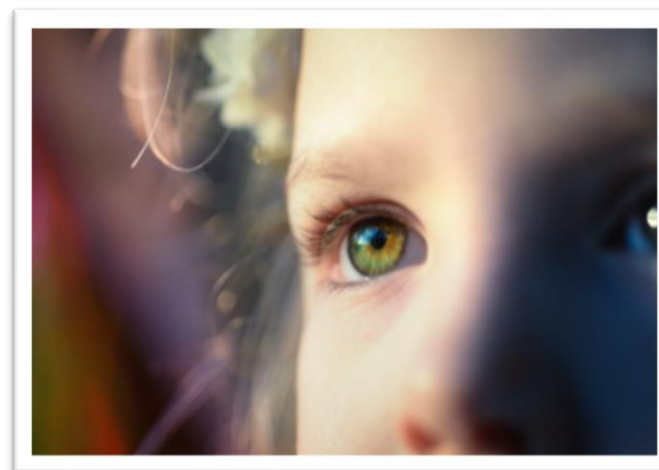
- Continued to work on a review commissioned in 2020-21 – One review is on-going and due for publication in October 2022.
- A Rapid Review was completed in April 2021, and it was agreed that a full practice review was required. However, due to parallel process we have needed to hold the review until the criminal investigations conclude. The CRG are hopeful that the review will restart in autumn 2022.
- Learning Review (published anonymously on the [National case review repository | NSPCC Learning](#)) - Reflection and Impact Workshop. The Case Review Group approved a proposal in December 2019 to hold a multi-agency workshop with the author of the Learning Review. The workshop was delayed due to Covid 19 and the national restrictions. The workshop was facilitated in-person in May 2022.

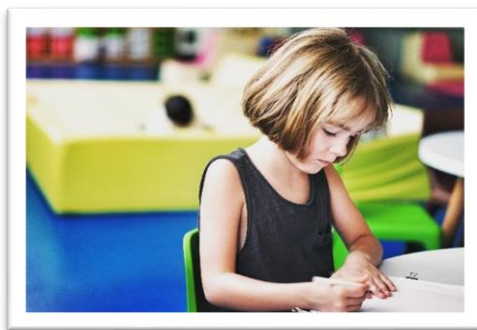
Attendees were asked by the author to discuss and assess the following -

- Impact of the review on agency systems and practice.
- How our learning review activity has improved outcomes for children and families across the city.

### The CRG also holds the responsibility to –

- Monitor BHSCP’s action plans following the publication of local and national practice reviews or completion of another type of review – [Child Safeguarding Practice Review Panel - GOV.UK \(www.gov.uk\)](#) .
- Seek assurance that partner agencies have developed and delivered action plans arising from local and national practice reviews or completion of another type of review.
- Use the learning from local and national practice reviews to inform policy, practice and the BHSCP learning and development programme.





The Child Safeguarding Practice Review Panel's annual report 2020 (Published 2021) notes that SCPs should have **'Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families.'**

Sir Alan Wood's Report: Sector expert review of new multi-agency safeguarding arrangements (May 2021) states **'We need to draw together a secure evidence base for the impact of independent challenge and scrutiny on the outcomes for children.'**

In December 2021 the Case Review Group (CRG) agreed a proposal to host the first Safeguarding Practice Review Reflection and Impact Workshop to establish the impact on practice of the Baby Alex Learning Review.

### The Workshop – May 2022 –

Attended by 22 practitioners from Sussex Police, SECAmbs, Early Help, SCFT, University Hospital Sussex, and Children's Social Care. A follow-up session was held for managers in the same agencies.

The participants discussed the Learning Review with the Review author including the findings, recommendations, and identified learning in the context of their own agencies.

Participants worked in groups to discuss challenges, improvements to practice/policy/procedure, further improvements, and key messages.

### Key Learning –

- Reflection & Impact Workshops provide an opportunity to 'check back' and evaluate whether learning continues to inform practice.
- Workshops also provide peer scrutiny and challenge between agencies which potentially provides further improvement opportunities.
- Learning and key themes/points from reviews to inform L&D decisions i.e. identification of 'gaps' in current programme or promotion of existing training offer in response to review findings.

### Next Steps –

- We will explore the potential to include Workshops as part of all Safeguarding Practice Reviews.
- We will explore the potential to include Reflection & Impact Workshops as part of the Terms of Reference for future Practice Reviews.
- We will share our learning from this process with East and West Sussex Safeguarding Children Partnerships as Pan-Sussex learning.
- Existing BHSCP Learning Briefings to be updated with additional learning and recirculated to all safeguarding partners as a commitment to continued improvement.

[The Child Safeguarding Annual Report 2020 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

[Wood Review of multi-agency safeguarding arrangements - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

**BHSCP Multi Agency Training Programme** – We provide multi-agency training & development for staff to help them safeguard and promote the welfare of children and young people. **Our training supplements the single agency training provided by partner agencies.**

The purpose of multi-agency training is to help practitioners:

- Work together effectively with colleagues across organisations
- Share knowledge & expertise
- Understand each other’s roles and responsibilities
- Understand how different agencies operate
- Know what services are available locally for children & families
- Recognise the value of multi-disciplinary working in safeguarding & promoting the welfare of children.
- Consider and hear the voice of the service users they work with.

During 2021-22 we continued to provide virtual training in line with Covid restrictions but re-introduced some in-person courses where possible with reduced numbers. Safeguarding Children 1 training continued to be delivered via eLearning with Day 2 and 3 being delivered in person towards the end of the year.

This table shows BHSCP provided training for **1315** practitioners across all courses including three practitioner learning events and a Pan-Sussex conference. Courses were attended by all agencies including – **526** practitioners from the local authority, **166** from health partners, **21** from Sussex Police, **299** from the education sector, **113** from community partners, and **91** from fostering and adoption. From March 2022 continued to increase as BHSCP re-introduced more in-person courses as the in-person training programme continued to return.

**Next Steps –**

- Re-introduce all courses virtually or in-person.
- Extend offer available through Multi Agency Training Programme 2023-24.

Course	Attendances
Graded Care Profile Training and Child Neglect	288
Safeguarding Children 2: Assessment Referral & Investigation	92
Safeguarding Children 3: Child Protection Conferences & Core Groups	60
The Impact of Domestic Violence and Abuse	47
Harmful Sexual Behaviours	15
Harmful Practices	33
The Impact of Parental Substance Misuse	38
Consent, Sex and Young People	38
Child Sexual Exploitation	31
BHSCP - Trauma Informed Approaches	166
Mental Health and Well-being, and Fabricated and Induced Illness	48
Exploitation	106
Safeguarding in a Digital Age and Online Safety	126
Safeguarding Children with Disabilities	23
Pan Sussex Safeguarding Children Conference	78
Practitioners Event - Child Sexual Abuse (CSA)	22
Practitioners Event - Working with Female Offenders	15
Practitioners Event - CSA Pathway	10
Difficult or Evasive Behaviour	20
Sussex Statutory Child Death Review Process	7
Professional Difference and Challenge	7
Improving Outcomes for Children who are Looked After	38
Multi-Agency Public Protection Arrangements MAPPA	6
Not known	1
	<b>1315</b>

140

**Pan-Sussex Safeguarding Under 5s Virtual Conference** – As part of our commitment to providing training delivered jointly with safeguarding children partnerships in East and West Sussex BHSCP co-delivered the virtual conference in November 2021.

The conference was attended by over 200 pan-Sussex delegates including 78 from Brighton and Hove. Local and national learning indicates that babies and young children are particularly vulnerable to abuse and neglect. Nationally, babies under 12 months continue to be the most prevalent group notified to the national safeguarding panel following serious incidences, with around 40% of serious case reviews involving children aged under 1. There were also a high proportion of cases involving non-accidental injury and sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk. Learning from the Pan Sussex Child Death Overview Panel (CDOP) also highlighted the need for a multi-agency response to the number of incidences of sudden and unexplained infant deaths where modifiable factors were identified.

The conference included speakers on: Out of Routine - a review of SUDI (Sudden Unexpected Death in Infancy), safer sleeping, the 'Myth of Invisible Men' (national safeguarding review panel report) - safeguarding children under 1 from non-accidental injury, and peri-mental health and infant mental health. Sudden Infant Death in Infancy, the Myth of Invisible Men and Family Hubs, and ICON are featured in the Learning and Improvement section below.

**SUDI** – In their 'Out of Routine' report the Safeguarding Practice Review Panel reported that out of the 568 serious incidents reported to them between June 2018 – August 2019, 40 involved infants who had died unexpectedly making this one of the largest groups of children identified. The report highlighted several factors for consideration including deprived socio-economic background. However, many of the recognised SUDI risk factors overlapped with those associated with neglect and child abuse.

The report concluded that most of these deaths are preventable, risk factors are well recognised, and the steps parents can take to reduce the risk have been delivered to parents as part of the clear, consistent, and evidence-based safer sleep messages for many years. The report also highlighted that SUDI prevention should be embedded within all relationship based safeguarding practice to be effective.

#### **Key findings and recommendations –**

- A better understanding of parental perspectives enables flexible and responsive partnerships with parents to develop supportive but challenging relationships to develop more effective safer sleeping discussions.
- The need for better links between SUDI and strategies for responding to neglect, issues related to deprivation and socio-economic factors, domestic violence, substance misuse, and parental mental health. This needs to be an all agency response not just within health agencies.
- Agencies need to explore use of behavioural insights and models of behaviour change to inform parents of risks and modifiable factors.

[Out of routine: A review of sudden unexpected death in infancy \(SUDI\) in families where the children are considered at risk of significant harm \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

THE CHILD  
SAFEGUARDING  
PRACTICE REVIEW PANEL

## “The Myth of Invisible Men”

Safeguarding children under 1  
from non-accidental injury caused  
by male carers  
September 2021

‘The Myth of Invisible Men - Safeguarding children under 1 from non-accidental injury caused by male carers’ was published in September 2021 by the Safeguarding Practice Review Panel looked at the following areas –

- What does incidence data highlight about patterns in situations where children have suffered serious harm or died because of non-accidental injury (NAI) and where their fathers/stepfathers/male carers are the identified as the perpetrator.
- What we can learn from interviews with men convicted of abuse about their individual histories, behaviours, and psychologies, and how these affected the perpetrated abuse.
- What was happening in the period before the abuse - how did these men manage their anger/frustration thresholds.
- Links between the abuse with domestic abuse, substance misuse, mental ill-health, parents being young and/or who are care leavers.
- How contextual issues such as race and ethnicity, culture and poverty may have affected what happened.
- What can we learn about the effect of good information sharing and information seeking.

The Child Safeguarding Review Panel report outlined the urgent need to engage with fathers and male carers more effectively:

- Commissioning services and practitioners need to ‘... to make the seemingly invisible visible and the hidden known.’
- The report recommends more should be done to engage, support and challenge fathers and male carers in order to prevent more babies suffering the harm detailed in the report.

[The Myth of Invisible Men \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

[Summary of "The myth of invisible men": safeguarding children under one from non-accidental injury caused by male carers \(bhscp.org.uk\)](https://bhscp.org.uk)

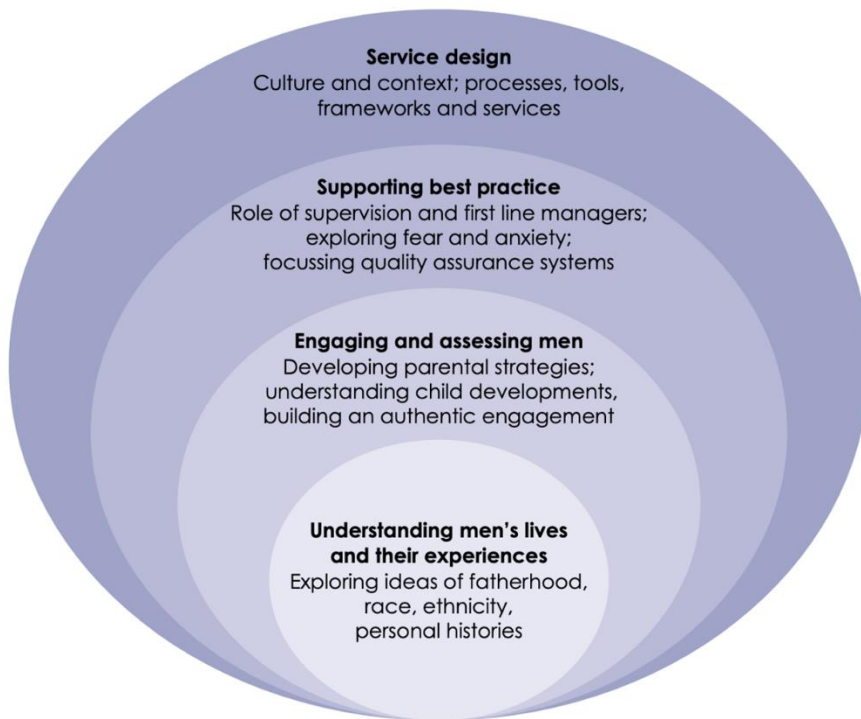
### Findings and Recommendations –

1. Funding to develop models of good practice – dissemination of learning should clearly identify ‘what worked with who and why’.
2. Pilot areas to be identified and funded by Government to develop ‘end-to-end’, multi-agency integrated service re-design to address the issues identified in the review.
3. Research to be commissioned by government to enable a better understanding of the psychology and behaviour patterns of men who have abused babies through NAI.



**Impact on Practice** – According to the report men are more likely the perpetrators of abusive head trauma, including more fathers and stepfathers. Contextual factors such as the pressures of living in poverty, worklessness, racism, and being a young or care-experienced parent can all be contributing factors.

1. Finding, engaging, assessing, and working with fathers and male carers is key.
2. The Child Safeguarding Practice Review Panel’s report builds on existing guidance to include the findings from their research and sets out a four tier model to help improve the engagement and assessment of fathers.
3. The model tiers are interlinked, and each should be implemented systematically to make the kind of step change necessary in working with fathers and protecting babies.



Child Safeguarding Practice Review Panel - Four Tier Model (Sept 2021)

**Family Hubs** – The report identifies the development of Family Hubs as one of five existing policy areas which could, with some minor changes, address many of the issues raised by the Myth of Invisible Men Report.

Family Hubs are currently central to the review and development of early help services in Brighton and Hove. Family Hubs will offer seamless support to the whole family, services for children and young people from pregnancy onwards.

Family Hub Networks will deliver strengthened targeted services whilst maintaining the preventative universal services currently accessed via Children’s Centres.

Family Hubs Networks will bring together GP services, midwifery, CAMHS, social work, health visiting, mental health services, speech and language services, reducing parental conflict teams, housing and financial support services, and early years settings – potentially addressing some of the contextual contributing factors linked to NAI/abusive head trauma.

Brighton and Hove Family Hubs will adopt a system-wide model of relationship based practice already successfully implemented across social work services. This will be underpinned by a trauma-informed approach, currently promoted by the Safeguarding Partnership.

**ICON – Babies cry, you can cope!** – Research suggests that some parents and care givers can lose control when a baby’s crying becomes too much for them. Some go on to shake a baby with devastating consequences for the child, the parents, and the rest of the family. Abusive Head Trauma (AHT) causes catastrophic brain injuries, which can lead to death, or significant long-term health and learning disabilities.


ICON was adopted by health and social care organisations in Brighton & Hove, across Sussex and nationally to provide information about infant crying, including how to cope, support parents and carers, reduce stress and prevent abusive head trauma in babies.

ICON was launched in Brighton and Hove in 2020 following a local learning review where a young baby had suffered significant non-accidental injuries. Partner agencies and organisations led by NHS Sussex looked at opportunities to talk to parents and care givers about prevention of AHT.

[ICON – Babies Cry, You Can Cope \(iconcope.org\)](http://iconcope.org)

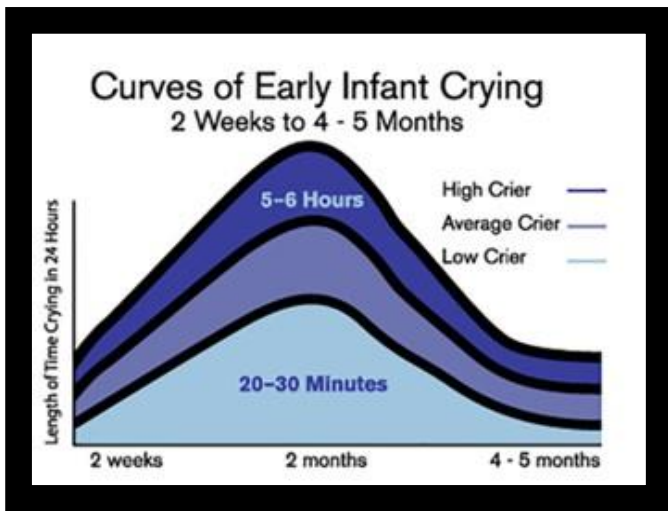
**I** Infant crying is normal and it will stop

**C** Comforting can sometimes soothe the baby – is the baby hungry, tired, or in need of a nappy change?

 It's **O**kay to walk away if you have checked the baby is safe and the crying is getting to you. After a few minutes, when you're feeling calm, go back and check on the baby;

**N** Never shake or harm a baby; it can cause lasting damage or death

**If you need support, speak to someone such as:  
your family, friends, Midwife, Health Visitor or GP**



ICON is an evidence based preventative programme designed to provide support to parents and carers with a crying baby. ICON was commissioned Sussex-wide as part of the learning from NAI serious case reviews / practice reviews across Sussex. Apart from preventing AHT, most people would appreciate some advice about how to comfort a crying baby and how to cope when it goes on for a long time.

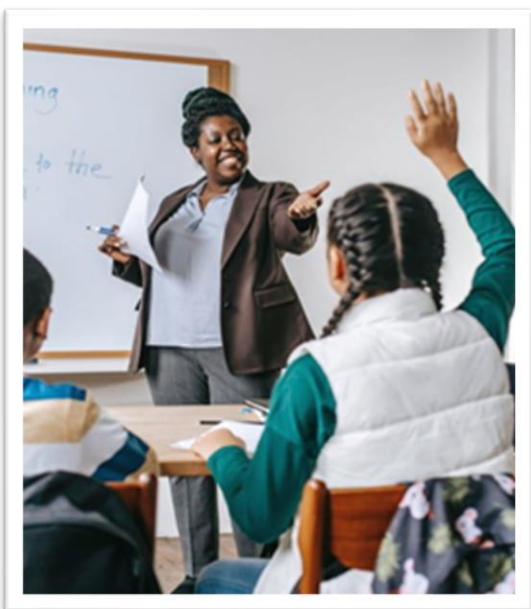
Evaluation of impact for preventative programmes can be difficult but nonetheless the partnership decided to support the ICON programme further by commissioning DadPad in 2022.

DadPad provides fathers and male partners with the practical skills they need at a time when many new parents can feel completely overwhelmed. The app includes advice on feeding, holding, changing, sleeping and getting to know your baby. Information on supporting relationships and each other’s mental health during this challenging time is also available. The app has information on the reasons babies cry and how to cope when the crying won’t stop. It also contains the ICON messaging.

[DadPad | The Essential Guide for New Dads | Support Guide for New Dads \(thedadpad.co.uk\)](http://thedadpad.co.uk)

The Learning and Development (L&D) Subgroup is currently Chaired by a Designated Nurse for Safeguarding Children - NHS Sussex, who is also the Chair of L&D Subgroups across the pan-Sussex area. The Subgroup meets three times per year to review the training programme, analyse training data such as attendance and evaluation feedback, and to develop the training programme with the L&D Officer.

The role of the Subgroup also includes consideration of BHSCP Learning Briefings from audit outcomes and child safeguarding practice reviews including national reports which link to training and learning. The Subgroup comprises of representatives from the wider partnership including Health, Children's Services, Police and Education.



### Key L&D Achievements and Challenges in 2021-22

**The Subgroup has developed clearer links with the other BHSCP Subgroups and pan-Sussex Safeguarding Children Partnerships (SCP).** Currently the L&D Chair, Business Managers and Training Leads meet at least twice a year to develop shared learning opportunities. The Training leads across Sussex meet bi-monthly to undertake the development of training opportunities.

**Rollout of NSPCC Neglect GCP2 training to frontline practitioners.** Following the impact of Covid-19, this had been delayed. This is now supported by a working group and more key professionals have been identified to receive full training to ensure continuity and embedding into multi-agency practice.

**Demand on frontline services due to high awareness of complex child safeguarding concerns and staffing issues** resulted in some training being cancelled at short notice due to the availability issues within the Training Pool members.

The BHSCP training offer is supported by a 'pool' of experienced practitioners from across the Partnership who give their time and expertise as part of their continuing professional development at no additional cost. The training pool are supported by the L&D Officer and can access accredited adult learning course to recognise and thank them for their commitment to learning.

The Partnership remain committed to providing a robust learning offer by commissioning external trainers; working closely with our neighbouring local authorities to share expertise and developing alternate learning mediums such as podcasts and 9 Minute Briefings.

During 2021-22, the focus of the Exploitation Subgroup was to act as a strategic governance multi-agency group overseeing the Exploitation Action Plan as part of the Community Safety & Crime Reduction Strategy 2020-23 with a real focus on children, young people, transitional and contextual safeguarding.

The multi-agency Subgroup developed a Criminal Exploitation Task and Finish Group to review the Waltham Forest Child C Serious Case Review and National Child Safeguarding Practice Review - 'It was hard to escape', identifying transitional safeguarding and leadership culture as two key areas to develop.

A mapping exercise to better understand where issues related to child exploitation, drug harm and serious violent crime were discussed to reduce duplication.

### Key Exploitation Achievements and Challenges in 2021-22 –

The outcome of the Criminal Exploitation Task and Finish Group informed the work of the Exploitation Subgroup and Exploitation Action Plan for most of the year. A short-term transitional safeguarding working group was established to review the current transitions processes for people who are being exploited and the development of action learning sets to support an improved multi agency risk management approach

A key achievement was acknowledging that the identify and function of this Subgroup had become confused. Therefore, Q4 of this year has been spent reviewing governance and purpose. It was agreed to re-focus the group as a tactical/operational group using the 4P approach identified by College of Policing to help re-engage and re-purpose the group (e.g. looking at preparation, prevention, protection and pursue). It is hoped this will reduce the previous difficulty in moving pieces of work forward effectively.

Some progress was made to develop a performance dashboard with key indicators of exploitation. This work was overtaken by a parallel piece of work within the Sussex Violence Reduction Partnership, so this piece of work was paused to avoid duplication of efforts.

### Plans for 2022-23

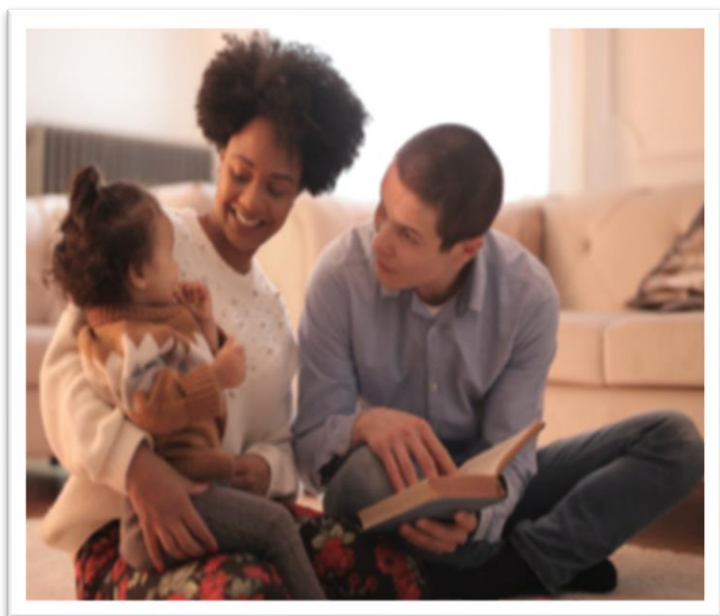
The key focus for 2022-23 will be to continue the preparations to re-form the Subgroup with a clearer identity and purpose with a greater focus on delivering task and finish pieces of work that better support the work of the Partnership to reduce child exploitation.



The Child Safeguarding Liaison Group (CSLG) is an interagency forum who meet regularly, usually monthly, to review and improve joint working practice in respect of inter-agency Child Protection processes. This includes analysis of examples of operational practice within the context of Child Protection enquiries and investigations. The Subgroup work together to challenge practice and, where necessary, bring matters to the attention of relevant managers and agencies on behalf of the Partnership with the aim of organisational and partnership learning.

### Two key areas of work during 2021-22 for CSLG were –

- Mental health pathways including suicide responses and suicide cluster considerations.
- Escalation and professional difference



### Key CSLG Achievements and Challenges in 2021-22 –

Key achievements during 2021 and into 2022 include maintaining active engagement and participation in CSLG. Maintaining an engaged and open-minded participation in learning from complex cases where existing processes are brought into question can be challenging at times, but the group embraced this way of working from the start.

Development of practice notes for services. Issues discussed include CSA, SUDI, complex health care packages and Mental Health pathways from custody.

Supporting the development of the Subgroup Chairs Forum to facilitate discussions around issues across the sub groups and ensure smoother running of the partnership functions.

The main challenge for the group was maintaining engagement with a virtual meeting. The group has a large number of participants so in the months following Covid-19 in-person meetings have not been an option.

**Plans for 2022-23 –** The group has started to include plaudits and cases where things have gone well. The aim to ensure the Partnership learns from cases of excellence as well as where things have not gone well. Professional feedback of CSLG continues to be very positive. Agencies are engaged and see CSLG as a productive forum in which to explore multi-agency learning – the plan for 2022-23 is to maintain this level of participation and to review the group often to ensure the group develops.

**Sussex Partnership Foundation Trust (SPFT)** – Mental Health Trust delivering a range of clinical services to children and young people and adults with caring responsibilities. SPFT also have specialist services such as Perinatal, forensics, and Early Intervention.

**Example of key child safeguarding achievement between April 2021 and March 2022** – SPFT benefited from increased funding during the past financial year and created new roles. SPFT maintained a full and thorough service throughout the global pandemic. We identified the continued offer of clinical consultation with staff and the support this offers as a real achievement of this reporting period. This had a marked influence on outcomes for children with the interface with partner agencies and was a real benefit. SPFT continued to offer specialist and CORE training throughout.

A review of our pan-Sussex data over the last 3 years demonstrates a significant increase in activity in safeguarding consultations and in engagement with our internal team and partner agencies.

- 2019/2020 **621** Safeguarding Children consultations.
- 2020/2021 **809** Safeguarding Children consultations, 30% up on the year before.
- 2021/2022 **1167** Safeguarding Children consultations, 44% up on the year before.

### Achievements and Challenges –

- BAME audit in 2020-21 raised the importance of this work in practice; SPFT are committed to improving inequalities.
- Partnership working is central and core business for us in safeguarding aligned to partnership priorities and prevention strategies. Local example is the QI project for children who are not brought to appointments.



- SPFT appointed a PREVENT practitioner role to work across teams and operational services to enhance the understanding, training, and awareness of radicalisation.
- As a pan Sussex organisation one challenge is linked to the implementation of different locality strategies. A pan-Sussex approach would help us to standardise systems/processes and audit activity, to optimise the support we offer to the service user.
- A key challenge has been the impact of the global pandemic and the effect on children and young people and safeguarding. The focus on child and adolescent suicide has been a priority for operational and safeguarding teams. We acknowledge the impact the pandemic has had on vulnerabilities and thresholds.

**Sussex Police** – One of the three statutory partner agencies within BHSCP.

**Example of key child safeguarding achievement between April 2021 and March 2022** – The creation and expansion of the *Crewmate App*.

- Sussex Police, as all forces are nationally, are engaged in delivering on the Governments manifesto pledge to recruit 20,000 more constables over a four year period. As a consequence, the service level of our front-line responders has declined sharply.
- Recognising this the force has sought to equip officers with at scene access to an array of incident and specific guides to assist them in identifying risk and responding appropriately.
- While this list is ever being revised and expanded it currently contains safeguarding information relating to – child abuse, neglect, County Lines, Child Sexual Abuse and Exploitation reports, CSE guide, Police Protection, sudden death child and infant, unaccompanied migrant child.

- Relationships created by the SCP structure and approach has resulted in live information with regards an immediate threat to a young person being passed directly to the most appropriate officer who was able to rapidly deploy resources to effectively mitigate that risk.
- Sussex Police received a high number of complaints relating to harmful sexual behaviour (HSB from a number of educational establishments in B&H, a number of which showed signs of escalation. We worked through the partnership and specifically with the third sector to fund and design a bespoke mentoring programme that could be delivered within educational establishments with the objective of challenging HSB at the earliest point. This was piloted within a local school with some promising early indications.
- One challenge for Sussex Police continues to be linked data sharing protocols –
  - Sussex Police developed the *Child to Notice Dashboard* in conjunction with East Sussex Safeguarding Children Partnership. This dashboard contains a wide array of data supplied by partners within that partnership and is used to better identify and assess the risk experienced by children.
  - We have been working with partners in B&H and West to expand this dashboard to include data from these respective areas but while existing information sharing agreements are in place challenges in respect of IT and movement to a cloud based system mean that the dashboard remains unintegrated.

**Brighton and Hove City Council Early Years and Childcare** – Provider of Early Help for Families with Children under 5 years including Council Nurseries providing places for high numbers of vulnerable children and placements for children with a social worker. Early Years and Childcare also provide training for Early Years staff across private, voluntary, and independent sector, and quality assurance re safeguarding in childcare settings.

**Example of key child safeguarding achievement between April 2021 and March 2022** - The Holiday Activities and Food (HAF) team introduced quality assurance for safeguarding policies of commissioned holiday club providers. They identified that 80% of the providers needed support with updating and strengthening their safeguarding policies and procedures. Training was commissioned through Safety Net to for all providers to attend.

**Impact** – Excellent take up of training places. All providers involved reported increased confidence to identify and respond appropriately to safeguarding concerns. Safeguarding concerns were picked up through HAF providers during school holiday periods that would not previously have been identified.

### Achievements –

- Graded Care Profile 2 working group and roll out of training. Children’s Centre service manager has been part of the working group who planned and rolled out this training.
- The Children’s Centre service and council nurseries staff have received GCP2 training, including all designated Safeguarding Leads. All those attending have reported how useful this tool will be to frame discussions around neglect with families. Some safeguarding leads have started to use the tool. One safeguarding lead will be joining the training pool in 2022.
- The Early Years consultant and Development Officer have started work with the Virtual school to assess how CIC/Children previously in care and those with a social worker are identified and supported in Early Years settings. This includes a service review (in progress) for council run nurseries to assess need, actions, and impact.

### How did Early Years and Childcare focus with the Partnership on prevention and Early Help –

- Through distribution of the Household Support Fund the Children’s Centre service supported 274 families in financial crisis/inadequate housing and food poverty through casework, emergency supplies, and food voucher distribution. On closing cases 85% of families reported their home circumstances to be a bit or a lot better after evaluation of the service received.
- Over 600 families used council nurseries during this 2021-22. All vulnerable families were prioritised for nursery places during Covid restrictions.







**Sussex Community Foundation Trust (SCFT)** – SCFT is committed to the promotion of the welfare of children and the protection of them from abuse and neglect at all levels within the organisation. SCFT can demonstrate compliance by fulfilling its duty to meet the safeguarding requirements of Section 11 of the Children Act 2004.

SCFT offers a range of Children Community health services which includes the Healthy Child Program (HCP) 0-19 years which is delivered by Health Visitors and school Nurses offering a Universal, Universal Plus and Universal Partnership Plus service to children and their families. Other services within the SCFT Brighton footprint include Community Children’s Nursing Team, Child Development services and therapists such as Physio, Audiology and Occupational Therapy.

The Sussex wide Children’s Sexual Assault Referral Centre (CSARC) is operationally managed by a SCFT Consultant Community Paediatrician and nursing service delivered by the Looked After Children nursing team.

**Examples of key child safeguarding achievements between April 2021 and March 2022** – SCFT Safeguarding Team supported a business case lead by the Clinical Commissioning Group (CCG - now Integrated Care Board - ICB) to increase the health staffing resource within Front Door for Families (FDfF). This included facilitating recruitment and management of short-term Specialist Nurse and administration roles, data collection to evidence need, and contributing to the narrative by highlighting and evidencing the need for specialist health input into multi-agency safeguarding decision for children.

This was achieved via monthly KPI data returns to the CCG. The Head of Safeguarding and Named Nurses facilitated the transfer of service from SCFT to the CCG (now ICB) to ensure a seamless provider transfer of such a crucial service; this included a new SCFT and ICB Information sharing agreement. Health staff in FDfF continue to have direct access to children’s SCFT held electronic health records. The new increased service provision was operational within the ICB on 1 April 2022.

**Impact** – An increase in staffing will ensure more cases open in FDfF will have specialist nurse oversight will information sought in a timelier and more cases can be screened by health.

SCFT are an active member of the CSLG; one referral made within this year was highlighting a child who was subject to MARAC and recorded as perpetrator of harm. This discussion supported professionals to identify child as victims within a domestic abusive context and should not be viewed as the perpetrator.

**Impact** – For this child the MARAC referral was removed from records; and replaced with wording that supported the status as victim within the situation. MARAC process also changed as a result to ensure cases similar as corrected agenda.

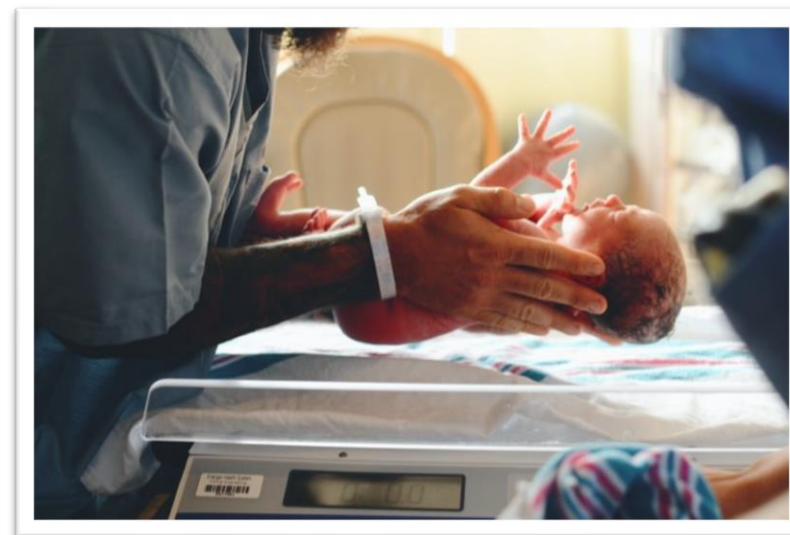
### Achievements and Challenges –

- **Key challenge for 2021-22** – Health Visitor vacancy in the HCP (Healthy Child Programme). For most of this year staffing within the Health Visiting service was on the organisation risk register and modifications to some core contacts made, including moving to virtual contact for universal families – whilst those requiring a more targeted or enhance service were seen face to face.
- **Key BHSCP achievement** – Challenge/escalation statement added to Pan-Sussex procedures and shared at all multi-agency meetings. This adds robustness and promotes positive change within the Partnership – SCFT leads are actively represented in the Pan-Sussex Policy and Procedures Subgroup. This was an outcome from mock JTAI of FdF which SCFT were involved in representing Multi Agency Safeguarding Hub (MASH) Health and HCP services.
- **Key SCFT achievement** – Specialist Nurses in MASH (provided by SCFT) have improved sharing of health information with social care & Sussex Police ensuring decisions are based on a broader picture at an early stage and by ensuring police domestic abuse notification forms (SCARF/SIGNS) are sent out to health practitioners in a timely manner. This information sharing function continued without covid impact other than peaks of increase in demand, as per peak in domestic abuse reporting via the Police.

**Brighton and Sussex University Hospitals** – Safeguarding children and young people remains a priority within Brighton and Sussex University Hospitals Trust (BSUH), which is the main acute hospital in the area, through a continued commitment to promoting safeguarding as an integral component of practice and keeping the child or young person at the centre of safeguarding decision making.

Partnership Working continues to be strong as BSUH is represented by the Named Nurse & Doctor at key strategic groups both internally and externally. This includes participation case reviews, in the audit programmes and the dissemination of the learning from reviews and audits.

In April 2021 Brighton and Sussex University Hospitals Trust (BSUH) amalgamated with Western Sussex Hospitals Foundation Trust (WSHT) to become University Hospitals Sussex Foundation Trust. The commitment to safeguarding children and young people will continue to be a high priority within the new Trust.



**Community and Voluntary Services (CVS)** – This sector plays a very significant and highly valued role in protecting and promoting the emotional health and wellbeing of children young people and families in Brighton and Hove. Representatives from a number of CVS are active members of Subgroups and the Partnership Board.

CVS organisations provide services from Universal Level to Specialist Services to address Acute & Chronic Need for young people in Brighton & Hove. They provide early recognition and intervention, referral to partner agencies and Front Door for Families. The large and diverse reach of charities, community groups, clubs and not for profit organisations is a cornerstone of good safeguarding practice.

### Achievements and Challenges –

- o The CVS organisations experienced significant negative impact through the pandemic because it restricted their ability to fund raise and deliver services.
- o Organisations such as RISE and Safety Net have collaborated on the roll out of ICON and neglect best practice. This has widened knowledge across the sector and improved opportunities to intervene earlier.
- o For some organisations this has improved reporting and for RISE this aligns well with the legislation change which now considers children as victim/survivors domestic abuse in their own right.
- o Across the VCS organisations noted increased complexity of cases. Concerns often include multiple issues and often affect multiple people. Subsequently, safeguarding concerns are taking more of organisational capacity and increased waiting lists.
- o The VCS responded swiftly to support those most at risk in Covid-19 putting in place a coordinated response intended to reach the most vulnerable – the flexibility of the sector created a strong safety net wrapping around the statutory services

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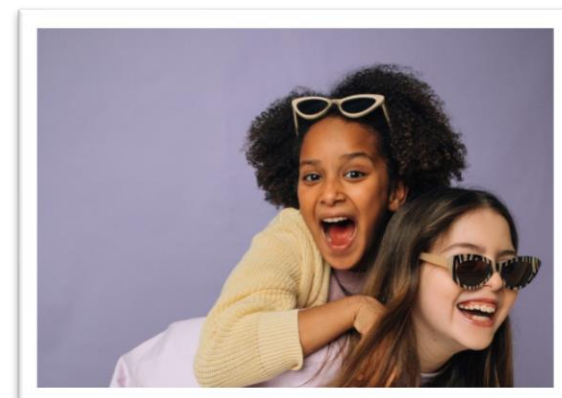


**East Sussex Fire & Rescue Service (ESFRS)** – This service delivers an emergency response function as well as a wide range of prevention activities, many aimed specifically at children and young people, in order to reduce risk of injury due to fire, road and water related incidents.

### Achievements and Challenges –

- o The development of an online version of **Safe Drive, Stay Alive** presentation was developed to deliver the same safety messages to young people about considering consequences before taking to the wheel or being a passenger being driven by a young person. The message, of make an informed decision, is backed up through the story board that demonstrates the impact on families, friends and the emergency services and includes the story provided by a young man imprisoned for causing death by dangerous driving that, because of his disposition, we found that young people could relate to.

- ESFRS used a series of 12 TikTok videos to emphasise the message of making informed decision before entering the water as part of their online version of **Water Savvy, Water safe**. Aimed at educating young people about how to stay safe in the water including check the depth before 'tomb-stoning' and awareness of cold water shock. These videos have had over a million views worldwide!
- In-person presentations returned as the Covid restriction were lifted but inline versions continue as they proved successful.
- **Safety in Action** is delivered to children aged 10-11 years in-person in schools. This initiative allows children to experience risky situations in controlled conditions. Online content was developed during Covid but there is now a concern that a cohort of children may have missed out on this educational opportunity described by RoSPA as life-long learning.



### Key areas of work with BHSCP and Partners –

- ESFRS broadened its engagement with other agencies, specifically CAHMS, to tackle an increase in mental ill- health.
- ESFRS inked with Police Schools Prevention Officers to provide support and intervention around fire setting as well as their **Watch** scheme that supports young people on the cusp of offending or being excluded into a structured series of visits to fire stations.
- Through engagement with Sussex Police Children and Young People Strategic Oversight Board ESFRS has increased its knowledge of the wider risks relating to young people and broadened its offer to provide mentoring and prevention support in appropriate cases.
- ESFRS worked with the Home Office to offer prevention education content to young asylum seekers placed in hotels in East Sussex and Brighton & Hove through the **Home Office Dispersal Scheme**.
- ESFRS deliver **home safety visits** to people who are particularly vulnerable to fire. This includes families with fire setters, victims of domestic abuse, children on a child protection plan as well as other families who are referred to ESFRS by other services. Staff are all trained in safeguarding through a mandatory annual training programme and **officers are often able to identify neglect** which is reported through an established referral route.
- ESFRS continues to work with a local school to develop a **Fire Cadet unit in Brighton and Hove to bring Fire Cadets to the city**. ESFRS established their first units in East Sussex in 2020 and now have 3 operational units – these have had a profound impact on the young people, aged 13 – 17 years, who have joined.

All activities in 2021-22 were undertaken in a Covid secure manner, but ESFRS are widening engagement as communities and services have opened up after the pandemic. During Covid ESFRS didn't stop their interventions, they just became more challenging to deliver in a covid-secure manner.

**What would ESFR like to see happen in the Partnership in 2022-23 –** Increased awareness of all member agencies and how collaborations could enhance the experience for young people.

BHSCP works closely with Safeguarding Children Partnerships in East and West Sussex. Many of the partner agencies are Pan-Sussex and as a result it is prudent to ensure child protection and safeguarding procedures are developed across the county.

**The Pan-Sussex Policies and Procedures working group** reviews, updates, and develops safeguarding and child protection policies and procedures in response to local and national issues, changes in legislation, practice developments, learning from practice reviews, and quality assurance activities including audits completed by the Monitoring and Evaluation Subgroup.

Since March 2020 approximately 95 policy/procedures/protocols/guidance documents have been reviewed by the group; some have been reviewed more than once in this timeframe. Since March 2021, several new policies and procedures have been published including:

- A new procedure which sets out the actions to be taken in the event of children and families moving across local authority boundaries, either on a temporary or permanent basis.
- A policy in relation to safeguarding children in hospital.
- A Children Missing Education Procedure.
- Responding to a potential cluster of suicides for those aged under 18.



The group also focuses on the re-drafting of existing policies and procedures including:

- Bringing together existing guidance around criminal and sexual exploitation with serious organised crime and gangs.
- An updated Safeguarding Children impacted by Domestic Abuse policy, following the Domestic Abuse Bill receiving Royal Assent.
- An updated Fabricated or induced illness (FII) and Perplexing Presentations (including FII by carers) policy following learning from local pan-Sussex cases.

A short briefing note is disseminated to the working group for onward cascading across their agencies to front line professionals after every meeting. The Pan-Sussex Child Protection and Safeguarding Procedures website includes professional briefing notes, and current policies and procedures.

The webpage is publicly accessible via [Welcome to your Pan Sussex Child Protection and Safeguarding Procedures Manual | Sussex Child Protection and Safeguarding Procedures Manual](#)

**Pan Sussex LCSPR Procedures** – Working with a Pan-Sussex perspective provides continuity but also assurance. Work is currently progressing on the development of a Pan Sussex procedure for conducting Safeguarding Practice Reviews. Local CRG reps have had sight of the proposed procedures and have been given opportunity to comment on the drafts; edits to be made to final version and we hope to be able to progress this further in 2022-23.

**Safeguarding Children Under 5** – The three Safeguarding Children Partnerships worked together to deliver a very successful 'Safeguarding Under 5s' virtual conference in November in which nearly 200 professionals attended – the conference is discussed fully in Learning section of this report.

The three Partnerships have worked together to support two publicity campaigns: "**ICON Week**" held at the end of September 2021 and '**It's Your Call Campaign**', including working with the NSPCC to promote community and wider partnership awareness of safeguarding children.

**Pan-Sussex Learning & Development** opportunities:

- *2021/22 training:* Multi-Agency Public Protection Arrangement (MAPPA), Improving Outcomes for Looked After Children, Harmful Practices. Suicide Prevention is a Pan Sussex offer via Grassroots – four sessions, two looking at under 16 year olds and two at 16-18 year olds.
- *Planned training in development:* Cultural Competency



**Suicide Prevention and Emotional Health and Wellbeing** – There is an emerging picture of increased pressure on already pressed CAMHS and acute services across Sussex. Acute hospital settings have also seen a rise in self-harm presentations. A Sussex Public Health Led Strategic Self-Harm and Suicide Prevention group has been established to take forward a Pan-Sussex strategy and take responsibility for actions arising from a spike in child suicides during May/June 2021.

A Self-Harm Learning Network has been established providing workshops for education staff and parents on responding to children and young people who self-harm. Other Pan-Sussex initiatives include - E-wellbeing self-harm webpages, and Schools Well-being Service including Primary Mental Health Workers providing 1:1 support in schools. Schools Wellbeing Service has been added to the 'consent to share safety plan' for children and young people who have presented at hospital with self-harm – the Service now follows up with schools and provides support to ensure school response is coordinated with the Primary Mental Health Worker. A cluster response plan was developed by West Sussex County Council to address local risks.

**Future developments include** - Self-harm guidance and flowchart for schools – for all statutory schools, a Toolkit in the event of an unexpected death or suicide in the school community – the final toolkit will be ready September 2022 and will provide schools with a holistic framework for prevention and postvention.

**The local Child Death Overview Panel (CDOP)** – Child Death Review Partners review the death of every resident child aged under 18 in West Sussex, East Sussex and Brighton and Hove. The death of a child is a devastating loss and one that profoundly affects all those involved. In April 2008, it became a legal requirement in England that Child Death Overview Panels (CDOP) conduct a review for all child deaths (including live-born babies of any gestation) up to the age of 18 years. The role of the review is to identify learning arising from the review process that may prevent future child deaths and to make recommendations. The Panel produce an Annual Report, so this report does not intend to reproduce all but the key points. This section will be used to draw together some key points relevant to Brighton and Hove and Pan-Sussex.

Between April 2021 and March 2022 CDOP were notified of 83 deaths of children living in Sussex. This was higher than in 2020/21 when the covid pandemic meant that deaths were lowest ever reported. A lower number of deaths in 2020/21 was also seen at a national level and is the year with lowest child mortality on record within England.

In 2021/22 CDOP reviewed a total of 70 child deaths - 9 for Brighton and Hove, 25 for East Sussex and 36 for West Sussex. From the 70 deaths reviewed by CDOP 31 (44%) of the cases had modifiable factors identified. CDOP noted in their 2021-22 Annual Report that there appears to be a general upward trend in deaths where a modifiable factor has been identified – for Pan-Sussex reviews and those in England generally. Some CDOP reviews are delayed beyond recommended timescales because of parallel processes or because they are subject to a Children Safeguarding Practice Review.

The CDOP report states children are most at risk of death in their first 12 months of life - over half of all deaths reported are infants under 1 year. Of the deaths notified to CDOP in 2021/22 -

- 40% were for babies less than 28 days old,
- 18% for babies 28-364 days old
- 14% for children aged 1-9 years old,
- 28% were for young people aged 10-17 years.
- At both a national and Sussex level the largest category of death is perinatal/neonatal event (33% for Sussex, 37% for England).
- This is followed by chromosomal, genetic and congenital anomalies (21% for East Sussex, 24% for England).
- Cancers are the third most common cause of death (10% for Sussex, 9% for England).

BHSCP partners continue to work closely with CDOP colleagues.

[CDOP annual reports - Sussex Health and Care \(ics.nhs.uk\)](https://www.ics.nhs.uk)

**Learning and Development Subgroup –**

- BHSCP to host an Anti-racist Practice conference as part of BHSCP Safeguarding Week 2022. Thematic workshops to cover some of the key disadvantages faced by children, young people, and their families in Brighton and Hove.
- Train the Trainer programme - offer refresh to existing pool members and to recruit more trainers from across agencies.
- Identify what support/development opportunities would help support training pool members in their training delivery role.
- Embed GCP2 and re-focus on neglect following the Covid-19 pandemic.
- Review BHSCP website - research, guidance, procedures, tools, and good practice case studies. Consider using a neglect 'toolkit' approach.
- Professional curiosity training to be reviewed in light of national Arthur and Star review. Professional curiosity to 'explore reported allegations as credible until proved otherwise'.
- April 2023 – new training programme – use this as an opportunity to complete training needs analysis to introduce new training courses.

**Monitoring and Evaluation Subgroup –**

- Continue work on BHSCP Performance Dashboard, additional information requests, and single agency frameworks.
- Refocus emphasis of Section 11 from compliance to improvement. Include staff survey as part of challenge/scrutiny events.

**Case Review Group –**

- Introduce Pan-Sussex Safeguarding Practice Reviews procedures and templates for all reviews from Rapid Review to full practice review.
- Introduce Reflection and Impact Workshops to Terms of Reference and process.

**CSLG –**

- Embed positive professional feedback in CSLG agenda/practice to ensure we learn through good practice as well as when things go wrong.

**Independent Scrutiny –**

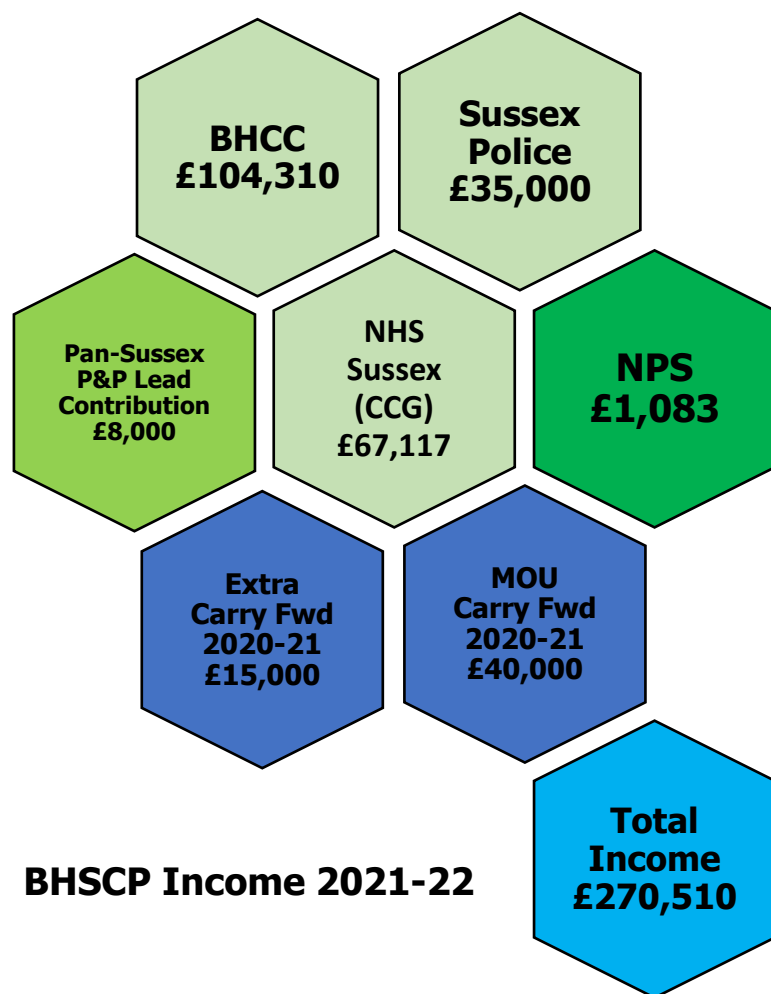
- Capture the voice of the child in all workstreams and as part of scrutiny programme. Recruit two Lay Members.
- Refresh Learning and Improvement Framework – consider how scrutiny and the voice of the child could improve practice in Brighton and Hove.

**Exploitation Subgroup –**

- Continue preparations to re-form the Subgroup with a clearer identity and purpose with a greater focus on Prepare/Prevent/Protect/Pursue, to reduce child exploitation



**BHSCP Expenditure – Headline Costs 2021-22**



Staffing	<b>£139,497.85</b>
Independent Scrutiny	<b>£11,959.36</b>
Training	<b>£10,688.31</b>
Learning Reviews (on-going)	<b>£9,827.50</b>
IT/Equipment & Resources	<b>£3,531.40</b>
Miscellaneous Costs – Miscellaneous Income	<b>£432.05</b>
Consultancy Costs (outside of SPR costs)	<b>£3,850.00</b>
<b>Total Expenditure</b>	<b>£179,786.47</b>
MOU Carry Forward to 2021-22	<b>£40,000.00</b>
Additional allocated funding to be carried forward to 2021-22 as agreed at Steering Group	<b>£50,723.53</b>
<b>Total Expenditure including carry forwards</b>	<b>£270,510.00</b>

Working Together to Safeguard Children 2018 states 'the safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate, ... to support the local arrangements ... and sufficient to cover all elements of the arrangements, including the cost of local child safeguarding practice reviews.'

## Contributors – with thanks to all who contributed towards this Annual Report

Lead Partners	Deb Austin, Naomi Ellis, D/Supt Jon Hull
Independent Scrutineer	Chris Robson
Subgroup Chairs	Justin Grantham, Rachel Egan and Sharon Ward, Emma Gilbert, Louise Jackson, DI Jon Gillings and Jo Player
Business Team	Sarah Smart, Daisy Piatt, Tom Edwards
Agency Leads	Martin Ryan and Jayne Bruce, Jo Gough, Helen Cowling, Sam Tyler, David Kemp, DI Jon Gillings, Jo Tomlinson, Michael Newman

## References and Websites

Population data	<a href="https://www.bhconnected.org.uk/brighton-and-hove-population-jsna-dec-2021.pdf">brighton-and-hove-population-jsna-dec-2021.pdf (bhconnected.org.uk)</a>
Latest BHSCP Business Plan is available from -	<a href="https://www.bhscp.org.uk/safeguarding-partnership-documents/business-plan-and-strategies/">https://www.bhscp.org.uk/safeguarding-partnership-documents/business-plan-and-strategies/</a>
The Wood Review 2021 - Child Safeguarding Review Panel	<a href="https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97822/wood-review-of-multi-agency-safeguarding-arrangements.pdf">Wood Review of multi-agency safeguarding arrangements (publishing.service.gov.uk)</a>
Working Together 2018 - Child Safeguarding Review Panel	<a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/68222/working-together-to-safeguard-children-2018.pdf">Working together to safeguard children - GOV.UK (www.gov.uk)</a>
Pan-Sussex Procedures website for professionals	<a href="#">7.2 Professional conflict resolution   Sussex Child Protection and Safeguarding Procedures Manual</a>
NSPCC Repository	<a href="#">National case review repository   NSPCC Learning</a>

Child Safeguarding Review Panel

[Child Safeguarding Practice Review Panel - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

Child Safeguarding Review Panel

[The Child Safeguarding Annual Report 2020 \(publishing.service.gov.uk\)](http://publishing.service.gov.uk)

The Wood Review 2021 - Child Safeguarding Review Panel

[Wood Review of multi-agency safeguarding arrangements - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

Out of Routine – Child Safeguarding review Panel

[Out of routine: A review of sudden unexpected death in infancy \(SUDI\) in families where the children are considered at risk of significant harm \(publishing.service.gov.uk\)](http://publishing.service.gov.uk)

The Myth of Invisible Men – Child Safeguarding Review Panel

[The Myth of Invisible Men \(publishing.service.gov.uk\)](http://publishing.service.gov.uk)

The Myth of Invisible Men – Child Safeguarding Review Panel

[Summary of "The myth of invisible men": safeguarding children under one from non-accidental injury caused by male carers \(bhscp.org.uk\)](http://bhscp.org.uk)

ICON

[ICON – Babies Cry, You Can Cope \(iconcope.org\)](http://iconcope.org)

DadPad – Support Guide for New Dads

[DadPad | The Essential Guide for New Dads | Support Guide for New Dads \(thedadpad.co.uk\)](http://thedadpad.co.uk)

Pan-Sussex Procedures website for professionals

[Welcome to your Pan Sussex Child Protection and Safeguarding Procedures Manual | Sussex Child Protection and Safeguarding Procedures Manual](#)

Child Death Overview Panel

[CDOP annual reports - Sussex Health and Care \(ics.nhs.uk\)](http://ics.nhs.uk)



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