Brighton & Hove Local Safeguarding Children Board
Annual Report 2013 / 2014

Safeguarding is everyone's responsibility

Brighton & Hove LSCB local safeguarding children board

Contents

An Executive Summary is available to view on the LSCB Website

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"It is a pleasure to be able to say that all agencies in the city understand the critical nature of safeguarding children. I will ensure that remains the case and help them work together effectively in the interests of children"
Graham Bartlett, Interview with Latest 7 Magazine

Introduction from the Chairperson

Welcome to the 2013/2014 Brighton and Hove Local Safeguarding Children (LSCB) Board Annual Report. This report reflects my first year as chair of the Board and explains the incredible amount of work that has gone on to meet the challenges of the revised Government Guidance Working Together to Safeguard Children 2013 and to embed a learning and improvement culture within the Board and therefore within its constituent agencies.

As the title of this report asserts, Safeguarding is Everyone's Responsibility. Whether you are a professional, a parent, a volunteer or none of those we all have a responsibility to ensure that our children have the best start in life, growing up happy, healthy and safe. The job of the LSCB is to ensure that the efforts of those agencies and groups who have contact with children work singly and collectively to ensure that children are helped, supported and protected. We have gone through a fundamental change in the way we do that. For example we have identified new priorities, set by board members. We have refreshed our training programme and linked it with our new multi agency audits and the outcomes of case reviews both locally and nationally. Our data and management information is being developed to allow us to see not just what was done but what difference it made.

One of the real strengths of the Board is the willingness of agencies to challenge and be challenged. That comes from the top with me commissioning an Effectiveness Survey to allow members to determine how they feel the board operates and is led. We are reaping the rewards of that at Board level and through the subgroups with all the members clear that the status quo is not acceptable.

We know we can do more in hearing the voice of children, parents, carers and frontline professionals. We are making efforts to do this by recruiting more lay members, involving staff more in our case reviews and ensuring that our audits focus on the experiences of service users.

I hope you find this report interesting and useful and urge you to share it far and wide so that more and more people become aware of who we are, what we do and, critically, speak to us about how we can improve the lives of our children.
Graham Bartlett
Independent Chair

Introduction

This report covers 1 April 2013 to 31 March 2014 and summarises the Board's structure, activity and progress during 2013/14, with a focus on the four priority areas as outlined in the Brighton & Hove LSCB Business Plan 2013-16.

There are approximately 49,947 children (aged under 18) living in Brighton & Hove, making up 18.3% of the City's population (Source 2011 Census). Whilst it is not possible to know every child at risk in Brighton and Hove due to the often duplicitous and secretive nature of abuse and neglect, keeping children safe will always be our number one priority. We are committed to strengthening safeguarding and child protection and to promoting early intervention and prevention to bring about better outcomes for the children living in the City.

Many groups of children in Brighton & Hove are vulnerable. They include: those subject to or at risk of Child Sexual Exploitation (CSE); Missing (Home, Education & Care); Trafficked Children & Private Fostering, as well as other risk groups. Throughout 201/14 we have looked to establish a new LSCB Subcommittee to monitor and scrutinise the work across the partnership in respect of these particularly vulnerable children and you will read more about the Subcommittee later in this report.

'If children and families are to receive the right help, everyone who comes in contact with them – midwives, health visitors, GPs, early years' professionals, teachers, youth workers, police, voluntary and social workers – has to play a role by identifying concerns, sharing information and taking prompt action.'
Safeguarding is everyone's responsibility, Working Together to Safeguard Children: March 2013.

Role of the Board

Brighton & Hove LSCB is made up of statutory and voluntary partners. These include representatives from Health, Education, Children's Services, Police, Probation, Children and Family Court Advisory and Support Service (Cafcass), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

Our main role is to coordinate what is done locally to protect and promote the welfare of children and young people in Brighton & Hove and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people. The efficacy of Brighton & Hove LSCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice.

Safeguarding children is everybody's responsibility. Our purpose is to make sure that all children and young people in our City are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained.

A corner stone of the LSCB's work is the provision of information to and from the public, potential and actual service users, staff working in partner agencies and others interested in children's welfare. In recognition of our belief that the responsibility to keep children safe and well belongs to everyone, Brighton & Hove LSCB's Participation & Engagement Subcommittee have implemented a Communication Strategy which you will read about later in this report.

Governance & Accountability

The Children Act 2004 places a duty on every local authority to establish a Local Safeguarding Children Board (LSCB).

The Government's Statutory Guidance, Working Together to Safeguard Children (2013) defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best life chances.

This is to enable those children to have optimum life chances and enter adulthood successfully.

As outlined in last year's annual report, LSCBs do not commission or deliver direct frontline services although they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed.

Each Board partner retains their own existing line of accountability for safeguarding.

The Board met 5 times during 2013/14 and was attended by senior managers from statutory and voluntary organisations, and sporadically attended by Lay Members. 2013/14 saw the appointment of a new Director of Children's Services, Pinaki Ghoshal and Councillor Sue Shanks, Brighton & Hove City Council's Lead Member for Children Services, still attends the LSCB as a participating observer; she continues to challenge the work of the LSCB through discussion, asking questions and seeking clarity.

This provides an additional scrutiny function to the Board and further ensures the Board is supported by the City Council.

In addition to the senior representatives, the LSCB values the input of professional advisers. The Board is attended by the (newly appointed) Designated Doctor and Designated Nurse, the City Council's Head of Safeguarding (who is the local authority Child Protection Adviser and Single Point of Contact for missing Children) and the Police Safeguarding Adviser.

Where there has been insufficient attendance or engagement at the Board, this has been appropriately challenged by the Independent Chairperson.

Regulation 5 (1) of the Local Safeguarding Children Boards Regulations 2006:
a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

1. The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention.
2. The training of persons who work with children or in services affecting the safety and welfare of children.
3. The recruitment and supervision of persons who work with children.
4. The investigation of allegations concerning persons who work with children.
5. The safety and welfare of children who are privately fostered.
6. The cooperation with neighbouring children's services authorities and their Board partners.

b) Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.

c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.

d) Participating in the planning of services for children in the area of the authority.

e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) relates to the LSCB Serious Case Reviews function and **Regulation 6** relates to the LSCB Child Death functions.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

In order to fulfil its statutory function under Regulation 5 an LSCB should use multi-agency data and, as a minimum, should:

- Assess the effectiveness of the help being provided to children and families, including Early Help
- Assess whether LSCB partners are fulfilling their statutory obligations set out in Section 11 of the Children Act 2004.
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned.
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

There are currently eight Subcommittees operating within Brighton & Hove LSCB, in which a significant amount of the LSCB's work is progressed. As with the full Board, membership is multi-agency. There is also a Leadership Group that is accountable to the full Board. You will read more from these Subcommittees later in this report, and the Subcommittee Structure chart can be viewed in Appendix 4

All Terms of Reference have been updated within the last year and there is recognition by all Chairs that the effectiveness and thoroughness of the Board requires that the work of each Subcommittee interacts with that of the others. Terms of Reference for all Subcommittees can be viewed online: Sub-Committee Terms of Reference

Key Relationships

Children & Young People Committee
In previous years Brighton & Hove LSCB reported annually, via the presentation of this report, to this body, highlighting how agencies have worked together to keep children safe and are address the issues facing children and young people at risk in Brighton & Hove. This accountability is now held by the Health & Wellbeing Board in place of the Children & Young People Committee. Brighton & Hove LSCB holds them to account so that services are commissioned accordingly.

Health and Wellbeing Board (HWB)
The HWB assumed its full statutory powers in April 2013 and the LSCB Chairperson is now a participant observer, increasing the influence of the Board by strengthening the relationship with this key strategic group. Clearer lines of accountability have been developed over the year and Brighton & Hove LSCB report annually to the HWB and continue to make sure key safeguarding issues are addressed.

Violence Against Women and Girls Programme Board (VAWG)
The Brighton & Hove LSCB Chairperson is an active member of the Violence against Women and Girls Programme Board. The two Boards have worked collaboratively on a number of child protection issues which are also crime types on the VAWG agenda, for example, the implementation of the Child Sexual Exploitation Strategy 2013-16, which you can read online: VAWG & LSCB Child Sexual Exploitation Strategy

Adult Safeguarding Board
The LSCB Chairperson is a participant observer on the Adult Safeguarding Board and the Chair of the Adult Safeguarding Board has been a participant observer at the LSCB. This relationship has been better defined over the year with Chairs meeting regularly and the development of a formal protocol.

Member Agencies Executive Management Boards
Board members are senior officers within their own agencies; this provides a direct link between Brighton & Hove LSCB and the various agencies' Boards.

Examples of Cross Regional & National Working:

- Association of LSCB Chairs
- Regional Business Manager Meetings
- Pan – Sussex Business Manager Meetings
- Pan – Sussex LSCB Chairs liaison and joint meetings with Police Crime Commissioner and Chief Constable
- Pan Sussex Sub Committees

Impact:

- improved working relationships with a more national context
- innovative ways of working
- sharing and disseminating learning and LSCB practice

LSCB Finance & Resources

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

There is no set formula on how LSCBs are funded, as each is different. It is not really possible to compare like for like and many contributions may be given in kind but not recorded in the budgets.

In 2013/14 the Independent Chairperson wrote to a number of agencies regarding their financial contributions. When an original budget of £146,050 was agreed, no increase had been applied for the last 3 years. On taking up the Chair, the new Chairperson had to ensure the LSCB functioned well and was able to meet its statutory duties. This included stabilising the budget and providing more clarity on contributions made. For example, costs had been absorbed by BHCC for the Training Programme and Child Death Overview Panel, and there was a 'hidden' arrangement for funding which was not equitably shared by other funding partner agencies. Additional contributions based on the gap and the projected additional pressures were sought for 2013/14. All contributing agencies met this challenge.

The full financial breakdown, plus the budget forecast for 2014/15, can be read in Appendix 1

Reflecting on the resource issues impacting on the LSCB and how we ensure effective use of resources the following points should be made:

- The LSCB budget does not represent the true costs of the Board's business and development work –'hidden' costs in City Council budget.
- National and local changes in the way Health services are commissioned and delivered is still to fully embed and the relatively new Clinical Commissioning Groups do not have the same remit or budgets as the previous Primary Care Trusts.
- Serious Case Reviews (SCRs) or other learning reviews present new financial pressures as and when these are agreed.
- The Learning & Development Sub Committee, as per their Terms of Reference, 'ensure best value of the available resources allocated to training' – by utilising free venues, in-house training providers, and other methods of ensuring value for money.

Monitoring & Evaluation (M&E)

What did we do? How well did we do it? What difference did we make?

Over the year the new Independent Chairperson has established a culture of accountability and challenge and the Monitoring & Evaluation (M & E) Sub Committee has driven the quality of service improvement and delivery of outcomes consistently across the partnership. The main focus of the Monitoring & Evaluation Sub Committee's work in 2013/14 has been developing and overseeing a programme of multi-agency audits (the findings of which can be found throughout this report) revising the management information provided to Brighton & Hove LSCB, and developing a Quality Assurance Framework (QAF) for the LSCB.

Building on the progress we've made towards performance management and quality assurance so as to strengthen the scrutiny and challenge function of the LSCB is our main priority. We will continue to strive to evidence the impact all our work has had on the lives of the children and families in Brighton & Hove. **Helen Davies, Independent Chair of the Monitoring & Evaluation Subcommittee.**

The membership has been expanded to include representatives from: Children and Adolescent Mental Health Services, Sussex Partnership NHS Foundation Trust, Brighton & Sussex University Hospitals Trust, also the Children's Services Quality Assurance Programme Manager, who has led on developing the QAF.

Key Achievements:

- A varied and responsive programme of multi-agency audit has continued throughout 2013/14 in Brighton & Hove.
- A multi-agency quality assurance programme for 2014/15, which plans to monitor and evaluate the quality of multi-agency frontline practice, including Early Help, has been approved.
- The M&E Subcommittee have had oversight of all single agency audit activity relating to safeguarding and child protection.
- A Quality Assurance Framework has been developed, further information on this can be read on page 52.

Challenges Ahead:

- The effective implementation of the QAF, especially embedding the learning from multi-agency audits with all partners, and using it to change practice and improve outcomes for children.
- Enabling all partner agencies to use the QAF for their own agency's quality assurance and keeping oversight of this.
- Ensuring that meaningful management information is available from all agencies.
- The M&E Subcommittee has focussed throughout 2013/14 on developing the management information presented to the LSCB into a multi-agency data set. Whilst some progress has been made obtaining data from the CCG, police and probation has been slow.

Child Protection and Children in Need Plans – Example of Multi-Agency Audit

For information on the number of children subject of Child Protection and Child in Need plans, see page 57..

In 2013/14 a multi-agency audit was undertaken of children who were the subjects of Child Protection plans and children who were subjects of Child in Need plans. The audit was undertaken in line with Ofsted inspections and Working Together 2013 guidance and there was a clear focus on impact and outcome. The audit selected 13 cases of children subject of a Child Protection Plan (CPP) or Child in Need (CiN) plan in August 2013 or in the preceding three months. The cases represented a spread of: categories of abuse; ethnicity, age and gender mix; and a mix of professional and service involvements

The audit found that practice was generally effective with children who were subjects of a Child Protection Plan, with good engagement from relevant agencies and plans leading to change in families and improvement in children's lives. However, with Child in Need plans, the picture was not so positive, with evidence of lack of focus and drift in some cases.

Key Findings:

- The recording of ethnicity is not consistent across and within agencies.
- There is a shared high level of commitment to engaging in the Child Protection process.

Child in Need Findings:

- Responses to referrals were prompt and decisions made in a timely way.
- The quality of up to date assessments varied from 42% scoring good, 29% adequate, 29% Inadequate.
- All agencies reported that they were fulfilling their responsibilities as outlined in the plan.
- In relation to reviewing how effective the plan was and having clear objectives, the scoring varied across agencies. Social care tended to score higher (good to adequate) compared to other agencies (inadequate to adequate). The difference in scoring between agencies for the same child would indicate that partners are not sharing their concerns effectively and jointly agreeing on whether the plan is having a positive effect.
- In almost half of the cases audited there was no evidence of management oversight, which compares unfavourably with the same section for children who were subjects of a Child Protection Plan.

Child Protection Findings:

- The referral process is not clearly understood by all agencies and, in addition, referrers do not appear to receive an acknowledgment in line with Working Together 2013.
- Once the referral meets the criteria for Child Protection the process for allocating a social worker and convening a case conference is smooth.
- All Agencies agree that actions are taken to ensure the child is safe and, in all six cases, it was felt that the nature and level of risk had been accurately assessed.
- The Child Protection Conference was felt to be effective and appropriately involved children and parents in every case; all were held within timescale and were quorate.
- The Supervision Process within social care does not appear robust. In 50% of the cases examined, the supervision was judged to be inadequate.
- Supervision arrangements in agencies outside social care vary from a formal process to ad-hoc advice giving if practitioners request it.
- Minutes from core groups are not circulated as effectively compared with minutes from case conferences.

An example of what performance data has told us:

The Subcommittee has analysed why the number of children subject of repeat Child Protection plans in Brighton and Hove is higher than the national average. Of the 353 children who became the subject of a Child Protection Plan during 2013/14, 97 (27.5%) were subject for a second or subsequent time, above the 2013 England average of 14.9% The main reason for this is repeated episodes of domestic abuse; Child Protection plans have ended because the abuse is believed to have ceased, but have to be reinstated when the domestic abuse recurs. This will be addressed in more depth in the planned multi-agency audit of domestic abuse in 2014/15.

In response to this audit the social care supervision policy was reviewed and requirements were reinforced with supervisors of staff.

Supervision/Management Oversight arrangements across all agencies were scrutinised as part of the Section 11 process. Staff who worked within the multi-agency arena were reminded of their responsibility as a core group member to challenge fellow colleagues if a plan is not felt to meet the needs of a child.

Single Agency Audits

A programme for monitoring single agency audits has been put in place. In 2013/14 all agencies were requested to provide their audit schedules for 2013/14 and 2014/15. The Subcommittee has received summaries from all agencies (after additional challenge) of key findings from their own audits.

In February 2013 my agency (Brighton & Sussex University Hospitals NHS Trust) undertook an audit to establish if all children with a Child Protection Plan who have hospital notes are flagged. All notes were checked as part of this audit and all were found to have been flagged correctly, giving assurance that the process was working correctly; this will be re-audited in 2014.

We also did an audit of the safeguarding and public health aspect of maternity notes from the hospital. We wanted to do this to provide an overview of the documentation of child protection, domestic violence and mental health enquires and referral forms, to ensure that midwives assess pregnant women for safeguarding risk factors and refer them to supportive services and also we wanted to create opportunities for continuous practice improvement and development of expertise. We found that booking information is completed well in most cases, however, there were some improvements which could be made to assist better communication about this area of practice.'
Debi Fillery, Nurse Consultant for Safeguarding Children & Young People, Brighton & Sussex University Hospitals NHS Trust

Complaints Regarding Child Protection Conferences

The LSCB has dealt with 4 complaints about Child Protection Conferences during 2013/14. The decisions were reviewed by a multi-agency panel made up of LSCB members who have no involvement in the case. This is in line with the Pan-Sussex Child Protection and Safeguarding Procedures. The options open to the panel are either to uphold the decision of the original Child Protection Conference or to reconvene the conference with a different chairperson. However, the original Child Protection Conference decision stands whilst the complaint is investigated.

The nature of these complaints were:

- Complaint 1 – Complainant unhappy that her children have remained on the Child Protection register after the latest RCPC (Review Child protection Conference). She doesn't understand why that is.
- Complaint 2 – General complaint about the Child Protection Conference.
- Complaint 3 – Complainant was only allowed in the Child Protection Conference for 5 minutes. She did not feel that she was heard and was made to feel unimportant.
- Complaint 4 – Complainant was unhappy with how the Child Protection Conference went.

No complaints were upheld. In the case of complaints 3 and 4 similar issues were highlighted: the importance of explaining thinking and reasoning to young people when attending conferences and to do so in a language they understand; the importance of good communication between the social work team and the Independent Reviewing Officer prior to a conference; and the importance of remembering how invasive and stressful Child Protection Conferences can be for young people.

The above complaints and the feedback received from children and young people on their experiences of Child Protection Conferences (which you can read on page 40), demonstrates that there remains work to be done in supporting young people to participate fully in their Child Protection Conferences.

Section 11 Audits

Section 11 of the Children Act 2004 requires agencies to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. The Section 11 Audit is the Brighton & Hove Local Safeguarding Children Board's (LSCB) method of assessing the safeguarding arrangements in place across the key partner agencies within Brighton & Hove.

The most recent Section 11 audits were completed by 31 March 2014, which a 'Section 11 Challenge Event' taking place on 30 May 2014. The findings and recommendations from the Challenge Event will be made available to the Board September 2014.

A revised self-assessment audit tool (devised in conjunction with East and West Sussex Local Safeguarding Children Boards) was used by agencies working with children, young people, and families to self assess their own safeguarding arrangements. Agencies were asked provide evidence where possible to support responses. In relation to the Community & Voluntary Sector Safeguarding, the Section 11 response was compiled by the elected voluntary sector representative, Terri Fletcher, with support from Community Works. All of the medium to large voluntary sector organisations working with children, young people and families across the city that are commissioned for services, were asked to complete a Section 11 audit.

In summary, findings appear to emphasise that there is commitment and engagement of senior management officers across a range of agencies in Brighton & Hove, demonstrating that the safeguarding & child protection agenda is placed at the appropriate level within individual agencies. Whilst senior management assurance is there, it was accepted that there is a need for organisations to set themselves high standards to create a 'Culture of Safeguarding,' where all staff in their organisations understand the importance of safeguarding and promoting the welfare of children. Attendance at LSCB meetings was recognised as needing improvement, but also as a challenge due to capacity and staff absence.

There was good attendance and engagement. I think that senior colleagues giving this time is very important. As CEO of the LA with the Chair of the LSCB accountable to me, I think this is a very tangible way of my demonstrating my commitment and accountability and using my experience of safeguarding and child protection.

Penny Thompson CBE
Chief Executive, Brighton & Hove City Council

There were positive common themes across agencies, these included:

All statutory agencies have established or, in the case of East Sussex Fire & Rescue Service and Police, are in the process of establishing safeguarding polices and procedures for staff that are easy to access.

Complaints and whistle-blowing procedures appear to be in place in all statutory agencies.

All statutory agencies have a clear accountability framework that covers individual, professional and organisational accountability for safeguarding children.

All statutory agencies reported they were either compliant or working towards compliance for ensuring equality of access for all sectors of the community.

All statutory agencies have in place a safer recruitment policy and records are maintained detailing checks carried out for employees in all agencies.

All statutory agencies reported they have effective interagency working at a strategic level.

All statutory agencies have in place agency-specific guidance on information sharing that is in accordance with Government guidance at both strategic and operational levels.

Some deficiency themes spanned a number of agencies, most significantly recognition and response to risk of Child Sexual Exploitation (CSE). It was recognised by all agencies that all were working towards an adequate response to the spectrum of risk covered by CSE. There was a view that, while this is not a new risk, widespread acceptance of the range and extent of the risks to children and young people was only recently brought to full attention. The importance of a comprehensive multi-agency recognition and response through the Multi-Agency Safeguarding Hub (MASH – more on this later) was agreed.

Other significant deficiency themes across a number of agencies included consideration of fathers, male partners and other significant adult males in the family in all assessments, online safety and safer recruitment.

What we will do next?

We held our first Section 11 Challenge Event at the end of May 2014. This is where we brought together the Chief Executives or deputies of Brighton & Hove LSCB partner agencies, those with a responsibility for promoting positive outcomes for vulnerable children through their professional roles, to challenge other services on their Section 11 audits. The Challenge Event offered all an opportunity to seek assurance that safeguarding children is effective amongst and between Board partners across the city so as to promote, improve and ensure best practice. We will now take forward the recommendations resulting from the audit and the subsequent Challenge Event.

Private Fostering

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

Current arrangements for the regulation of private fostering originate from concern following the death of Victoria Climbé in 2000. Victoria was privately fostered by her great aunt.

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

In 2013/14 a range of initiatives were undertaken to highlight the notification arrangements to existing and potential private foster carers, voluntary and statutory agencies, and members of the public as follows:

- Four half-day training sessions were delivered to approximately 70 social workers from ACAS & CIN in Oct & Dec 2013.
- A Private Fostering awareness raising event with Language Schools/Colleges took place in March 2014. The event was very well attended and it provided an opportunity for the department to establish (from the schools & colleges) whether any of their students (under 16) were living in private fostering arrangements.
- The LSCB multi-agency private fostering training has been refreshed in 2013/14 and a new programme will start in Sept 2014 to be delivered each quarter.
- Brighton & Hove continues to have detailed and thorough information about Private Fostering available via the Council website with dedicated web pages of information and links to other sites. In addition, the LSCB has used social media to raise awareness about private fostering including Private Fostering Week (July 14), links to the BAAF 'Somebody Else's Child' campaign material and information in the LSCB electronic newsletter.

In 2013/14 the Local Authority Private Fostering Annual Report was presented to the LSCB. Following discussion East Sussex Fire and Rescue Service said they would be happy to offer safety checks for homes of Privately Fostered Children and a Lay Member suggested youth sports teams should be made aware of Private Fostering as they are well placed to make referrals.

Monitoring Compliance with Duties and Functions

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

New PF Arrangements during the year	2011-12	2012-13	2013-14
	4	17	34

Private Fostering activity has increased in 2013/14. At the start of the year (1 April 2013) there were 9 children reported as being in private fostering arrangements. During the year,35 new notifications were received and thirty four were confirmed as being private fostering within the definition.

All new notifications received an initial visit, with 97% taking place within 7 working days. The England average for 2013/14 is 80%.

This year Children's Services provided mandatory training to social workers on private fostering and statutory requirements. Consequently, we saw an increase in the percentage of cases where visits to children were carried out within the timescales required by Regulation 8 of the Private Fostering legislation (which is at least 6 weekly in the first year). At 77% this is an improvement on the previous year (59%) and above the England average of 67% (2013-14).

In 2013/14 most children living in private fostering arrangements are aged 10 to 16 and one child is aged 5-9. Five children were born in the UK and thirty children were born overseas.

Twenty six arrangements ended during the year, leaving a total of 17 children in Private Fostering arrangements at 31 March 2014.

Reason why the Arrangement Ended: (Using data fields proposed by Ofsted, Jan 14)	Number
Overseas child returned voluntarily to country of origin	5
Overseas child returned to country of origin via Home Office intervention	0
UK born returned to parents	1
Became 'looked after child'	0
Educational/sporting/vocational opportunity ended	0
Child turned 16 (or 18 if disabled)	14
Moved to another private fosterer	1
Other	5
Total	**26**

Note: Of the 'Other,' 4 young people moved from the host family to the residential part of the college; one further arrangement was deemed to be unsuitable and the young person was moved to alternative accommodation.

Under the National Minimum Standards for Private Fostering each local authority is required to report annually to the Chairperson of the Local Safeguarding Children Board on its assessment of the welfare of privately fostered children. The Council's report for 2013/14 will be presented to the LSCB in 2014.

Management of Allegations of Adults who work with Children

Working Together to Safeguard Children (2013) contains the statutory guidance surrounding this issue and requires the local authority to investigate any situation where a person may have:

- behaved in a way that has harmed, or may have harmed, a child;
- possibly committed a criminal offence against, or related to, a child or;
- behaved toward a child or children in a way that indicates they may pose a risk of harm to children

There is no current nationally agreed data set for allegations against people working with children, making comparison of data between Local Authorities difficult. This year the Sussex regional LSCB's agreed to adopt the LADO data set used the by Thames Valley authorities as a step towards a uniform reporting set. The following data will be requested annually and it is hoped this will aid comparison across areas in forthcoming years. Currently data is not collected in relation to allegations that refer to historic events. This will be included in 2014/15 data set.

Referrals by Employer and Type:	Neglect	Suitability	Sexual	Emotional	Physical	ICT	Total	%
Children Social Work Services		10			4		**14**	**6.4%**
Early Years Services	1	32	2	1	9		**45**	**20.5%**
Faith			2		1		**3**	**1.4%**
Foster Care	6	15	6	2	4		**32**	**14.9%**
Health	1	8	5			1	**14**	**6.4%**
Other		1					**1**	**0.5%**
Police				1			**1**	**0.5%**
Probation		1					**1**	**0.5%**
Residential LA	1	1					**2**	**0.9%**
Residential Non LA		4	1	1	1		**7**	**3.2%**
Schools	1	53	5	2	16		**77**	**35%**
Self Employed					1		**4**	**1.8%**
Transport		3	3			1	**6**	**2.7%**
Voluntary Org		8	2				**10**	**4.5%**
Youth Services		3					**3**	**1.4%**
Total	**10**	**142**	**26**	**7**	**36**	**2**	**221**	**100.0%**

Previous Department for Education research indicates a growing trend of increasing referrals over the past 4 years. This is no different in Brighton & Hove:

2010/11	2011/12	2012/13	2013/14
16	112	184	221

There have been fewer instances of poor reporting by agencies to the LADO. Those cases where reporting was an issue resulted in meetings and improved outcomes through organisational learning.

Of the 221 referrals in 2013/14, 68 involved employees of Brighton and Hove City Council (BHCC) which represented services across Schools, Early Years, Youth, Residential and Children's Social Work Services. School environments and the teacher/pupil relationship continued to total the most significant number of allegations made (77) representing 35%.

Children's Social Work Services data is made up of a variety of professionals working with and for children, including sessional workers and independent/contracted staff. 9 of the 14 cases involved BHCC staff and 4 of these involved qualified social workers regarding their 'suitability' to work with children. 3 cases were 'unsubstantiated', the other 'substantiated' and resulted in individual learning.

There has only been one incident involving a lack of compliance regarding allegations procedures during 2013-14 involving maintained schools. The outcome led to organisational learning for the school and subsequent improved liaison with the LADO. The increased reporting is relative to the general increase nationally and locally the past few years. This is likely to be attributable to the role of the LADO having a raised profile amongst agencies and the impact of high profile cases in the media involving teachers, members of various faiths and celebrities.

The trend relating to the significant increase in the number of referrals relating to the suitability and conduct of professionals continues – 64% of all referrals in 2013-14 compared to 46% in 2012-13. Issues within an individual's private life can raise concerns about their suitability and eligibility to work with children.

The number of referrals regarding Local Authority foster carers has increased from 13 in 2012-13 to 23 in 2013-14. It should be noted that the way in which allegations against foster carers are recorded has changed, with both foster carers being reflected in the figures even if the allegation is against one individual carer. Of the 23 allegations against foster carers, 7 were couple carers and were therefore counted as 14 in the total figure. There are 3 ongoing criminal cases, all of these from Dec 13/Jan 14 and involve complex, police led investigations into alleged historical abuse against 3 individuals who have foster care partners.

Allegation Outcomes[1]:

The outcome finding of 'unsubstantiated' is one that continues to cause the most difficulty for everyone concerned in the allegation against staff process, particularly employees who consider they have been found 'not guilty'. The importance of all organisations in following allegations procedures has been highlighted by a number of high profile media cases and serious case reviews where investigative processes have been flawed and agencies and employers have not followed procedures.

	Substantiated	Unfounded	Unsubstantiated	Not Known	Malicious	False
Children Social Work Services	3	3	8			
EYS	29	7	8		1	
Faith	1	1	1			
Foster Care	17	2	9	3		2
Health	8	2	4			
OTHER	1					
Police	1					
Probation		1				
Residential LA	1		1			
Residential Non LA	5	2				
Schools	40	11	25		1	
Self Employed	3	1				
Transport	4	1		1	0	
Voluntary Org	9		1			
Youth Services	2	1				
Total	**124**	**32**	**57**	**4**	**2**	**2**

[1] Definitions: **Substantiated –** A substantiated allegation is one which is supported or established by evidence or proof. **Unfounded –** This indicates that the person making the allegation misinterpreted the incident or was mistaken about what they saw. Alternatively they may not have been aware of all the circumstances. For an allegation to be classified as unfounded, it is necessary to have evidence to disprove the allegation. **Unsubstantiated –** An unsubstantiated allegation is not the same as a false allegation. It simply means that there is insufficient identifiable evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence. **Malicious –** This implies a deliberate act to deceive. For an allegation to be classified as malicious, it is necessary to have evidence, which proves this intention. **False -** there is sufficient evidence to disprove the allegation

HR Outcomes:
There is a range of responses by employers following the conclusion of a management investigation into an allegation against a member of staff. These must be proportionate and ensure children are protected from harm.

The use of alternatives to suspension is actively discussed at Strategy Meetings and this message is reinforced by the updated Department for Education Guidance, Keeping Children Safe in Education 2014. Of the 34 individuals 'suspended', 15 were 'reinstated' following investigation.
There have been no instances reported in the past year of pupil exclusions regarding allegations deemed to be 'malicious' in schools. This is the same as last year.

Referral Outcomes:
The outcome of no further action after Initial Evaluation[2] has seen a significant rise in 2013-14, 60% up from 31.5% in 2012-13. Criminal investigations decreased to 21.3% from 31.5% in 2012-13; s.47 investigations have also decreased to 12.2% from 13.6% in 2012-13. Significantly, disciplinary procedures have increased the past 3 years from 24% (2011-12) to 43% (2012-13) to 53.85% in 2013-14.

The data appears to demonstrate employers understanding that an employee's conduct and suitability may meet the threshold for contacting the LADO, resulting in fewer safeguarding procedures being initiated, but where disciplinary action has been necessary. Previously the LADO was only contacted when significant and more obvious incidents occurred. There is a 'grey area' between conduct and suitability (disciplinary) and significant harm (s.47/police) in which advise should be sought from the LADO to determine if it meets the criteria. In referring those in the 'grey area' there has been an increase in suitability category and less in formal safeguarding procedures. The Allegation Management Procedure within Brighton & Hove appears to be well embedded in a range of statutory and voluntary organisations. There is always more work to be done to raise the profile across all services and employers and this will continue. In Children's Services the LADO plans to attend Team Meetings across services, including induction meetings with the Learning Development Officer and Newly Qualified Social Workers.

[2] **No further action after Initial Evaluation:** Refers to the initial discussion with the referrer, and this may include Children's Services and/or the Police about whether the alleged incident falls within the scope of these safeguarding procedures. Following the initial discussion/inquiries there may be no need for further action under these procedures. Further assessment or investigation may be undertaken in accordance with other Regulatory frameworks such as the Assessment of Children in Need (Section 17 C.A'89), or via an employer's disciplinary procedures.

	Strategy Discussion	Section 47	Police Investigation	Charge	Conviction	Internal Investigation	NFA after initial evaluation
Children Social Work Services	2	2	2			8	8
EYS	6	5	8	3		23	33
Faith							2
*Foster Care	16	7	10			13	13
Health	3		3	1	1	7	8
OTHER						1	0
Police							1
Probation							1
Residential LA	1					1	1
Residential Non LA	4		3	1	1	9	11
**Schools	16	10	12	4		45	48
Self Employed		1	2	1			1
Transport	2	1	5			2	
Voluntary Org	4	1	2	1		8	5
Youth Services	1					2	2
Total	**55**	**27**	**47**	**11**	**2**	**119**	**134**

Child Death Overview Panel

The Child Death Overview Panel (CDOP) is the inter-agency forum that meets regularly to review the deaths of all children normally resident in East Sussex and Brighton & Hove. It is a sub-group of the two Local Safeguarding Children Boards (LSCBs) for Brighton & Hove and East Sussex and is therefore accountable to the two LSCB Chairs, Reg Hooke, Chair of East Sussex LSCB and Graham Bartlett, Chair of Brighton & Hove LSCB. If during the process of reviewing a child death, the CDOP identifies the following then a specific recommendation is made to the relevant LSCB(s).

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

During 2013-14 there were no recommendations made to the LSCBs regarding the need for a serious case review. Some recommendations were made regarding matters of concern about the safety and welfare of children and wider public health concerns. These included recommending to the East Sussex LSCB that:

- East Sussex LSCB should recommend that West Sussex LSCB consider asking Police Traffic Management to review speed restrictions and other road safety measures for schools within West Sussex.
- When the Rapid Response Procedures are reviewed there should be discretion given to the paediatrician and police involved at the time of the death to exercise professional judgement as to whether all of the Rapid Response Process has to be followed.

Recommendations made to the Brighton & Hove LSCB were that:

- That the issue of enabling greater discussion between clinicians involved in the care of the child and the pathologist/coroner at the time of the post mortem/inquest should be pursued.
- The LSCB to explore how to raise the profile nationally of the benefits of breast milk banks so as to reduce the risks of babies developing of Necrotizing Enterocolitis (NEC).

There were additional recommendations made to member agencies of both LSCBs which related to issues specific to particular case histories and not necessarily having general relevance.

Organisation of the Child Death Overview Panel.
Fiona Johnson is the Independent Chair of East Sussex and Brighton & Hove CDOP. The panel members comprise representatives from key partner agencies who together have expertise in a wide range of issues pertinent to children's well-being and are listed below:

Fiona Johnson –Chair
Carolyn Baillie – CDOP Coordinator
Jane Mitchell - South East Coast Ambulance NHS Service Foundation Trust
Edmund Hick – Sussex Police
Ali Jenkins - Specialist Nurse for Child Deaths
Deb Austin – Head of Safeguarding
Dr Anne Livesey - Designated Paediatrician
June Hopkins – Designated Nurse
Lydie Lawrence - Public Health
Fiona Rose – Named Midwife
Dr Cassie Lawn – Neonatologist

The administrative work of East Sussex Brighton & Hove CDOP is organised by the CDOP Coordinator, with support from the CDOP Chair and other panel members.

National Developments, Challenges and Achievements.
Working Together 2013 was published in March 2013 which reaffirmed the role and function of the Child Death Overview Panel. The CDOP works within the context of the Learning & Improvement Framework which covers a range of reviews and audits of which the CDOP is a part. CDOPs are required to report annually to the DfE on the functioning of the Panel and this year the data return required even greater detail about the outcome of case discussions. Last year a national research project on how public health data from CDOPs are collected and analysed was undertaken during 2013. Findings from this research highlighted the missed opportunities to capitalise on the work of CDOPs by the failure by Government:

> '…to collect, analyse and disseminate local CDOP data nationally. There was a clear and vociferous call from CDOP staff and chairs for a proper national system of collecting, analysing and reporting CDOP data which would enable appropriate alerts and alarms to be issued and which would provide a focus for national information sharing and learning.'[3]

To date the Government has not indicated what if any action will be taken in response to this research.

[3] Jennifer J Kurinczuk & Marian Knight National Perinatal Epidemiology Unit University of Oxford Child death reviews: improving the use of evidence Research Brief DfE October 2013

Local Developments, Challenges and Achievements.
An audit of the rapid response process across Sussex was undertaken during Spring 2013 and findings from this audit were presented to the CDOP during 2013. Local procedures have been reviewed during 2013 in response to the findings from the audit and the changes in Working Together 2013. Parents have contributed to the CDOP process by providing feedback on services received. This has continued throughout 2013 and parents have contributed to most reviews about children who die beyond the neonatal period. The CDOP continues to work closely with the Coronial Service providing coroners with information and receiving information from them.

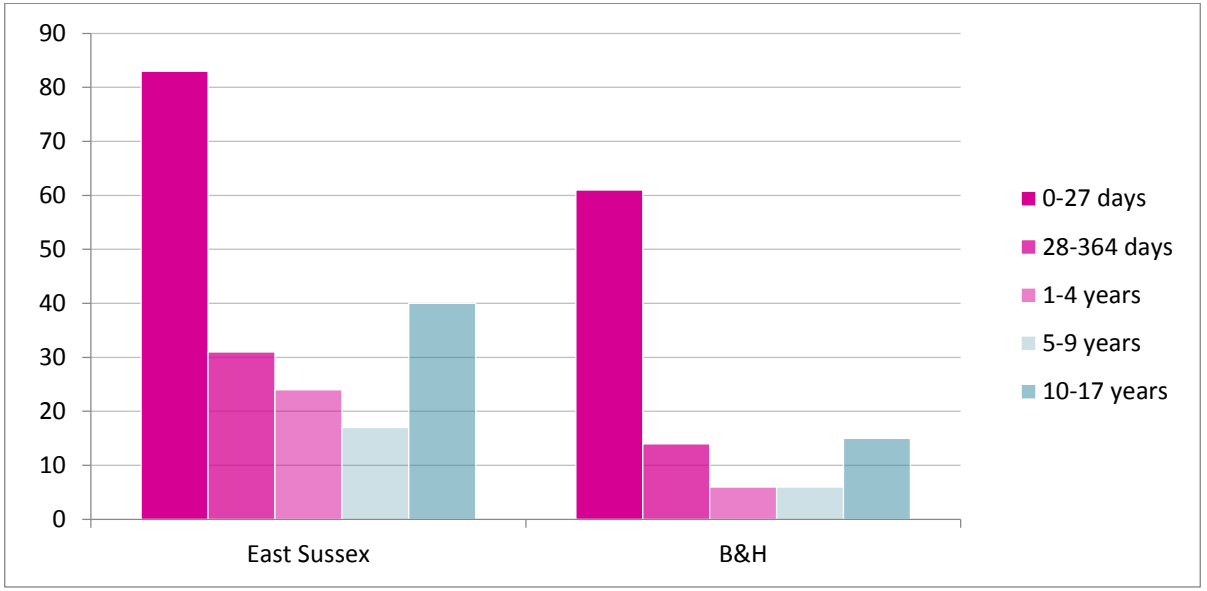
The CDOP has held 15 meetings in the past year (including 4 Brighton & Hove neonatal panels and 5 East Sussex neonatal panels).
The main work of the panel is to review the deaths of all children who die across East Sussex and Brighton & Hove, on behalf of the two Local Safeguarding Children Boards (LSCBs). Between April 2013 and March 2014 the CDOP was notified of 52 deaths of children who were resident in East Sussex (36) and Brighton & Hove (16) which is an increase in numbers of deaths since last year. The CDOP has reviewed a total of 44 (26 East Sussex & 18 B&H) deaths during 2013/14. There will always be a delay between the date of a child's death and the CDOP review being held; of the 18 Brighton & Hove reviews completed in 2013/14 7 were completed within six months. This is a significant deterioration in performance which can be explained in part by sickness on the part of the CDOP administrator. The purpose of the review is to determine whether the death was deemed preventable, that is one in which there are identified modifiable factors which may have contributed to the death. If this is this case the panel must decide what, if any, actions could be taken to prevent such deaths in future. Of the 240 deaths reviewed between 2008 and 2014 thirty have been identified as having factors which may have contributed to the death and could be modified to reduce the risk of future deaths. Of the eleven reviews that were completed during the year that had modifiable factors nine related to babies. Modifiable factors included inappropriate sleeping arrangements for babies and high risk pregnancies where there were problems with the obstetric and midwifery care. All of the cases reviewed were very different and there were no obvious patterns or trends that could be identified.

Child Death data
In Brighton 20% of the population are aged under 18 years (55,000 out of 273,000). This compares to 23% for the South East region and for England. (Source: Census 2011)

All deaths notified to CDOP from 1st April 2008 to 31st March 2014	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	**Total**
Brighton & Hove	16	20	11	21	18	16	**102**

Deaths notified to CDOP last year showed a slight decrease which is within the expected range for the areas. The mean and median average figure over the six years is 17. Data will need to be monitored for a much longer period before trends can be identified.

Age at death of all children notified to CDOP 2008 – 2013



The age distribution of deaths in children follows an expected pattern linked to national trends with most deaths being seen in children in the first month of life followed by deaths in the first year of life, with an increase in deaths during adolescence.

Ofsted

No Ofsted inspection was undertaken of the Local Authority or LSCB in 2013/14. However, there is still a comprehensive service improvement plan underpinning future inspections following an unannounced Ofsted Inspection of Safeguarding and Looked After Children in March 2011.

Key issues noted for action from the 2011/12 inspection were:

- the LSCB's lack of capacity to undertake quality assurance work and large scale audit work;
- the consistency of multi-agency work;
- developing a greater mutual understanding of each other's practice quality; and
- the depth of understanding of race, culture and identity across the children's workforce.

As you will have read, the LSCB now has in place a functioning Monitoring & Evaluation Subcommittee, which is chaired by an independent person who has lead on developing a quality assurance programme for the Board. Throughout 2013/14 a Designated Nurse for Child Protection was allocated one day a week for Brighton & Hove LSCB audit work. Improvements in the consistency of multi-agency work have been consistently gauged through further audit work. Single agency audits have been routinely presented to the Monitoring & Evaluation Subcommittee. Issues relating to race, culture and ethnicity have in part been addressed through the LSCB's Learning & Development Mission Statement, see Appendix 3 and the LSCB multi-agency training programme.

Key focus points the Local Authority and the LSCB have been working on for inspection include:

- Audit Practices, both single and multi agency
- Child Sexual Exploitation
- Missing Children, from Care, from Home, & from School
- Early Help and the system as a whole
- Disseminating and optimising learning from Serious Case and Learning Reviews

Serious Case Reviews (SCRs)

As per *Working Together to Safeguard Children* (2013), LSCBs are required to consider whether to initiate a serious case review when a child dies (including death by suspected suicide) or is seriously injured, and abuse or neglect is known or suspected to be a factor. The main purpose of a serious case review is to learn lessons to improve the way in which agencies and professionals work both individually and collectively to safeguard and promote the welfare of children.

Brighton & Hove LSCB intends to use the Social Care Institute for Excellence's (SCIE) Learning Together model for investigating SCRs. This methodology had been highlighted in the Munro Review of Child Protection (2011). Staff from the LSCB and in LSCB partner agencies have been trained using the SCIE model throughout 2013/14, in preparation for reviews. This ensures the LSCB has the capacity and experience 'in house' to undertake reviews.

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

In 2013/14 one Serious Case Review was initiated and findings are pending as at 31 March 2014. This Serious Case Review is being carried out using the SCIE Learning Together model.

Liam's Story
Liam was just a few weeks old when he was taken to hospital with multiple non-accidental injuries. A SCR was instigated because there were concerns that agencies did not share crucial information about Liam's father, which may have impacted on the outcome.

Liam's story raises a number of concerns. The risk care leavers might pose to their own or other children are not being adequately identified, meaning that they are left without the support they need as parents and children may go unprotected. In midwifery services, it would appear that social information is mainly sought in respect of an expectant mother rather than both parents, which means that important information impacting upon an assessment of risk may not be obtained. Information technology systems may not offer up easily accessible case history information on which to assess risk. Full findings will be presented to Brighton & Hove LSCB in 2014.

LSCB Business Plan 2013 – 2016 #yourLSCB's Key Priorities

The Brighton & Hove LSCB Business Plan was developed and further refined during a LSCB Development Day in July 2013. It reflects key objectives and actions needed in order to help make children and young people safer in Brighton & Hove. The Board selected these priority areas due to either their prevalence in the cases agencies see or because we believe them to be unseen or hidden forms of abuse which we need to work together to tackle. Alongside these priorities we decided that help given to children, before they suffer abuse, is a key area to develop. Early Help ensures that all children, and their families, who are experiencing problems get the support they need from a range of agencies before it's too late.

Priority Area 1: Responses to Specific Safeguarding Concerns

Children and young people in Brighton & Hove are protected effectively from

Neglect
Sexual abuse
and **Sexual exploitation.**

Priority Area 2: Participation & Engagement

- The views of parents, carers, children and young people are contributing to learning and practice.
- Parents, carers, members of the public, staff and managers have an improved understanding of the LSCB.
- Staff and managers are informing learning and improvement.

Priority Area 3: Service Responses

- The process for the early help assessment and the type and level of early help services to be provided is effective in meeting the needs of children and families.
- There is a prompt and assured response when referrals are made or new information is received about child care concerns.

Priority Area 4: Accountability

The Board is better coordinated and ensuring the effectiveness of what is done by partner agencies.

Priority Area 1: Responses to Specific Safeguarding Concerns

Children and young people in Brighton & Hove are protected from neglect.

30.5%

Of the 2,351 **single assessments** completed in 2013/14, 718 **(30.5%)** identified neglect as a factor at the end of the assessment.

33%

Of the 288 children subject of a **Child Protection Plan** as of 31 March 2014, 95 **(33%)** had neglect recorded as a category of abuse.

What making a difference will look like: Well-timed, good quality and noticeable involvement by everyone necessary, which shows us children are safeguarded from neglect.

What we did:
A neglect multi-agency audit was undertaken in 2013, findings & challenges were presented & discussed at Board in March 2014.

We are working on a multi-agency basis around neglect. We have undertaken a benchmarking audit described in this report, with a view to clarifying exactly what the issues are in the way we respond to neglect issues.
Deb Austin, Head of Safeguarding, Children's Services.

This was designed as a baseline audit with the purpose of evaluating current multi-agency practice before putting in place a Quality of Care assessment tool in an attempt to improve practice. The audit revealed that multi-agency working was a strength in all cases but there were a number of concerns that featured regularly in cases of neglect, notably:

- response to referrals focusing on events not trends
- periods of drift in some cases
- outcomes of interventions not tracked effectively
- insufficient attention to recording children's wishes and feelings.

A positive aspect of this audit was the seeking of feedback from parents.

What we will do next:
A follow up audit will take place later in 2014/15 to evaluate the impact of the new assessment tool.

The LSCB training programme includes three 'core' child protection courses, which contain neglect case studies. A specific LSCB Neglect training course in 2014/15 will incorporate learning from the first multi-agency audit as well as training front line practitioners to use a new Quality of Care Assessment Tool following its use in pilot cases.

In 2014/15 there will be a LSCB Safeguarding Board Bulletin that will feature information and updates for professionals on city wide activity in response to Neglect.

My agency undertook a single agency neglect health retrospective review of 12 months, looking at 16 cases, 44% female and 56% male ranging from 7 months – 10 years. This concluded that a significant amount of information can and should be gained prior to health medical, the medical team could be more standardised in the assessment documentation and that medicals are time consuming but do provide a concise summary and do identify unknown health needs for the child. These findings were shared with colleagues from across agencies in the city at Brighton & Hove LSCB's Monitoring & Evaluation Subcommittee in February 2014.
Ann White, Named Doctor,
Sussex Community Trust.

In my agency Named Professionals have been involved in a multi agency neglect working group which has involved a multiagency neglect audit .I am a Named Nurse and also the Board lead for neglect, I am leading a pilot with the Principal Social Worker on developing Quality of Care tool for practitioners .

Yvette Queffurus Named Nurse Safeguarding Children
Sussex Community Trust

Significant numbers of children affected by family drug and alcohol use experience neglect. Brighton Oasis project was able to work with a significantly higher number of children this year due to increased funding via Charitable Trusts. Provision of a service to children in their own right ensures they have a safe, confidential space to express their feelings, reduce isolation and build self-esteem. In the last year, Young Oasis has offered child centred arts and play therapies to 77 children and young people. Many of the children have experienced neglect and disruption including time in foster care or living apart from their birth parents permanently. Their monitoring using the New Philanthropy Capital (NPC) wellbeing tool shows significant increases in the following aspects of wellbeing after the therapeutic intervention; Satisfaction with Friends, Community, with School and increased life satisfaction.
Terri Fletcher, Director, Safety Net.

Children and young people in Brighton & Hove are protected from sexual abuse (CSA)

What making a difference will look like: Well-timed, good quality and noticeable involvement by everyone necessary, which shows us children are safeguarded from sexual abuse.

What we did:
In February 2014 a Child Sexual Abuse (CSA) audit was undertaken as a follow up to an audit carried out in 2012. The 2012 audit concluded that there were gaps in both recording and service delivery and recommended a further audit 12 months hence to look at progress. An action plan from the 2014 is in place which aims to ensure:

- strategy discussions are multi-agency and, as a minimum, include involvement by relevant health disciplines
- records of children who have made allegations of CSA are clear, accurate, up to date & include relevant information
- all children are spoken to in households where there are allegations of CSA
- better recording of Police requests for medical examinations or rationale for why no request is appropriate
- Pan-Sussex joint investigation training for police and social workers should include a refresher session on responding to CSA referrals and recording.

6.1%

Of the 2,351 **single assessments** completed in 2013/14, 143 **(6.1%)** identified sexual abuse as a factor at the end of the assessment.

Of the 288 children subject of a **Child Protection Plan** as of 31st March 2014, 20 **(6.9%)** has a category abuse of sexual abuse recorded.

6.9%

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Sussex Community NHS Trust undertook a CSA medical profile retrospective review over 12 months (January 2012 – December 2012) involving 35 cases. One of the recommendations from this audit was to continue to request Achieving Best Evidence (ABE) prior to the CSA Health Assessment medicals. This benefits the child as they do not have to keep repeating the details, and helps the medical staff know what focus to put on the examination.
Ann White, Named Doctor, Sussex Community NHS Trust

Children’s Services have been part of the multi-agency audit on child sexual abuse discussed within this report. It was helpful to get an interagency perspective on what the strengths and what the areas of development are in working these complex cases.
Deb Austin, Head of Safeguarding, Children’s Services.

What we will do next:
An Interagency Forum on CSA is proposed for early 2015. This will include staff working with children & families in Brighton & Hove to a forum style recognition and awareness-raising session.

In 2014/15 there will be a LSCB Safeguarding Board Bulletin, which will feature information and updates for professionals on city-wide activity in response to CSA.

Metrics in relation to CSA will continue to be reported to the Board via the Management Information Report.

Paediatricians from Brighton & Hove are working with colleagues across the county and NHS England to establish a Paediatric Sexual Abuse Referral Centre (SARC) with excellence and equity of care across Sussex for children up to and including the age of 13 years. The service model is more than the medical examination and includes the provision of support in a seamless manner. The aim being to have Crisis workers (support staff) trained to work with children and families involved from the outset, followed by counselling /therapy services provided local to the child's home. We are delighted to hear that funding for Child Independent Sexual Violence Advisors (CISVA's) to support families across Sussex has been secured. This enhanced service will improve quality of care for sexually abused children across Sussex and are hopeful that it will become fully available in 2015.

'CCG commissioners are working with providers to ensure victims of CSA receive appropriate therapeutic support.'
June Hopkins, Designated Nurse, B&H CCG

Safety Net and the Survivors Network have received funding to provide support and preventative services to young people at risk of and who have experienced sexual abuse. The work includes school based activities, a group work programme, counselling and a residential.
Terri Fletcher, Director, Safety Net

As paediatricians we are guided by children's disclosures and behaviours that might/do indicate CSA. This is a challenging area and sharing of information, recent and crucially historically, and effective joint meetings is vital to ensure these vulnerable children are protected and supported. Working together helps us to understand each agencies roles better and share knowledge in an area that is often complex and that may be lacking any concrete evidence of CSA
Jamie Carter Designated Doctor and Board lead for CSA

Children and young people in Brighton & Hove are protected from sexual exploitation (CSE)

This year has shown that data surrounding children at risk of sexual exploitation is not sufficiently robust. We are putting this right.

What making a difference will look like: Well-timed, good quality and noticeable involvement by everyone necessary, which shows that children are safeguarded from sexual exploitation.

An LSCB Child Sexual Exploitation Strategy with actions in place for the next two years.

What we did:
In July 2013, Brighton & Hove LSCB confirmed Child Sexual Exploitation (CSE) as a priority area. Since this time CSE has been adopted by the Violence against Women and Girls (VAWG) Programme Board, with an action plan developed from the CSE strategy implemented and monitored by the VAWG Programme Board, within the Community Safety, Crime Reduction and Drugs Strategy for 2014 – 17. The VAWG Programme Board is accountable to the Safe in the City Partnership Board. The Brighton & Hove LSCB Independent Chairperson sits on the VAWG Programme Board.

The VAWG is responsible for commissioning services and Brighton & Hove LSCB are responsible for scrutiny and assurance of them. This joint approach is unusual and has attracted interest from the South East region.

A quarterly CSE Steering Group, under the auspices of the VAWG and attended by the LSCB Business Manager, supports the Community Safety Partnership/Police/LSCB strategic plans and monitors ongoing prevalence and responses to CSE. This is chaired by Detective Chief Inspector, Head of Safeguarding, Brighton & Hove Division, Sussex Police, who is also a lead professional operating within the LSCB as a CSE lead. You may read his update later in this report.

There is a Pan-Sussex CSE Strategy, as well as a joint Brighton & Hove LSCB and VAWG Programme Board CSE Strategy 2013-16 and action plan. This action plan focuses on:

- raising awareness: across practitioners & within communities to reduce children and young people's vulnerability and improve early identification
- understanding what's happening: improving our evidence base
- developing a strategic response: joining up approaches across statutory and voluntary & community agencies
- improving interventions: improving support for victims & families and facilitating policing & prosecutions in order to hold perpetrators to account

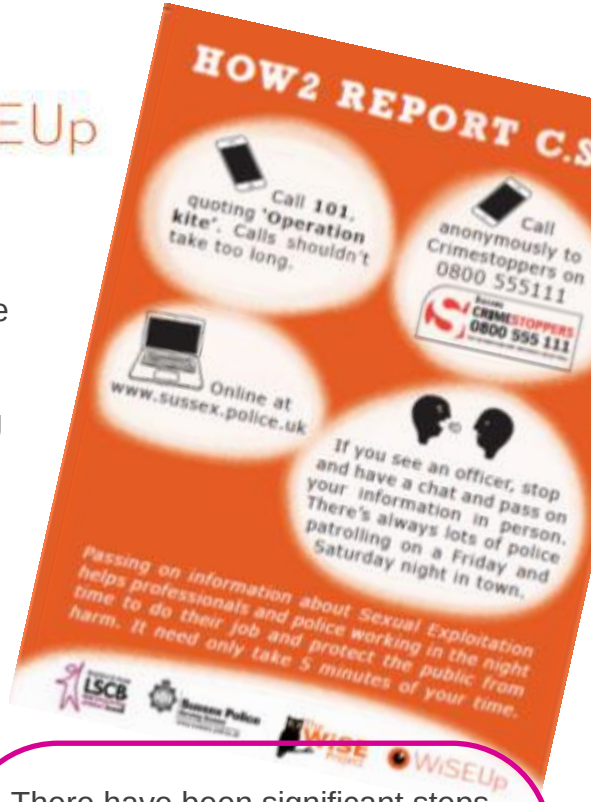
In addition there is a monthly multi-agency operational meeting (Red Operation Kite) the purpose of which is to share information among relevant agencies and identify those children and young people (age 12 - 25) in Brighton & Hove at high risk of sexual exploitation. A scoping exercise and strategic problem profile has been undertaken in relation to CSE, which has collated the multi-agency intelligence picture in Brighton & Hove.

WiSE[4] provides 'Preventing and Disrupting the Sexual Exploitation of Children & Young People' training for frontline professionals on behalf of the LSCB. Further information on this course is detailed later within this report. The number of professionals who have received training is 367, more on this later in the report.

In March 2013 the LSCB started work on a Safeguarding Board Bulletin. This featured information and updates for professionals on city-wide activity in response to CSE. This included details on the event that was run on 28 March 2014 in partnership between The WiSE Project, & Sussex Police which aimed to raise awareness of CSE amongst workers in the Night Time Economy in Brighton & Hove. It mirrored the National Working Group's 'Say Something if You See Something' Campaign.

The table below shows the number of cases worked by WiSE during the year ending 31 March 2014.

Cases worked by WISE Latest Year Ending March 2014	Number
Number of young people case worked	86
Number of young people receiving a joint intervention	12
Number of lead professionals advised/provided with tools	31
Number of drop-ins/outreach/detached sessions	124
Numbers of targeted peer groups	12



There have been significant steps in responding to the needs of children and young people at risk of CSE & missing during the past year. There is a comprehensive missing procedure in place and some excellent interagency working, as evidenced by the Red Op Kite CSE meeting and Operation Pipeline, a police investigation into localised sexual exploitation of children'
Deb Austin, Head of Safeguarding, Children's Services.

[4] The WiSE Project is a service for 13-25 year olds who are experiencing sexual exploitation or are at risk of experiencing it. The project is also a point of call for advice and guidance for those working with young people who have suffered from sexual exploitation.

What we will do next:
In 2014 the Brighton & Hove LSCB Vulnerable Children Monitoring Group was established which scrutinises the operational responses made by a number of groups in the City whose work supports a specifically vulnerable cohort of children, including those who are missing, privately fostered as well as those who are at risk of CSE.

In 2014/15 Brighton & Hove LSCB will be auditing a selection of cases held by Red Operation Kite. The audit tool will look at interagency working, responding to risk, outcomes for the young person, how the young person's voice is represented, and how this is understood within a professional network.

We will be looking at how to better support professionals to recognise and respond to the risk of CSE via training opportunities.

Sussex Partnership NHS Foundation Trust, are working towards engagement in all the relevant local groups looking at child sexual exploitation at both a strategic level and at operational level with clinical and managerial leads appointed to these groups. Staff in Children and Adolescent Mental Health Services (CAMHS) are familiar with and have started using the sexual exploitation risk assessment framework (SERAF) to support their work and recognition of CSE. We have been proactive in our approach to recognising and responding to the risks posed by CSE. An awareness raising session has taken place with Safeguarding Link Practitioners and a brief has been delivered to operational managers across adult services as well.
Zo Payne, Designated Nurse, Sussex Partnership NHS Foundation Trust

From 1 April 2013, all Local Authorities in England were required to record factors identified at the end of assessment 'in order to ascertain the child's needs, the parent's ability to meet those needs, and the impact of wider family and environmental factors.' Of the 2,351 Single Assessments completed during the year ending 31 March 2014, 143 (6%) identified Child Sexual Exploitation as a factor at the end of the assessment.

In Brighton and Hove, across a variety of agencies, we have reacted quickly to get better at looking after those children at risk of CSE. Red Operation Kite has been set up to flag CSE cases as early as possible and we now have interagency risk assessment conferences to ensure safety packages around those children most at risk. The development of the Multi-Agency Safeguarding Hub opening in September 2014 is yet another initiative to improve our response to this priority area of safeguarding.
Carwyn Hughes, Detective Chief Inspector, Head of Safeguarding, Brighton & Hove Division, Sussex Police (CSE Board Lead).

Priority Area 2: Participation & Engagement

The views of parents and carers are contributing to learning and practice.

Do you regularly obtain the views of children, parents & carers?

Do you ask what difference the service has made to their lives?

What making a difference will look like: Audits and other programmes evidence a link between quality assurance and feedback from parents and carers.

What we did:
Obtaining the views of parents and children in safeguarding work is underdeveloped because it is hard to do, especially in what can be the fraught nature of safeguarding work. Yet it is clearly a rich seam, not just in terms of understanding the quality and impact of services now, but as a source of learning and organisational development.

Brighton & Hove LSCB has challenged partners to demonstrate how the voice of parents and carers influences their work and the Monitoring & Evaluation Subcommittee requested all partner agencies provide reports on feedback they received from service users/their families. This was wide ranging, with clear evidence that agencies were taking feedback seriously and acting on it.

In March 2014 the LSCB Communications Strategy was approved, which is part of our effort to reach out to communities & particularly young people, so we can hear what they want most from the LSCB partners and get their views on how that should be delivered.

Brighton & Hove Children's Services undertook an exercise in seeking service user feedback during 2013/14, which was shared with the Monitoring & Evaluation Subcommittee. You can read the feedback throughout this report. Included in this was feedback from families after Child Protection Conferences. An example of feedback included:

- 60% strongly agreed and 36% agreed they were given the opportunity to give their views at conference
- 47% strongly agreed and 39% agreed that if their child was the subject of a Child Protection Plan they were clear about what needs to change or happen for the conference members to be able to consider ending the plan
- 50% strongly agreed and 41% agreed their views were listened to during the whole Child Protection process.

What we will do:
We will fully embed the Quality Assurance Framework (QAF). A key part of the framework will be to assess the impact that interventions & services have on users and their families, and their experiences. As part of this process, the views of parents and carers will be sought on a regular basis to inform learning and drive service improvement. We will need to receive and act upon the views and experiences provided via quantitative and qualitative data from single and multi-agency performance reporting and audits, Serious Case Reviews and other management reviews.

Lay Member recruitment to be undertaken throughout the Summer 2014. Parents and carers to be invited to apply to be lay members.

In any Serious Case Reviews and Learning Reviews the Brighton & Hove LSCB commission will work on the basis that, where practicable, families will always be involved in the process in recognition that their perspective can be very informative and may result in more meaningful findings.

The views of children and young people are contributing to learning and best practice.

What making a difference will look like: Audits and other programmes evidence a link between quality assurance and feedback from children and young people

What we did:
LSCBs must act on the duties outlined in the Children Act (2006) in that they are to listen to children, young people and their families and to draw on 'their insights when engaged in their other functions.'

The multi-agency audit on CSA asked for evidence of the child being spoken to and seen alone where appropriate, and also documentation of the child's wishes and feelings, as well as the child's understanding of the situation. 12 cases were audited, there were 4 cases where there were issues of concern (33%) and this was either Met or Not Applicable in 8 cases (66%).

Young people over the age of 12 are invited to attend their Child Protection Conferences and are offered support to do this by the Youth Advocacy Project. From October 2012 to March 2013 there were 68 cases that involved young people. Between January & June 2013 the Youth Advocacy Project got results from 13 young people through questionnaires following the conferences. An example of feedback includes:

- 62% felt that their views were taken into account, and 31% felt this was partly true
- 92% felt safer as a result of participating in their conference and 8% felt this was partly true.

We have tried to promote the direct participation and input of children and young people in the work of Brighton & Hove LSCB at a strategic and operational level. The Participation & Engagement Subcommittee, ran a short consultation with youth organisations on the ChildLine Report, which highlighted a rise in contacts about cyberbullying and self-harm in January 2014. Youth organisations (in-house and voluntary sector) were asked to discuss 3 questions with young people. The following young people responded:

- The Youth Council members (representatives from all the secondary schools and colleges and some youth groups) aged 11-19 (up to 25 with SEN)
- Youth Service universal provision aged 13-14 (group response)

Their responses, which linked the increase in cyberbullying with the increase in self-harm and suicidal thoughts, were fed into a LSCB newsletter which was circulated in February 2014 across a wide range of agencies working with children and families in Brighton & Hove. You can read their full feedback here.

What we will do:
As with ensuring the views of parents and carers are contributing to learning and best practice, the Quality Assurance Framework (QAF) process will seek the views of children and young people to inform learning and drive service improvement.

Lay Member recruitment will be undertaken throughout the summer of 2014. It will be targeted at care leavers, young carers, and young ambassadors.

In any Serious Case Reviews and Learning Reviews commissioned by Brighton & Hove LSCB, we will work to the basis that, where practicable, children and young people will always be involved in the process, in recognition that their perspective can be very informative and may result in more meaningful findings.

Parents, carers and members of the public have an improved understanding of the LSCB.

I am committed to supporting the Board to ensure that the views of children, young people and parents/carers are taken into account. In doing so we foster better relationships with youth and parent groups in the city and help raise the profile of Brighton & Hove LSCB. Most importantly, by focusing on the child's voice, their journey and their identity in our Board activities (such as the multi-agency audits, and then feeding these findings back to professionals) we enhance the importance of listening, hearing and recording the experience of the child.
Andy Reynolds, Director of Prevention & Protection, East Sussex Fire & Rescue Service & Chair of the Participation & Engagement Subcommittee.

What making a difference will look like: LSCB Communications Plan implemented.

What we did:
Throughout the year we have made sure that the Brighton & Hove LSCB website demonstrates and communicates about the LSCB's work and effectiveness.
We have, via Participation & Engagement Subcommittee activity, developed links and built relationships with existing parents' and carers' groups and forums.

Parents/Carers of the Parents' Forum database were emailed for feedback about the LSCB website and offered an opportunity to give further comments about future communications with the LSCB. 43 parents responded, all of whom were accessing Brighton & Hove children's services.

In March 2014 the LSCB established the 'Board briefing.' This is a short, succinct briefing that gives the wider community an update on Board discussions, challenge and actions following each quarterly full Board meeting. This is circulated via the website and twitter and also across the partnership by Board members who are encouraged to promulgate the briefing throughout their agencies to staff and service users.

What we will do:
Feedback from parents and carers was collated in the summer of 2014 and the suggested amendments to the website are being made. Furthermore, the LSCB will be working in collaboration with Safety Net from 2014/15 to get safety messages to parents with children at primary schools via a Safety Net and Brighton & Hove LSCB parent newsletter. This will help raise awareness of safeguarding issues amongst parents and carers and equip them with the knowledge to ensure children stay safe. Consideration will be given about how best to deliver safety messages to parents with children in secondary and independent education.

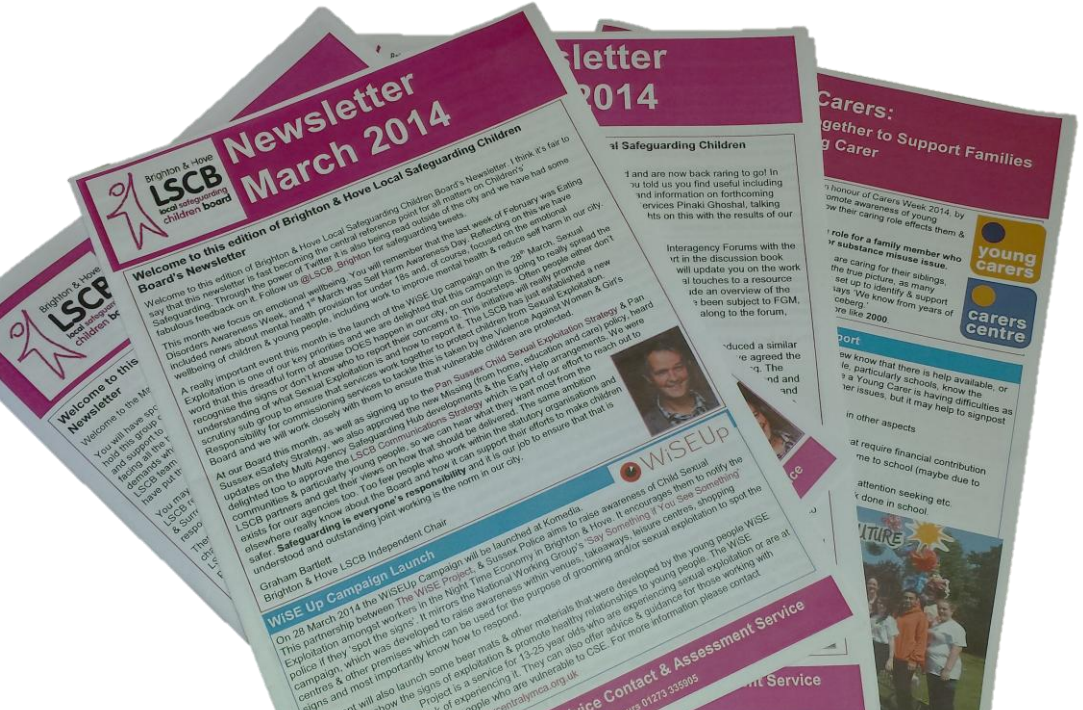
Staff and managers have an improved understanding of the LSCB.

> ‘All LSCB newsletters have been widely circulated to staff, including to primary care colleagues. I’ve also made sure all relevant information has been added to the safeguarding area of the CCG extranet for easy access’. **June Hopkins; Designated Nurse CCG**

What making a difference will look like: LSCB Communications Plan implemented

What we did:
As with improving parents and carers understanding of Brighton & Hove LSCB, the same ambition exists for our agencies too. Too few people who work within the statutory organisations and elsewhere really know about the Board and how it can support their efforts to make children safer. **Safeguarding is everyone’s responsibility** and it is our job to ensure that that is understood and outstanding joint working is the norm in our city. The Communication Strategy & thematic plan is one of our vehicles to achieve this.

The Brighton & Hove LSCB Multi-Agency Training, Serious Case Review Seminars, Newsletters, Board Briefings, Safeguarding Bulletins, Website, Twitter and multi-agency case audits have encouraged two-way communication with professionals working with children and families in the city.



What we will do:
Following the 2013/14 Section 11 audit, a recommendation for Board consideration was a Brighton & Hove LSCB annual conference with front line workers. The purpose is to share case studies and best practice relating to safeguarding as well as to improve staff and managers understanding of the workings of the Board.

Staff and managers are informing learning and improvement.

Are the views of your staff valued & taken seriously?

Do you regularly observe frontline practice?

What making a difference will look like: Audits evidence a link between quality assurance and feedback from staff and managers.

What we did:

Two Serious Case Reviews: Implications for Practice lunchtime seminars where run by the Head of Safeguarding in 2013/14. Serious Case Reviews play an important part in both individual and collective learning about how we can improve our responses to protecting children. The seminars were very well attended and afforded an opportunity for multi-agency professionals to learn from one another. Feedback included:

1. What was helpful?	2. What have you learnt today?	3. How will you put your learning into practice?
It helps to think about **recurring themes**/learning and how we can use this info when delivering safeguarding training to my team.	To think about ways to best **listen** to younger children;	Ensure I continue to **share information** with children's services when working in my role as a tenancy officer.
It is a reminder of the key lessons learnt in serious case reviews and the factors to be mindful of when identifying risk, i.e. **domestic violence**.	To put emphasis on **thinking the unthinkable**	Be **reflective** in my practice and be aware of thinking the unthinkable even if this may not be what we want to think. Not to isolate situations and **make links.**
It is helpful to discuss and listen to **other colleagues perspectives**.	Not to be afraid of **common sense**.	In supervision sessions, to ensure **child's voice** is at the centre.

In 2013/14 the CSE Steering Group undertook a mapping exercise across professionals in Brighton & Hove to hear their views and understanding of the prevalence of CSE in the city to inform learning and improvement.

Staff and managers working across the partnership are engaged in the LSCB Newsletters and Bulletins. This is a collaborative exercise to ensure the newsletter is informing learning and improvement. Newsletters have included interviews with frontline staff, multi-agency audit findings, briefings from local and national Serious Case Reviews, as well as promoting multi-agency training and events.

In March 2014 the Board approved a recommendation from the Participation & Engagement Group to establish 'Interagency Forums,' these are not formal training inputs but bitesize discussion forums run over a few lunchtime hour slots. These sessions explore issues that affect the safety of children & adults in our city, provoking discussion and learning as well as nurturing partnership working across organisational boundaries.

What we will do:
It is important to have a constant feedback loop from the frontline to senior management and those with governance responsibilities, not just in terms of what is or is not working but also to assist with ideas for improvement so that changes can be made systematically. The Quality Assurance Framework will play an important role in how we do this. Key activities to do this are set out in the QAF and include, staff surveys and interviews, focus groups, staff evaluations of partnership working and 'walking the floor' and observation of frontline practice by senior managers.

We will continue to host Serious Case Review: Implications for Practice seminars, taking main themes from national and local Serious Case Reviews and focusing on a number of meaningful recommendations and actions with a multi-agency audience.

We will continue to run Interagency Forums like the two sessions in May 2014 hosted by Brighton & Hove LSCB and VAWG on Female Genital Mutilation (FGM) which were attended by 90 professionals working with children and families in the City. The sessions launched an FGM Resource Pack, which contained information and guidance for people who may encounter women or girls at risk of, or having undergone, FGM.

Brighton & Hove LSCB is signed up the SCIE Learning Together methodology for all Serious Case Reviews. This systems approach has a heavy emphasis on engaging frontline professionals and their managers as active participants in the process, while the review is being undertaken, when findings are being shaped, and in driving impact. All Serious Case Reviews and Learning Reviews will be the B&H LSCB's vehicle to providing a framework to listen and learn from frontline professionals.

We want all children in Brighton and Hove to thrive and be safe, to achieve their absolute potential and to have good life chances. We are determined to provide early help and support to children when they need it.
Pinaki Ghoshal, Executive Director, Children's Services Brighton & Hove City Council.
Graham Bartlett, Independent Chairperson, Local Safeguarding Children Board.

Priority Area 3: Service Responses

Early Help meets the needs of children and families.

What making a difference will look like: Local Threshold Document is published

Well-timed, good quality and noticeable involvement by everyone necessary shows that children's welfare is promoted and they are safeguarded from harm.

What we did:
The Early Help Partnership Strategy 2013 – 2017 was successfully launched at a well-attended conference on 5 November 2013. This described how agencies will need to work together to provide Early Help in the city. The Early Help Strategy described Early Help by highlighting the description in Working Together 2013, **'providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.'** The strategy goes on to say that, in a nutshell, **'Early Help is about stopping problems escalating.'**

In March 2014 we approved and signed off the Threshold Document (Interagency Threshold of Need and Intervention Criteria) and this was circulated for wider consultation with agencies in Brighton & Hove. The new document was designed to support more robust decision-making around blurred cases. It provides guidance for professionals and service users to: identify and assess level of individual need; and clarify the circumstances in which to refer a child to the Multi Agency Safeguarding Hub (MASH), the Early Help Hub (EHH) or to a specific agency to address an individual need.

The Threshold Document can be found at www.brighton-hove.gov.uk/content/children-and-education/childrens-services

Throughout 2013/14 two multi-agency audits of the Common Assessment Framework (CAF) were presented to the Monitoring & Evaluation Subcommittee. They revealed some sound practice. Key areas for improvement included:

- assessment skills
- consultation with other professionals involved with the child and family
- taking account of and recording the wishes of children and young people
- including all family members in the CAF.

The findings were fed back to lead professionals involved with the audited cases, reported to the CAF reference group for action and were built into training programmes. A follow up audit will take place later in 2014/15.

What we will do:
From 1 September 2014 the proposal is to bring together key parts of services to create an integrated 'Early Help Hub' (EHH). This hub will offer a new route for advice and referral and will support professionals in the city to target, coordinate and provide Early Help interventions to families that need additional support beyond what they already receive, but that do not meet the threshold for the council's social work service.

Brighton & Hove LSCB will want informative and robust performance data reported from the EHH so as to measure the timeliness and quality of responses and the impact on outcomes for children. It will help test the hypothesis that the development of the Early Help offer will, over time, reduce the number of children needing additional services.

An Early Help audit and a Referral and Response audit will be carried out by the Monitoring & Evaluation Subcommittee in 2014/15

When the Early Help Hub and MASH will go live, supported by the new Thresholds document, there will be interagency briefings for operational managers, led by the Chairperson of Brighton & Hove LSCB and the Director of Children's Services, plus a series of training sessions for practitioners throughout the Autumn 2014.

Brighton & Hove LSCB communications in January 2015 will be reflecting on the impact of Early Help and MASH initiatives.

There is a prompt and assured response when referrals are made or new information is received about child care concerns.

What making a difference will look like Establishment of local Multi-Agency Safeguarding Hub

Well-timed, good quality and noticeable involvement by everyone necessary shows that children's welfare is promoted & they are safeguarded from harm.

What we did:
The proposal to develop a Multi-Agency Safeguarding Hub (MASH), (as well as the publication of the new Threshold document) has been actively agreed and on Brighton & Hove LSCB's agenda over the last couple of years.

It has been agreed that Brighton & Hove's MASH will be a team of professionals based together sharing information in order to make timely and correct decisions to protect and support children and young people. The team will consist of social work staff, police officers and staff from Housing, Education, Youth Offending, Probation and a range of Health providers. There will be very close links between the MASH and the EHH.

The attraction of this model is it is proven to be more effective in the identification of vulnerable children and improving the speed to which those children receive the most appropriate help, including Early Help, from single or several agencies. The challenges that existed at the end of March 2013 in setting up the MASH, which appeared to be agreeing the model to be used, and finding suitable premises that are secure and large enough to house all the personnel and IT systems, have been fully resolved.

What we will do:
When the Early Help Hub and MASH will go live, on 1^{t} September 2014,, supported by the new Thresholds document, there will be interagency briefings for operational managers, led by the Chairperson of Brighton & Hove LSCB and the Director of Children's Services, plus a series of training sessions for practitioners throughout autumn 2014.

Brighton & Hove LSCB will continue to review the Threshold criteria and this will continue to be a focus in the Brighton & Hove LSCB Strategic Priorities and Business Plan for 2013-16.

Data from the MASH will be reported quarterly to the LSCB and will include: numbers of cases deemed in each rating, i.e. Reds, Ambers and Greens; the % of decisions that were made within the set time frame; and attendance at MASH by the various reps. This will assist the LSCB in monitoring that well timed, good quality and noticeable involvement by everyone necessary is promoting children's welfare and safeguarding them from harm.

Early Help Performance – The Family CAF (Common Assessment Framework)

The CAF is a shared assessment tool for use across all services for children and all local areas in England. It aims to help early identification of children with additional needs and promote coordinated service provision. The CAF is undertaken with the consent and full participation of the child and their family.

There is no national benchmark for CAF activity as all local authorities are free to define their own thresholds and targets.

The target of 60 CAFs per month is a locally set target based on the average number of previously unknown families referred to ACAS per month. In April 2013, 26 CAFs were initiated that have been recorded to date:

- 12 (46%) were initiated by Health Visitors
- 5 (19%) by Family Coaches
- 3 (11.5%) by Youth Workers.

2 or fewer CAFs were initiated by Family CAF workers, School nurses, Social Work students and Community workers.

40 CAFs were initiated in February and 42 in March, giving a quarterly average of 36 per month. The yearly average from May 2013-April 2014 is 31 per month, significantly below the target of 60 per month.

The overall number of open CAFs currently stands at approximately 520. The recording of CAF Assessment data has been collected on CareFirst since April 2013. Despite an increase, centrally reported CAF activity levels are an ongoing area for development.

Priority Area 4: Accountability

The Board is better coordinated and ensuring the effectiveness of what is done by partner agencies.

What making a difference will look like: Review completed of Board arrangements and changes confirmed

Outcome Based Accountability (OBA) is established as a model for informing the LSCB of the quality of partner agency work.

Learning & Improvement Framework published

Review completed of LSCB core data requirements. So that Informative and robust data on safeguarding activity is presented routinely to Brighton & Hove LSCB for scrutiny

Review of Board arrangements

What we did:

One of the challenges identified in 2012/13 was for Brighton & Hove LSCB to be well coordinated (particularly across the subcommittees) and ensure that the monitoring and evaluation functions are well resourced to help inform the Board of what difference we are making to keep children safe in the local area.

Throughout the year the terms of reference of each Subcommittee have been revisited and bought in line with the Learning Improvement Framework. The effectiveness and thoroughness of the Board requires that the work of each Subcommittee interacts with the work of the others, whereby the output of one Subcommittee informs the input to another. This in turn creates the opportunity for the Board to evaluate the effectiveness of agencies' services to safeguard and promote the welfare of children.

Each Subcommittee – with the exception of the Chid Protection Liaison & Safeguarding Group, which is more case specific in approach – has a work plan in place which proves to be a robust method of reporting into the Board. The Board in turn challenges the progress of the Subcommittees against their work plan and in ensuring there is multi-agency accountability and assurances in place.

In 2013/14 a Participation & Engagement Subcommittee, which started out as a Task & Finish Communications Group, became a standing subcommittee of the Board. For reasons explained previously, the Child Sexual Exploitation Subcommittee moved out of

the LSCB to under the auspices of the Violence against Women & Girls Programme Board although it still reports to the LSCB and its performance is scrutinised by the Vulnerable Children's Monitoring Group. The Education Safeguarding Subcommittee and the Health Advisory Group moved outside of the LSCB, as these groups are not multi-agency in approach. Whilst these groups stand outside the LSCB, they continue to dovetail in when necessary. A new chair of the Monitoring & Evaluation Subcommittee was appointed who has provided real rigour to the assurance the LSCB needs.

The biggest change has been to the Executive Subcommittee. This was a chief officer led committee designed to keep top managers aligned with safeguarding and ensure prompt clear decisions if needed in between main Board meetings. Key safeguarding advisers also attended. In October 2013, a review of governance arrangements identified that the Executive Group was not the most effective model for Brighton & Hove LSCB. It was acting as a second Board and making decisions on that should have been made by the Board. There was a limited joined up approach between subcommittees and the main Board was not receiving adequate reports from subcommittees and the Executive on work to progress the Business Plan. In response a Leadership Group was formed in its place. The Leadership Group meets quarterly and is accountable to the full Board. Its purpose is to drive the implementation of the Brighton & Hove LSCB Business Plan. It is attended by the chairs of each subcommittee, who oversee progress against work plans of each others group to ensure consistency and a joined up approach between all the subcommittees of the LSCB.

At every full Board there is a short presentation by one subcommittee on a rota basis. This keeps the wider Board up to date on subcommittee activity and affords an opportunity for further multi-agency scrutiny.

Throughout 2013/14 Brighton & Hove LSCB has footnoted in its minutes all 'challenge,' which has taken place between and by Board partner agencies. We have established a challenge evidence folder that includes these challenges, which have taken place within the meeting, but also goes some way to describe the kind of challenge happening within the life of local multi-agency practice.

What we will do:
Current subcommittees are:

- Leadership
- Monitoring & Evaluation
- Learning & Development
- Participation & Engagement
- Child Protection Liaison Group
- Vulnerable Children Monitoring Group
- Serious Case Review Panel
- Child Death Overview Panel
- Pan-Sussex Procedures

We want to think innovatively about how the Board can better facilitate challenge to the effectiveness of what is done by its partner agencies, and to demonstrate our commitment to this function by giving a running commentary of activity and challenge to a wider audience via the Board Briefings.

In recognition that Board meetings can be long and 'paper heavy' we trailed a new approach to covering Board business in June 2014. We allocated time to discuss a range of topics in smaller groups as well as having whole Board discussions. Feedback on this approach suggested it provided a greater opportunity for participation, reflection and challenge amongst members.

Having undertaken a performance and effectiveness survey to better gauge how Board members rate the efficacy of the Board we will work with the findings from this, which although mostly encouraging did highlight room for improvement. One of the things the LSCB needs to do on the back of this survey is to look at current membership and representation at the subcommittees to make sure it is diverse, stable and active.

Outcome Based Accountability

What we did:

Quality assurance is about assessing the quality of the work agencies undertake to safeguard children and understanding the impact of this work in terms of its effectiveness in helping to keep children and young people safe. We know that effective quality assurance will contribute to a culture of continuous learning and improvement.

The Quality Assurance Framework (QAF) has been in development throughout 2013/14. It is based on an 'Outcomes Based Accountability' (OBA)[5] approach and guided by the framework developed by Local Government Improvement and Development & the London Safeguarding Children Board.[6] The QAF increases understanding of a given area of business/concern by considering:

- What we do (Quantity)
- How well we do it (Quality)
- What difference we have made/whether anyone is better off (Outcome)

[5] Mark Friedman, *Trying Hard is Not Good Enough*, 2005, Trafford Publishing.
[6] Local Government Improvement and Development & London SCB, Improving Local Safeguarding Outcomes: Developing a strategic quality assurance framework to safeguard children, 2011.

It does this by obtaining information from a range of sources, using a variety of methods, including case records, the experience of children & parents, experience of the workforce and other organisational activity (e.g. supervision).

There are so many dimensions to safeguarding that if we tried to quality assure everything it would become unmanageable. There is a need therefore to focus on a discreet number of defined areas, which Brighton & Hove LSCB concludes are the most important. The areas of focus will be determined by local need following consultation with all partner agencies and informed by evidence such as findings from research, audits, management information and learning from serious case reviews.

What we will do:
We will now focus on effectively implementing the QAF, especially embedding the learning from multi-agency audits with all partners and using it to change practice and improve outcomes for children.

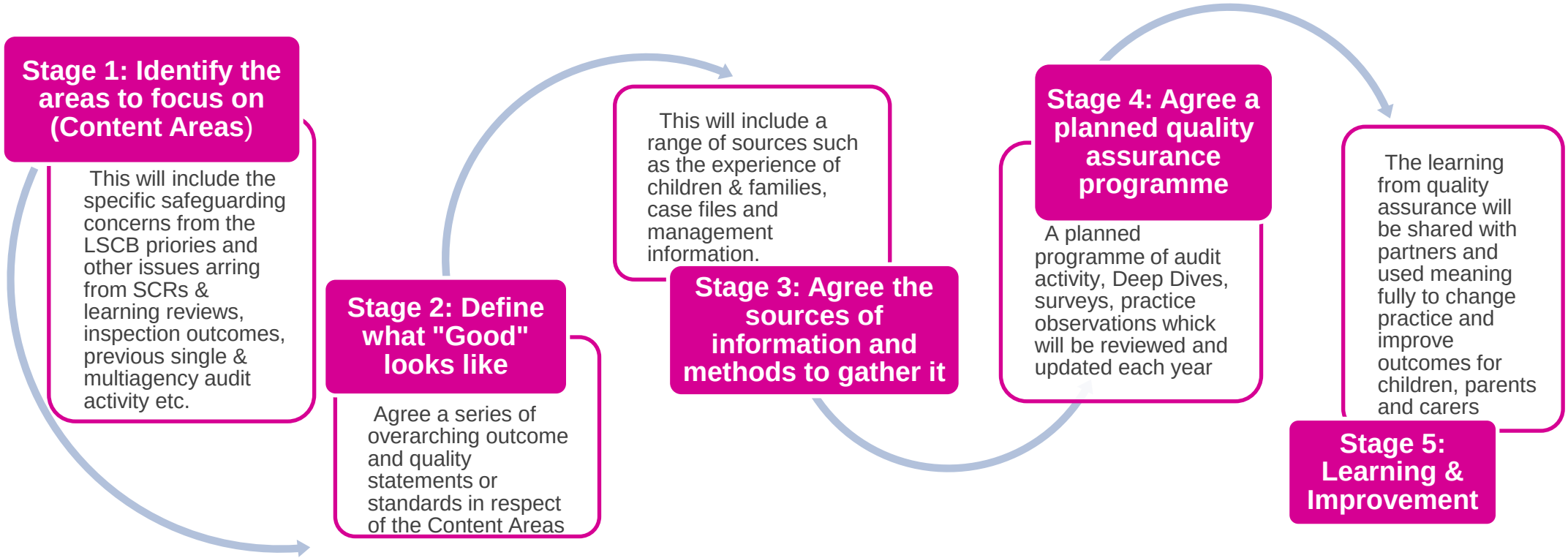
We will need to enable all partner agencies to use the QAF for their own agency's quality assurance and keep an oversight of this.

We will need to ensure the QAF supports us to know how parents, carers and children feel treated by the professionals and agencies they interact with.

As staff and frontline managers will often know about the quality and impact of their own services, and those of partner agencies they work with, we will need QAF activity to support collection of these viewpoints.

The LSCB QAF brings agencies together with a common purpose to assess the quality of the work undertaken in the city (both individually & collectively) to keep children safe. It also contributes to a culture of continuous learning & improvement
Tina James, Quality Assurance Programme Manager, Children's Services

The Monitoring & Evaluation Subcommittee will take a lead role in the implementation of the QAF, which will be achieved through 5 stages:



Learning & Improvement Framework

What we did:

Our learning culture has been enhanced by the programme of multi-agency case audits. These have given a valuable insight into the child protection system and how single agency service delivery and working together impacts on outcomes for children.

The Brighton & Hove LSCB Learning & Improvement Framework, which can be read here, has been approved and implemented. This encourages professionals and organisations protecting children to reflect on the quality of their service and learn from their practice and that of others. It underpins the LSCB's learning ethos and spans the work of all subcommittees.

The QAF has been designed to ensure that Brighton & Hove LSCB effectively meets Regulation 5c of the LSCB Regulations 2006 requirements and aligns with the Learning & Improvement Framework.

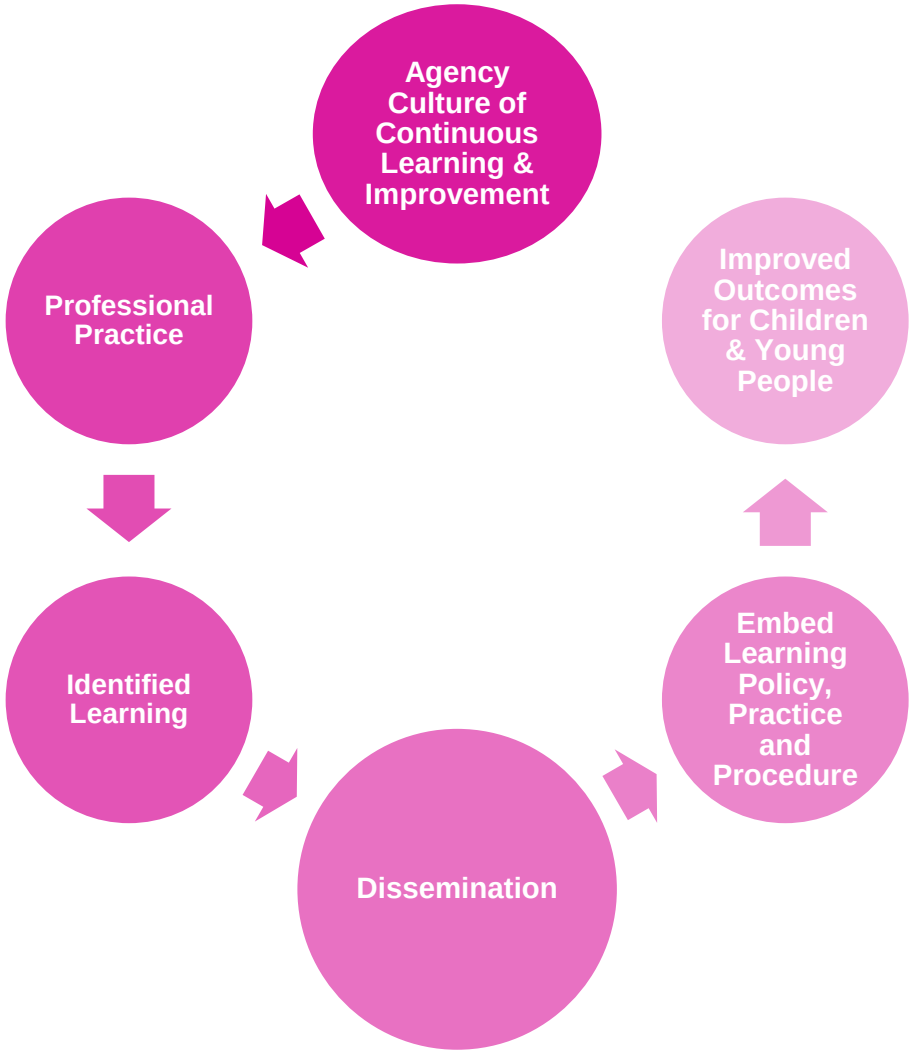
Brighton & Hove LSCB's SCR Procedure has been agreed with clear lines of communication for referrals and decision-making. Significant work has been completed to clarify the role the SCR Subcommittee has to lead on the Learning & Improvement Framework and to ensure the independence of the LSCB Chair in decision making on SCRs and other learning reviews.

What we will do:
We will keep the Learning & Improvement Framework under review and when needed will adapt the Framework to ensure learning has a demonstrable impact on improving services for children and families in Brighton & Hove.

The LSCB Independent Chairperson will continue to meet, via the Leadership Group, with the subcommittees Chairpersons to drive the LSCB's Business Plan and manage the interface between the work of the subcommittees. The Leadership Group will continue to have a pivotal role in further developing the learning and improvement framework.

We must recognise that learning and improvement is not exclusive to Brighton & Hove LSCB and we need to be better at importing learning from, and exporting learning to, other bodies, including the Health & Wellbeing Board, the Safeguarding Adults Board and through the Association of Independent LSCB Chairs.

A Cycle of Learning & Improvement



Core data requirements

What we did:

Throughout 2013/14 we have tried to develop a robust multi-agency data set, which includes both key nationally and locally collected multi-agency child protection data to give the Board a better picture of multi-agency work. This data is reported quarterly to the Monitoring & Evaluation Subcommittee via a Management Information Report, for scrutiny ahead of it being tabled at full Board.

The purpose of this data set is to highlight:

- progress towards meeting the Brighton & Hove LSCB Business Plan priorities
- major changes to performance and quality assurance measures
- any additional information pertaining to the safeguarding and welfare of children and young people in Brighton & Hove.

What we will do:

It has not been easy to see where referrals are coming from in the Community & Voluntary Sector. With the establishment of the MASH it is anticipated this will be improved, with a more consistent approach to separating referrals from advice enquiries.

We need to make further improvements to the Management Information Report to ensure an effective multi-agency data set to better scrutinise and challenge child protection performance across the partnership.

How safe are children and young people in Brighton & Hove?

2013/14 Performance Summary

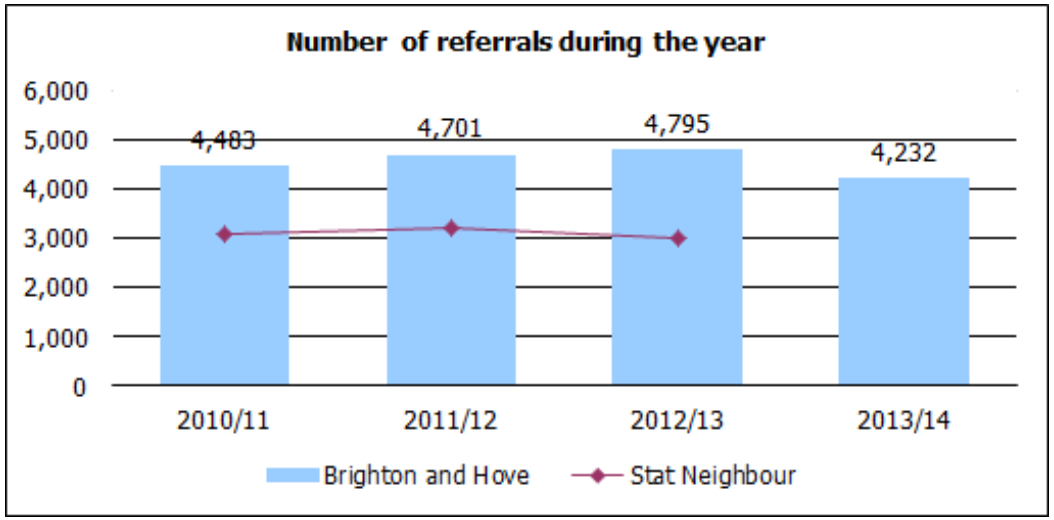
The full Board and the Monitoring & Evaluation Subcommittee have, throughout the year, reviewed child protection activity and performance data. Brighton & Hove LSCB has tried to establish a more multi-agency dataset to give the Board a complete and assured picture of whether our work is making a difference to children and to adequately alert the Board of any risks in the system. Whilst progress has been made, this remains an area of improvement for the LSCB.

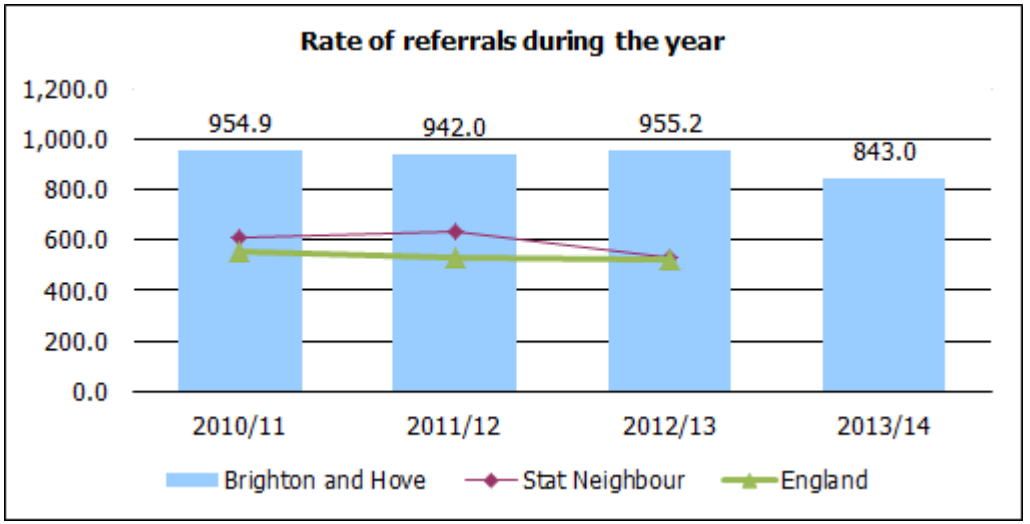
Referrals

It is important to highlight that figures for 2013/14 are provisional and subject to change as the CIN Census has not yet been submitted to the Department for Education. Comparator data for 2013/14 will not be available until November 2014.

The number of referrals to Children's Social Care has continued to fall during 2013/14, falling from 4,795 in 2012/13 to 4,232 in 2013/14, an 11.7% decrease.

Although the rate of referrals per 10,000 children aged under 18 has fallen from 955.2 in 2012/13 to 843 in 2013/14, this remains significantly above the 2012/13 England average of 521 and statistical neighbour average of 531.





Re-referrals

The re-referral rate is 29% for 2013/14, an improvement from 38.2% in 2012/13 but above the 2012/13 England average of 24.9%.

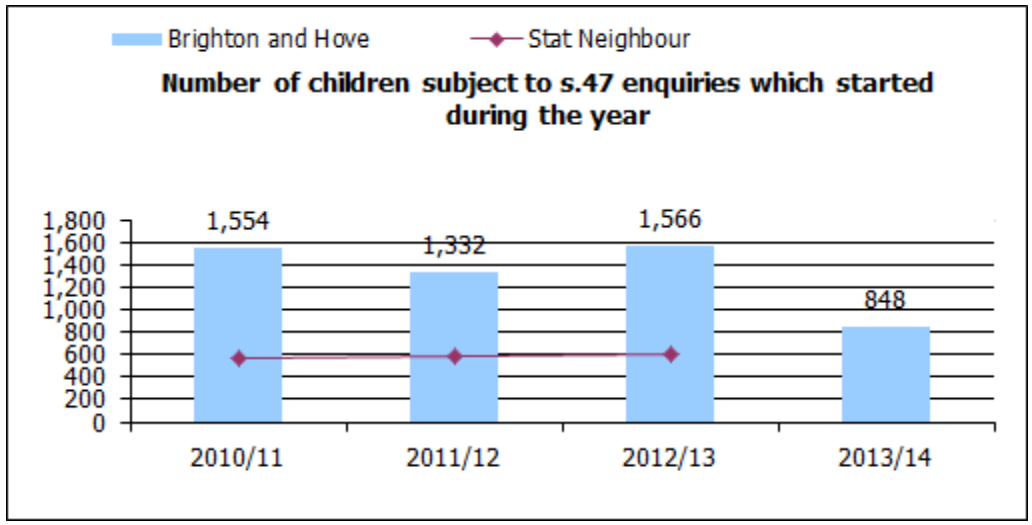
Single assessments

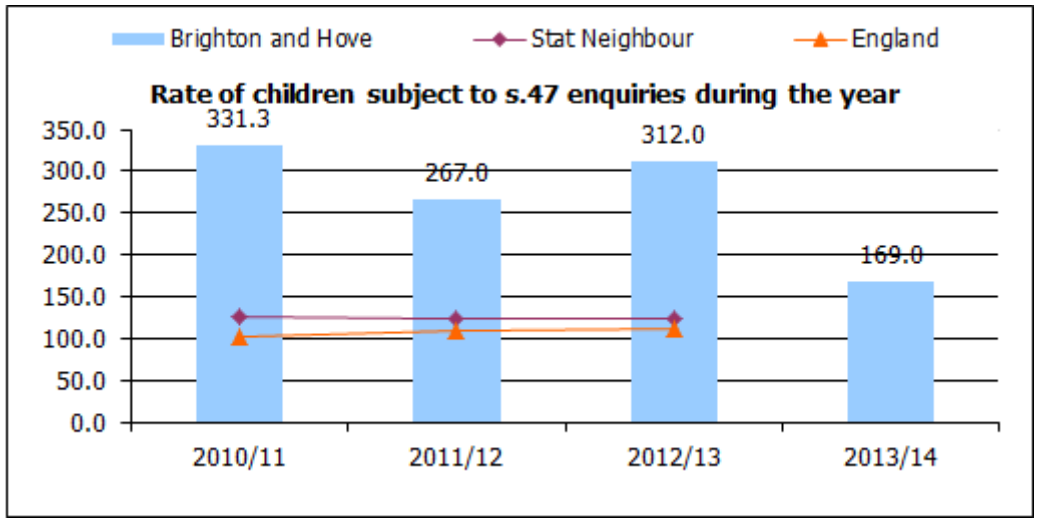
Brighton & Hove launched the single assessment in April 2013 and it is not possible to provide trend data for initial and core assessments in this year's annual report. Comparator data on the number of single assessments completed and by duration will not be available until November 2014. Provisional figures from the 2013/14 CIN Census show that 2,351 single assessments were completed during the year, with 82.6% completed within 45 working days.

Section 47 Enquiries

In cases where a child is believed to have suffered or be at risk of significant harm, a strategy discussion takes place. Professionals from the relevant agencies will meet to decide whether to initiate a section 47 enquiry. This refers to an enquiry under section 47 of the Children Act 1989 and initiates further investigation.

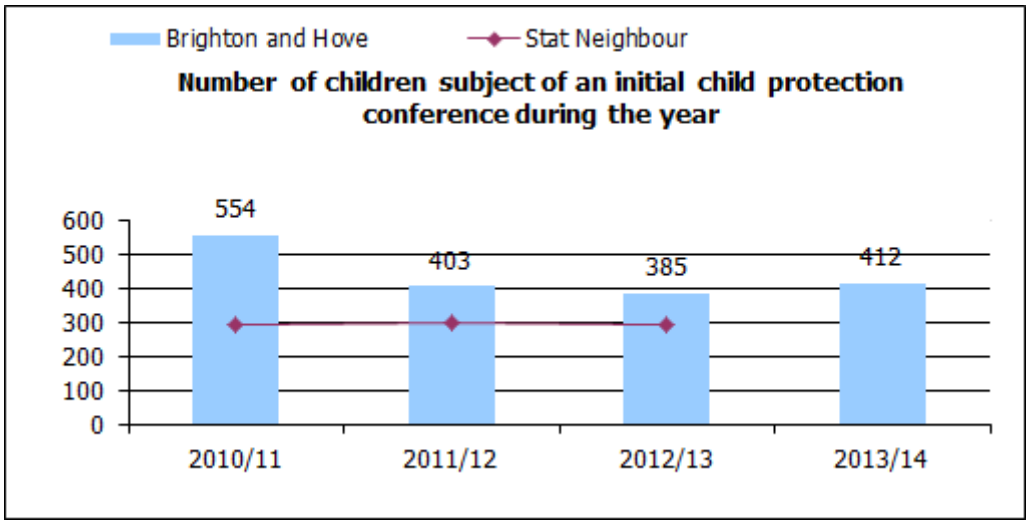
The number of section 47 enquiries started during the year ending 31 March has fallen from 1,566 in 2012/13 to 848 in 2013/14. The decrease in the number of section 47 enquiries is mainly due to a change in how section 47 enquiries were calculated in 2013/14. In previous years, the strategy discussion was used to identify section 47 enquiries and this was changed to the section 47 record in 2013/14.

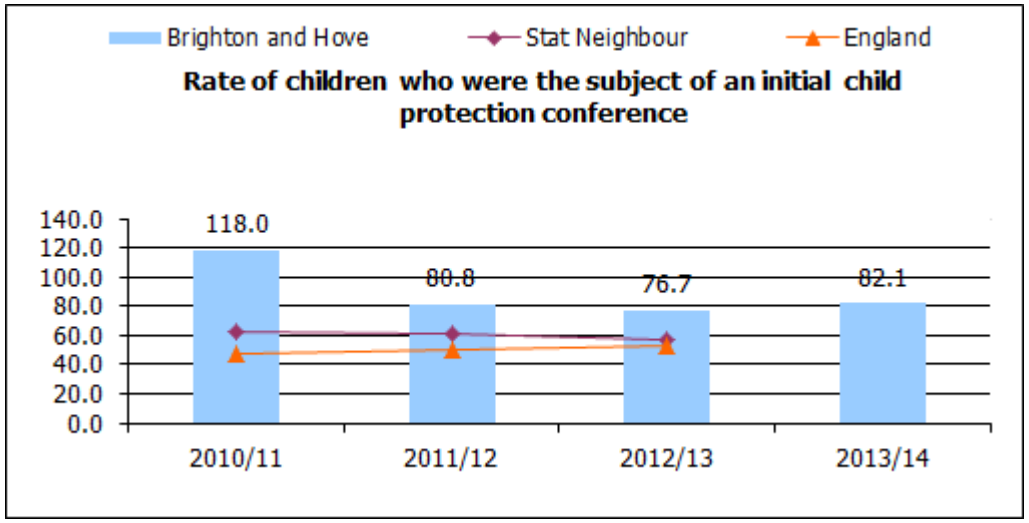




Initial Child Protection Conferences

The number of children subject of an initial Child Protection Conference has risen slightly from 385 in 2012/13 to 412 in 2013/14.





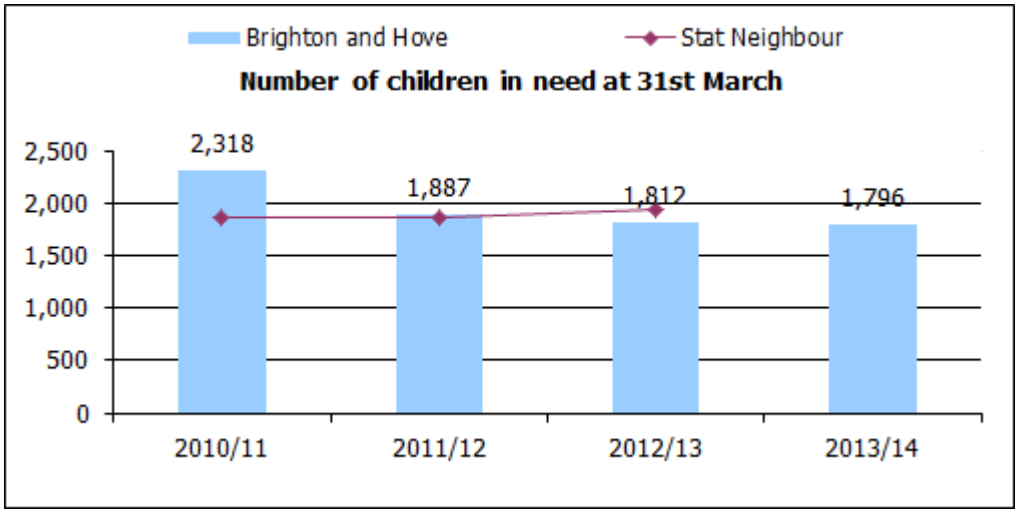
The rate of children subject of an initial Child Protection Conference has risen from 76.7 in 2012/13 to 82.1 in 2013/14. This is significantly above the 2012/13 national average of 52.7 and 56.8 for our statistical neighbours. 75.7% of initial child protection conferences were held within 15 workings of a strategy discussion, an improvement from 60.5% in 2012/13 and above the 2012/13 England average of 70%.

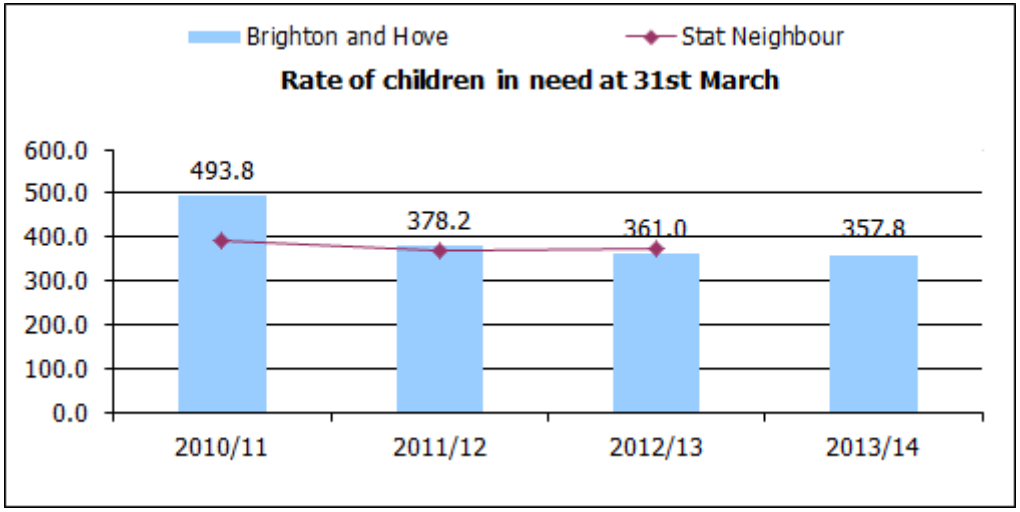
89% of children where invited to attend or contribute to the Child Protection Conference (14% increase from last year), 43% of children contributed to the Child Protection Conference (13% attended with an advocate, 17% attended on their own, and 13% had their views represented by an advocate – a 15 % increase from last year). You will have read the feedback on Child Protection Conferences from young people and families earlier in this report.

Brighton & Hove have high rates of children in need, in care, and with Child Protection plans.

Children in Need

The number of Children in Need has fallen year-on-year from 2,318 as at 31 March 2011 to 1,796 as at 31 March 2014.





As at March 2014, 357.8 per 10,000 children in Brighton & Hove were identified as being in need, this is below the average of the South East which is 373.5 per 10,000, but above the 2012/13 England average of 332.2.

In February 2013 the Child in Need service selected some cases randomly, and sent people questionnaires about their experiences of services. They repeated this in July 2013. Parents and carers feed back included:

- 85% said that the social worker was open and honest about what opinions were following the visit
- 86% of parents/carers said that the social worker was easy to contact (we did not think this was good enough and so took action to remind social workers to discuss contact arrangements and expectations)
- 85% of parents/carers felt that the work they did with the social worker achieved the outcome they had hoped for.

They asked children and young people questions which were graded on a scale of 1-10 where 1 = No never and 10 = Yes always. Some examples of the children and young people's responses include

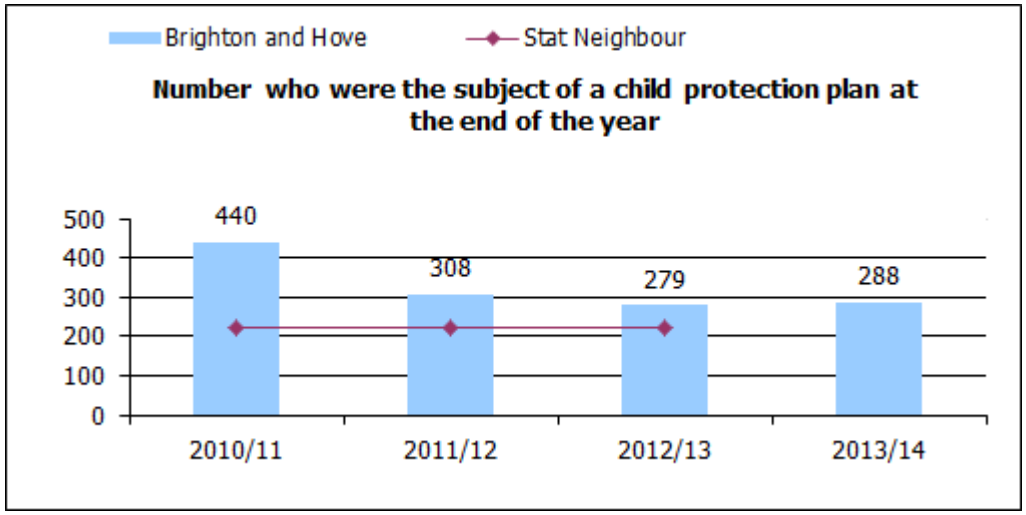
- 39% said their social worker always involved them in decisions about their lives (with 43% rating this between 5 and 9)
- 50% said they felt the social worker listens to them, understands what they are saying and how they are feeling (with 36% rating this between 5 and 9)
- 58% said that overall they felt their social worker helped them and their family (with 27% rating this between 5 and 9)

This was an invaluable exercise which highlighted that the main issues for discussion with staff were around the need to explain rights, the complaints procedure, and confidentiality more clearly to service users. Furthermore, there were a number of questions where parents or young people had raised specific issues of concern – and these were taken forward as a priority.
Richard Hakin, Head of Service, Children in Need, Children's Services.

Children with a Child Protection Plan (CPP)

Children who have a CPP are considered to be in need of protection from either neglect, physical, sexual or emotional abuse, or a combination of these factors.

Evidence nationally shows that children who grow up in families where there is domestic violence, mental illness and/or parental substance misuse are most likely to be at risk of serious harm. There is an option to record multiple categories and the Board requested a breakdown of these to better understand what children are at risk of in Brighton & Hove. This showed that we are slightly above the national average for children subject to Sexual Abuse (6.9% as at year end, against national average of 4.7%) and this continues to be a priority concern for the LSCB.

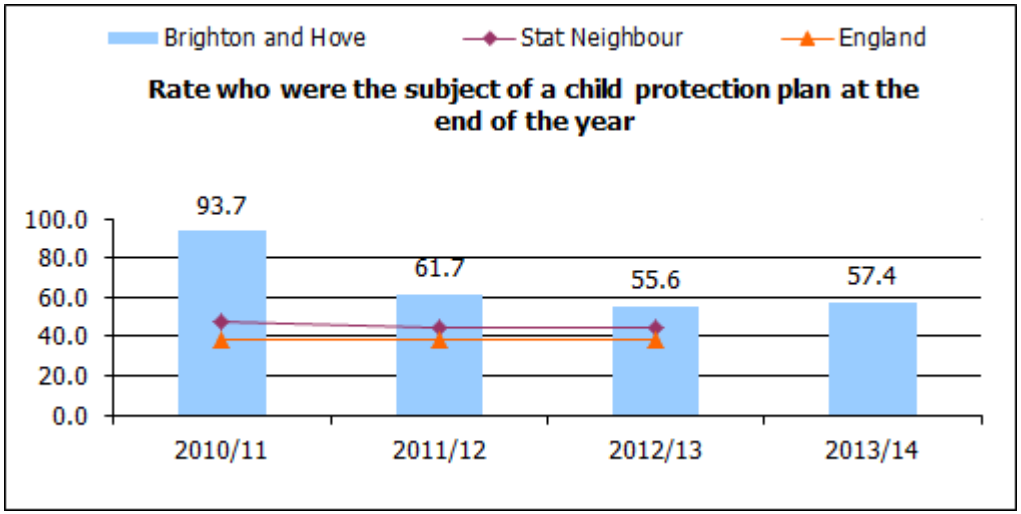


As at March 2014, 288 children were the subject of a Child Protection Plan. The number of children subject of a Child Protection Plan has risen slightly from the 279 reported at 31 March 2013. As described earlier in this report, audit findings suggest that this rise was in part a reaction to the number of children that were stepped down to a CiN plan bouncing back.

The rate of children subject of a Child Protection Plan is 57.4 as at 31 March 2014, above the England average of 37.9 and statistical neighbour average of 43.9.

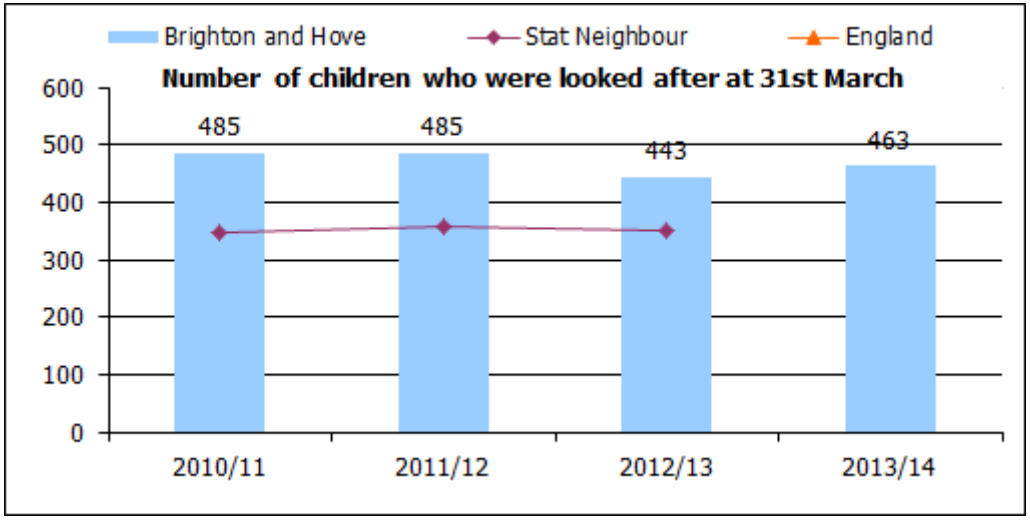
Of the 344 children that ceased being subject of a Child Protection Plan during 2013/14, 5.2% had been subject of a plan for 2 years or more at the point of being de-planned, in-line with the 2013 England average.

Of the 353 children who became subjects of a Child Protection Plan in 2013/14, 97 (27.5%) were for a second or subsequent time. Performance has deteriorated from 14.5% in March last year and is significantly worse than the 2013 England average (14.9%). Figures remain high and a priority for Brighton & Hove LSCB to monitor during the coming year.



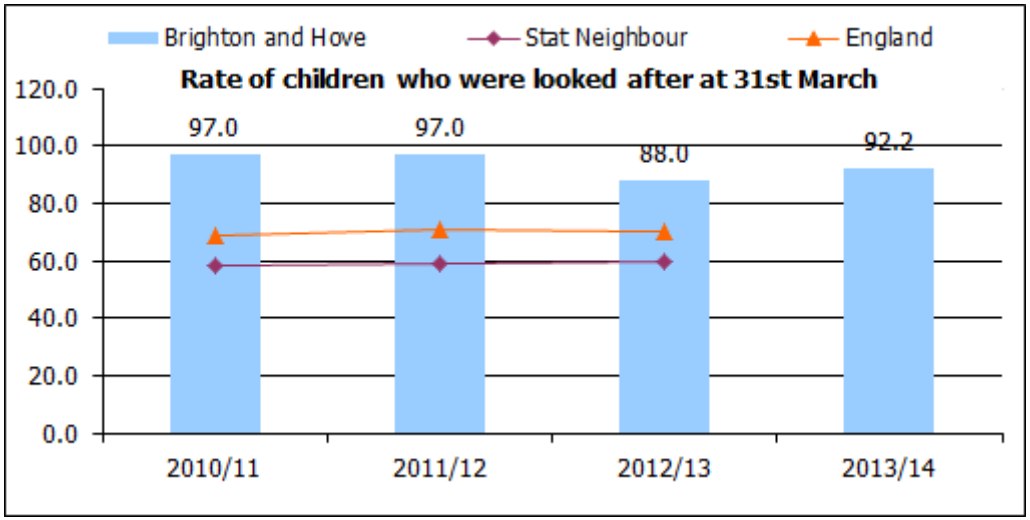
You will have read earlier in this report about the audit on Child Protection and Children in Need Plans which identified areas of good practice and areas of concern which provided a baseline of performance.

Looked After Children



The number of Looked After Children at the year end is 463. This is a rise from the 443 Looked After Children in March last year.

The rate of Looked After Children is 92.2 per 10,000 as at 31 March 2014, above the 2013 England average of 60 and statistical neighbour average of 70.



Children in Care at the end of KS2 achieving L4+ in Reading, Writing and Maths

National Data is now available for Reading, Writing and Maths level 4+ since Dec 2013. However, there is no published combined figure for Reading, Writing and Maths available for looked after children (LAC) nationally. As the cohort numbers are low for Brighton & Hove LAC we have calculated and reported the combined percentage of children in Brighton & Hove schools achieving Level 4+ in Reading, Writing and Maths for 2012/13 (59.7%). The benchmark and target figure has been removed as this is not available combined but the subjects' benchmarks are:

- Reading 71%(18) pupils achieved level 4+ for Brighton and Hove LAC compared to 63% Nationally.
- Writing 50%(12) pupils achieved level 4+ for Brighton and Hove LAC compared to 55% Nationally.
- Maths 54%(13) pupils achieved level 4+ for Brighton and Hove LAC compared to 59% Nationally.

Children in Care at the end of KS4 achieving 5+ A-C including English and Maths

Of the 44 Year 11 pupils in the Virtual School at the end of the academic year, 35 will be formally reported on to the DfE with regard to their GCSE or equivalent results. These children have been in the care of Brighton and Hove continuously for a year on the 31st March 2013.

In Brighton & Hove 4 pupils achieved five A*- C GCSEs including English and Maths – this equates to 11.0%. This is currently a significant increase on last year's validated figure of 6% and is slightly below the national average of 15.3% (2013). Of the 35 students 13 (37.1% of the cohort) achieved 5A* - C at GCSE. This is currently above the national average of 36.6% (2013).

Missing Looked After Children (LAC)

There were 89 missing LAC episodes during the year ending 31st March 2014 with 31 LAC missing for more than 24 hours from their agreed placement, an increase from 57 missing LAC episodes and 23 LAC missing in the previous 12 months. Of the 31 children who went missing from their agreed placement during the last 12 months, 12 were male and 19 were female.

Children in Care & placed in Brighton & Hove by other Local Authorities

As at 31 March 2014, there were 47 Looked After Children placed in Brighton & Hove by other Local Authorities.

All Children in Care are offered annual health reviews. Many of these are undertaken by the School Nurses or Health Visitors, but children who do not attend a school in Brighton & Hove or who live out of area are assessed by the LAC nurses. They have been collecting service user feedback through questionnaires since July 2012, and have about a 50% response rate. Most questionnaires are given out at the time of the visit and handed back then or returned later in a pre-paid envelope. Some questionnaires have been posted out following the visit. Feedback included:

- 100% said that during their visit they felt they had enough time or opportunity to ask any questions
- 100% said they would be happy to use the service again
- 100% said they had received a helpful and courteous response
- Over 80% said it was easy to contact the service

Positive quantitative feedback included:

“Helpful lovely lady”

“The nurse was informed and had a lovely way of talking to the children”

“Very good service and knowing your concerns are being looked at by a health professional.”

Children exposed to Domestic Violence

Using national data it is estimated that in the last year in Brighton & Hove between 5,800 and 11,900 women experienced domestic violence, 3,000 women experienced sexual assault, and 7,200 women were victims of stalking. There remains no comparative data at local authority level, and so domestic violence could not be included in the indicators to provide a comparison between authorities. 148 (51.9%) children subject of a child protection plan had Domestic Violence/Abuse recorded as contributory factor for becoming subject of a child protection plan.

Brighton & Hove Violence against Women and Girls Forum (VAWG)

During 2013-14 Brighton & Hove VAWG Forum members reviewed the key functions and purpose of the forum and its membership. A key decision was taken to broaden the Forums remit to include all VAWG crime types in line with the Brighton & Hove VAWG strategy and structures.

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

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

Members of the Forum are drawn from the community & voluntary sector (CVS) and statutory agencies engaged in tackling VAWG crime types in Brighton & Hove

Its role in relation to the LSCB is to:

- To give the VAWG Forum perspective in the development and evaluation of safeguarding children policies, procedures and practices.
- To contribute and to comment on documents/issues presented at the LSCB and to disseminate relevant information to VAWG Forum members

- To attend LSCB meetings and development days.
- To promote greater awareness of VAWG issues, developments and services, and to disseminate information, policies and procedures to LSCB members
- To participate in the audits and evaluations of the LSCB and those carried out by the LSCB.
- To identify gaps in service provision and training needs for members of both forums
- To promote effective communication between the LSCB and VAWG Forum.
- The VAWG Forum Chair attends the Safeguarding Adults Board providing a link between adult and child safeguarding issues from a VAWG perspective.

Summary of Activities for 2013 -2014

- The VAWG Forum Chair regularly attends and contributes at LSCB meetings
- VAWG Forum members, deliver training on domestic violence, and sexual exploitation as part of the LSCB training programme.
- VAWG Forum members participate in Domestic Homicide Reviews. The recommendations are considered at future forums and LSCB meetings.
- VAWG Forum members have been involved in the development of the Multi-Agency Safeguarding Hub (MASH) and Early Intervention Hub.
- VAWG Forum monitors receives performance information on domestic and sexual violence
- VAWG Forum received presentations from local providers services on topics such as “Child Sexploitation and the Night Time Economy “.

What difference has the DV forum/members made to Safeguarding Children?

- Ensured that the safety of children and young people affected by VAWG is paramount.
- Raised awareness of the impact of VAWG on children and young people.
- Raised awareness of services providing support to survivors of VAWG including the gaps in knowledge and provision to equality groups such as BME and LGBT.
- Raised awareness of services providing support to perpetrators of domestic violence.
- Raised awareness of preventative /early help interventions and programmes working across the range of VAWG.

- Promoted good practice in working with survivors of VAWG, especially children and young people.
- Improved identification of domestic violence across statutory and voluntary sector.
- Improved survivor pathways to support and satisfaction with services provided.
- Provided a forum for information sharing and sharing of good practice for professionals.

What we will do next

In March 2014 the LSCB heard about Sussex Police's intention to trial 'Operation Encompass' with West Sussex. This is with regard to information sharing between agencies about domestic abuse and it is a potential scheme that will alert schools and GPs to incidents. The pilot for Operation Encompass goes live in West Sussex from 1 September 2014. Progress will be reviewed after a couple of months to allow roll out across Sussex as quickly as possible.

The LSCB Monitoring & Evaluation Subcommittee commissioned a two-stage multi-agency audit of domestic abuse cases, which started in August 2014, and is the first multi-agency audit undertaken in line with the new Quality Assurance Framework. The cases audited covered a spectrum of levels including Child in Need, Child Protection Plan (and second time on a Child Protection Plan) and Looked After Children. The audit assessed strengths and gaps, including family involvement, the effectiveness of interventions and the experience of the child and made a number of recommendations. After addressing the recommendations the next stage will be to look at how Early Help is used in cases, and the final stage will be to capture the voice of the child, and service user feedback, led by the recent Coordinated Action Against Domestic Abuse (CAADA) report.

Missing Children

We know that children missing from their home or placement could be at a higher risk of sexual exploitation, missing out on their education, engaging in criminal behaviour and be more exposed to other risk-taking behaviours.

Brighton & Hove LSCB aims to provide a unified multi-agency approach to make sure the needs of these children and young people are met appropriately and effectively. The Missing Children Strategy was approved by Board in March 2014. This was agreed to be a solid operational policy that looks at what puts children & young people at risk of going missing, and is proactive in approach. It reflects the statutory guidance released in June 2013 and joins together the three strands of children missing from home, care & education (including elective home education). In this year, Deb Austin, Head of Safeguarding, Children's Services, became Single Point of Contact (SPOC).

The strategy covers:

- what steps to take to preventing children going missing
- what to do when a child is reported missing, and the route to getting them to safety
- what to do when a child returns, to find out why they went missing, and lessen the possibility of a reoccurrence

Read more about what the Local Authority are doing in response to missing children on page 74

What we will do next

- The Missing Strategy will be rolled out, with reporting systems adapted to contain the risk grading in May & June 2014, in preparation for the start of the MASH. Work to commission a provider to undertake the Independent Return Interviews will be finalised.

- The LSCB will receive updates from the Single Point of Contact (SPOC).

- We will develop our management information report to include information on the number of children missing from their home/neighbourhood and the number of return interviews conducted per month.

Learning and Development Sub Committee

What did we do? How well did we do it? What difference did we make?

Brighton & Hove LSCB has a responsibility to develop policies and procedures in relation to the 'training of persons who work with children or in services affecting the safety and welfare of children…to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children' (*Working Together, 2013*)

With oversight from the Learning & Development Subcommittee, a LSCB Training Strategy and a comprehensive multi-agency training programme was developed and delivered by Brighton & Hove LSCB during 2013/14. Issues from national Serious Case Reviews (SCRs) and other case reviews were analysed, considered and incorporated to ensure that the content of the training programme related to emerging issues of concern, as well as to core safeguarding learning, that all practitioners working with children and their families need to understand.

We now have realistic information on the true cost of the training programme, which previously had been hidden in the council's safeguarding budget, and must now make sure that all the courses represent value for money.

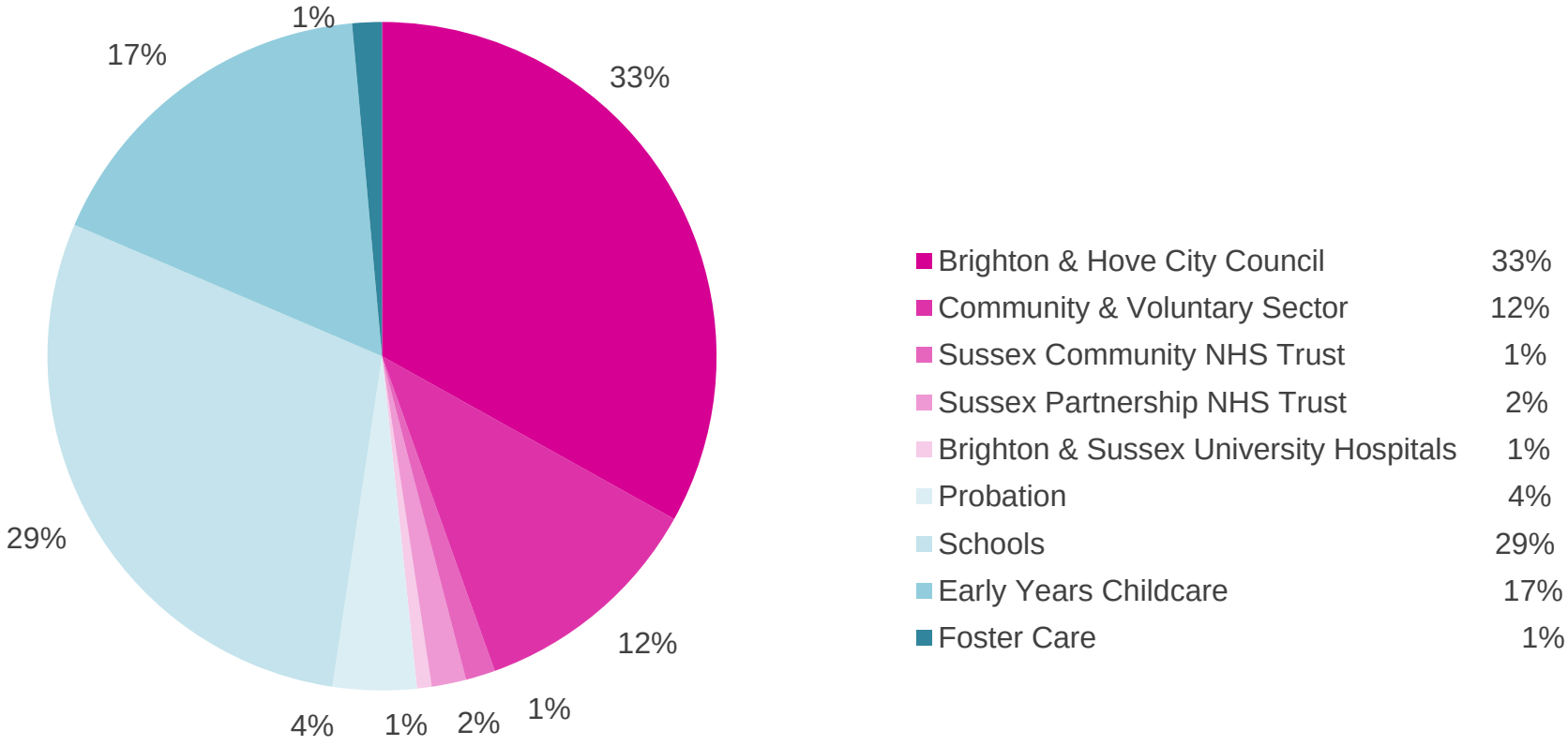
The LSCB annual training programme for 2013/14 was planned and successfully delivered. The training programme includes three core child protection courses and a series of other courses covering specialist areas. There is a heavy demand for the training programme with some courses being oversubscribed resulting in a waiting list being used. The LSCB Training Manager, Michael McCoy, plans and manages the multi agency training programme.

Partner agencies are responsible for arranging Level 1 training (which covers a basic understanding of child protection such as signs and symptoms, how to make a referral) and the LSCB is responsible for multi agency training.

During the year 2013-14, 22 child protection courses (Level 2) were delivered with 420 practitioners attending, an increase from 19 core courses delivered in 2012/13 with 395 practitioners attending. A further 16 specialist courses (Level 3) were delivered with 182 practitioners attending, compared to 22 specialist courses delivered in 2012/13 with 326 practitioners attending.

Brighton & Hove LSCB: Multi-Agency Training Attendance for 2013-14		
Course title	Number of Courses	Number of Attendees
Level 2 – Core Child Protection Courses		
Developing a Core Understanding	9	181
Assessment, Referral and Investigation	6	119
Child Protection Conferences and Core Groups	7	120
Level 3 – Specialist Child Protection Courses		
Domestic Violence and Abuse	5	70
Preventing and Disrupting the Sexual Exploitation of Children & Young People	3	35
Learning from Serious Case Review Seminar	2	72
Substance Misuse and Parenting Capacity	0	0
Mental Health & Children's Services: Working Together with Families	1	12
Joint Investigation for Social Workers 4 days	1	9
Undertaking Safeguarding Children Assessment Workshops	0	0
Multi Agency Public Protection Arrangements (MAPPA)	2	16
Safeguarding Children with Disabilities	2	31
Totals:	**38**	**602**

Attendance at Brighton & Hove LSCB Core Training Courses by Agency 2013-14				
	Developing a Core Understanding	Assessment, Referral & Investigation	Core Groups & Child Protection Conferences	**Total**
Brighton & Hove City Council	66	26	47	**139**
Community & Voluntary Sector	23	17	8	**48**
Sussex Community NHS Trust	5		1	**6**
Sussex Partnership NHS Trust	7			**7**
Brighton & Sussex University Hospitals		1	2	**3**
Probation	9	5	3	**17**
Schools	37	41	44	**122**
Early Years Childcare	34	23	15	**72**
Foster Care		6		**6**
Total	**181**	**119**	**120**	**420**



The Learning & Development Subcommittee has developed into a proactive group with clear terms of reference and work plan. Much of 2013 was spent on establishing basic benchmarks i.e. clarifying budget, identifying training needs etc. During 2014 the group will be building on systems to ensure quality and effectiveness of both single and multi-agency training.
June Hopkins, Chair of Brighton & Hove LSCB Learning & Development Subcommittee

The Learning & Development Subcommittee continued to report to the main LSCB regularly on the progress to deliver the multi-agency training programme and developments for discussion and resourcing.

Since July 2013 the attendance of the Subcommittee increased with improved representation from the majority of Board partner's agencies.

A Train the Trainers programme is in place to ensure there is a pool of practitioners to facilitate the training programme in addition to the LSCB Training Manager. Strong commitment is evident from across the partnership. A two day course is run each year after which delegates are expected to co-lead as trainers at 2-4 courses per year.

It has been a challenge to get formal collated evaluation reports regarding the LSCB multi-agency training this year. This has meant it has not always been possible to shape the training programme and verify quality standards. Whilst an annual Training update was presented to Board in March 2014, it did not show trends and findings based on evaluation data due to the absence of this information.

There is no current method of evaluating whether the learning has a direct impact on practice – the Training Manager trailed an approach whereby a number of delegates were contacted three months post attending the Core Group & Child Protection Conferences in March. However, take up was low with only five delegates responding to the request. The LSCB vigorously challenged this and a new approach is to be adopted for 2014/15.

Course content has been revised to ensure the voice of the service user/carer and equality and diversity issues are given more prominence.

Key Challenges for next 12 months

- Training course on Neglect to be agreed once Quality of Care tool piloted
- Training course on CSA developed. Previous CSA training has been medically focused and training needs to take a broader approach
- Review of CSE training provision
- The impact and effectiveness of multi-agency safeguarding training needs to be formally evaluated so that its effectiveness can be assessed and improved
- Analyse findings from single agency training needs analysis tool with Section 11 submissions

Safeguarding Children in Education

Brighton & Hove City Council's Education and Inclusion Team plays a pivotal role in ensuring that the statutory duties placed on schools and local authorities, via their education functions, are carried out effectively.

Section 175 of the Education Act 2002 and related statutory guidance places specific responsibilities on schools to safeguard children and promote their welfare. It is the role of the local authority to provide support, training and challenge to schools (including academies) and early years settings.

In June 2013 the B&H LSCB was presented with findings from a Safeguarding in Schools audit in which 75% of schools have participated. Schools do not have to complete the audit and the 25% who didn't participate were followed up the Attendance Strategy Manager, Behaviour & Attendance Partnership. In summary, it was concluded that schools have Designated Teachers who receive adequate and appropriate child protection training and that schools work well with colleagues in Children's Services and the Education and Inclusion Team are reassured that when a concern is raised schools act swiftly and work well to make sure that children are as safe as they possibly can be at school.

Brighton & Hove Education and Inclusion Team were required to complete a Section 11 audit tool. On the whole the audit supported the assurances given to the Board in June 2013. However, a significant area that will benefit from closer scrutiny is the designated lead for safeguarding receiving supervision in relation to the role and the gaps in guidance regarding individual or group supervision. Evidence that senior managers monitor supervision and the information that staff receive about any further support that is available.

What we will do next
In April 2014 new safeguarding guidance for schools 'Keeping Children Safe in Education' was published and the new safeguarding in schools audit tool was updated in light of this. Findings to inform next steps will be presented to the full Board in December 2014.

LSCB Member Agencies' Safeguarding Reports 2013/14

Brighton & Hove City Council Children's Services

What did we do?
Within Brighton & Hove City Council, overall accountability for safeguarding arrangements for children rests with the Executive Director of Children Services. This post was appointed to on a permanent basis in July 2013 following a period when interim arrangements were in place. The Executive Director is supported by three Assistant Directors and an extended directorate management team. Challenge and support to safeguarding arrangements within the City is provided by the Head of Safeguarding, who has direct accountabilities to the Executive Director.

During 2013/14 a number of important developments/initiatives have taken place which include:

- Missing procedures with identified Practice Leads for children missing from home, education and care have been developed and responses to children missing has been supported by the continued close working with Sussex police colleagues;
- a pan-Sussex CSE strategy has been developed and an operational CSE group has been embedded;
- the Schools Safeguarding Audit has been reviewed and amended and the 2013/14 audit is currently out for completion;
- the Safe and Well at School Survey (SWASS) has been undertaken with 8139 children aged between 11 and 16 participating in this, equating to 72% of children in this age range;
- a core training programme has continued to be delivered to Children Service's staff with 107 different training events being delivered to 1730 staff; an established school safeguarding training programme has continued to be provided with 148 teachers and governors attending five specific courses;
- a revised Supervision policy has been developed and launched, supported by a programme of coaching and mentoring training for supervisors;
- the Quality Assurance Framework, which assures that all children receiving a social work service are protected from harm, has been refreshed;
- a Threshold document has been developed which provides a framework for referrals into Children's social work and early help services;
- the development of an Early Help Hub and Multi-Agency Safeguarding Hub commenced with a launch date of 1 September 2014.

How well did we do it?
The Schools Safeguarding audit from 2012/13 had an 80%+ response rate and it is anticipated that responses for the 2013/14 will reach or exceed this level. Responses from the SWASS highlighted amongst other issues that, 89% of students reported feeling safe at school; bullying has fallen significantly from 26% of pupils reporting this in 2005, to 13% in 2013; the proportion of U16s reported to be engaged in sexual activity is 19%, below the national average of 28%. It is acknowledged that additional help is needed to support Lesbian, Gay and Bisexual pupils as they are amongst those more likely to experience bullying and to report being unhappy at school. Work to address this has included the student equality conference held March 2014.

There has been a range of quality assurance activity during 2013/14, including audits around the threshold for children entering the care system; 2nd time Child Protection Plans; responses to child protection issues in adoption cases. Deep dive audits into practice within the Child in Need Team and Children in Care Service have also taken place. Strengths have been identified around multi-agency working; improved outcome focused planning and the involvement of children in decision-making. Areas for improvement include the increased involvement of Independent Reviewing Officers between statutory reviews; recording of supervision and evidence of management decisions.

How did we make a difference?
There continues to be effective arrangements in place to protect children within Brighton & Hove from abuse and harm.

The results of the 2012/13 Schools Safeguarding Audit indicated that across the city, safeguarding in schools was robust. This is further supported and evidenced by safeguarding not being raised as an issue in the 26 Ofsted inspections undertaken in Brighton & Hove schools in 2012/13.

Quality assurance activity shows that overall, the quality of social work is sound, although requiring improvement.

The implementation of the Missing policy has provided a clear and coherent framework for working with this particularly vulnerable cohort of young people.

Effective interagency working , particularly with the police and WiSE has led to the establishment of a multi agency operational CSE group that identifies and oversees the care planning for young people identified at high risk of CSE. This ensures a co-ordinated and informed response is provided to this cohort of complex young people with particular vulnerabilities.

Brighton & Hove Clinical Commissioning Group (CCG)

The CCG has in place a director who is Lead for safeguarding children. During the year the vacant Designated Nurse post was filled and a new Designated Doctor appointed. The Designated Doctor post has been increased to 0.4 WTE (up from 0.2WTE) and covers the funding for the Designated Doctor for Child deaths. In addition there is a Named GP, who provides support to Primary Care in the city..

What did we do?

The CCG has a statutory responsibility for ensuring that the organisations from which they commission services provides a safe system that safeguards children and adults at risk of abuse. The CCG has in place a safeguarding work plan to ensure it is compliant with its duty.

The ways in which assurance is obtained from services commissioned by the CCG include:

- Monthly Quality Monitoring Review meetings, & monthly performance and contract meetings with providers.
- Monitoring of Serious Incidents.
- Supervision with Named professionals.
- Meetings with named Professionals and Leads for safeguarding across independent providers of health care monitoring of actions for health providers in relation to serious case/ leaning reviews

Internal Mechanisms

- Safeguarding reports are taken bi monthly to the Safeguarding Committee meeting.
- Annual safeguarding children report is presented to and signed off by the CCG Governing Body (May 2014)

How well did we do it?

NHS England Local Area Team Assurance report from June 2014 l looked at 6 domains and NHS England marked each area for Brighton & Hove CCG as Assured:

1. Are patients receiving clinically commissioned high quality services?
2. Are patients and public actively engaged and involved?
3. Are CCG plans delivering better outcomes for patients?
4. Does the CCG have robust governance arrangements?
5. Is the CCG working in partnership with others?
6. Does the CCG have strong and robust leadership

An Independent Safeguarding Audit in March 2014 found that:

- the CCG has taken account of the regulatory framework within which it operates in regard to the safeguarding of vulnerable adults and children;
- the CCG has in place an appropriate safeguarding governance framework which ensures that appropriate policies, plans and procedures are embedded;
- and that these responsibilities are effectively discharged at operational level

Brighton & Hove CCGs Internal Assurances:

- CCG staff are required to undertake mandatory safeguarding training to ensure staff meet the requirements set out in Safeguarding Children and Young People: roles and competences for health care staff 2014.
- CCG Safeguarding Children Awareness Audit carried out in early 2014 indicated that over 80% of staff knew where to find the safeguarding policy. 100% knew where to take a safeguarding concern.
- Supervision is provided by the designated professionals on a case by case basis. The Designated and named GP access external supervision.

How did we make a difference?
We have ensured all commissioned services have robust safeguarding procedures in place that comply with section 11 requirements

Brighton & Sussex University Hospitals NHS Trust

What have we done?
The BSUH Safeguarding Children Committee has continued its responsibility to ensure that the internal governance arrangements and statutory requirements for safeguarding children and child protection are met. The systems, processes and policies are constantly under review to ensure that they comply with local and national guidance and an action plan which addresses local issues and actions from national & local serious case reviews. The Annual Safeguarding Children Report 2013-2014 was presented and agreed by the Trust Board in March 2014 and a follow up report will be presented in November 2014

There is an appropriate structure of dedicated practitioners who provide a team approach to safeguarding children. The Named Nurse, Doctor and Midwife have continued to play an active role in the LSCB by attending the Board meeting as professional advisors to the Chief Nurse and being involved in a number of the subcommittees and short term working groups including the Monitoring & Evaluation subcommittee, the Child Protection Liaison Group , the Learning & Development subcommittee, and the Multi Agency Safeguarding Hub (MASH) working group.

In addition the named Nurse has been part of the local serious case review and SCIE learning review having undertaken Social Care Institute for Excellence (SCIE) Learning Together training.

In March 2014 BSUH completed a regional update of the Section 11 audit and then participated in a 'challenge' event in May 2014. An action plan is in place to address the Amber areas and is being monitored by the BSUH Safeguarding Children Committee.

The recent CQC visit made positive comments about the safeguarding service. The adult A&E department and the Children's emergency department are vigilant in risk assessing adults & young people and refer to the Local Authority as appropriate. There is a designated day time service to undertake child protection medicals when required. There is a health IDVA working with A&E, maternity and the Sexual health clinic to raise awareness of domestic abuse which is well evaluated.

The hospital sexual health clinic are working with the vulnerable children group to ensure staff recognise and refer this group of young people. The teams are aware of The WiSE Project and have worked closely with them to gain a conviction.

The improved pathway for young people with mental health issues related to self-harm has reviewed and supported 144 young people. There is a year on year increase which reflects the issue of children's mental health being affected by a multitude of issues but an increasing trend seems to be the use of social media sites.

How well have we done it?

The total BSUH workforce requires some level of statutory safeguarding children training, (7000 people). The content of the training reflects the learning from serious case reviews, local learning, the 3 priority areas of concern highlighted by the LSCB (sexual abuse, neglect & sexual exploitation), and that suggested by the intercollegiate document.

Level 1 (All non clinical staff) requires 3 yearly update.
Level 2 (All clinical staff who see adults) requires 3 yearly update
Level 3 (All clinical staff who see children) requires annual update

Training is monitored using the OLM system which illustrates that key areas such a paediatrics and midwifery have achieved 80% compliance. The recent CQC visit across the Trust found that staff were aware of their safeguarding responsibilities and knew how to report safeguarding issues and abuse.

In addition all staff have access to the safeguarding team and safeguarding supervision is undertaken on a case by case basis when staff identify a safeguarding concern about a child. Certain members of staff who carry caseloads in areas that are high risk for child protection (eg teenage pregnancy midwife, substance misuse midwife) have regular one to one supervision about complex cases.

Daily safeguarding ward visits continue at RACH enabling improved case discussion for nurses on approximately 450 children pa. The Named Doctor continues to give safeguarding supervision to medical staff on an ad hoc basis, and participates in the Monday teaching sessions and the Thursday peer review meetings

There is an on-going programme of single agency audits:-

Audits undertaken		
Section 11 audit updated Overview of CP medicals LSCB notes audit Maternity CP, MH, & DV documentation & referral.	CP flagging Staff confidence of caring for young people with eating disorders. Babies under a month attending A&E with feeding issues.	Ward discussion overview Training evaluation Flagging & SW notification Referral forms. Infants attending with ALTE

What difference has it made? :
The Section 11 audit has provided reassurance that Brighton & Sussex University Hospitals Trust continues to be able to demonstrate a safe service, although there are challenges such as the rising numbers of complex children with safeguarding issues and the issue of adapting to the changing provision and organisation of social care and community liaison services.

The audits have shown that care is of a good quality with documentation and risk assessment being of a good standard and staff are able to demonstrate they know who to contact if they had a concern about a child. There have been changes to practice brought about by working with the multi-agency partners including the bruise pathway, liaison about premature babies, and the process of initial contact.

Clinical Staff are involved in the Strategic and operational multiagency groups and awareness of neglect & Child Sexual exploitation has been incorporated into all safeguarding children training programs.

Debi Fillery Nurse Consultant for Safeguarding Children & Young People on behalf of BSUH

www.bsuh.nhs.uk @BSUH_NHS

Sussex Partnership NHS Foundation Trust

Governance: What did we do?
We reviewed our membership of each LSCB subgroup to ensure appropriately senior and consistent representation.

Supervision: What did we do?
We strengthened our approach. The two Lead Nurses in Adult Community Services now have a clear statement in their job descriptions identifying them as leads for Safeguarding Children in their team. Each is tasked with driving safeguarding children up the agenda in team meetings where patient care is reviewed and reminding staff of the need to identify patients as parents on the team boards. The Named Nurse, and two leads meet regularly and are embarking on some training to ensure that staff are aware of how to get extra help for families. Family Forum meetings are just being implemented ensuring that cases can be discussed with a view to supporting the CAF/ TAF process. Carole King and Julia West from what will be the Early Help Hub, will be involved in this meeting.

How well did we do it?
We now have assurance that patients who are parents are identified. Further work is underway to make the proactive consideration of CAF / TAF routine.

How did we make a difference?
The difference is made by improving the overall system and approach. Working with staff outside our own speciality is critical to managing risk. Offering early help to families where this didn't happen before will hopefully enable other services to offer children in these families, access appropriate to their needs.

Quality Assurance Activity: What did we do?
We reviewed our trust-wide safeguarding group, strengthened membership and matched it to the six LSCBs we work with.

How well did we do it?
The structure is stronger, the profile is higher and the outputs have included revisions to the training content we work to.

How did we make a difference?
It meant that at a strategic level, connections were made right across the Trust as a whole, with some clear standards agreed and monitored.

Training: What did we do?
We have reviewed our overall position and are reviewing our training. There has been a renewed drive to ensure that clinical staff are up to date and have accessed learning to assure competencies to Level 2/3 training. By autumn 2014 the Named Nurses will have run a number additional focussed sessions for staff in Adult Community services, Personality Disorder Services, Secure and Forensic Services and Living Well with Dementia Services

How well did we do it?
We know that in challenging financial times, we must focus relentlessly on the quality of training and the value added as a result of staff being trained. Targeting our approach has made it easier to achieve the objective of ensuring that all staff are up to date at all times with the training they require. The training content is benchmarked against the competencies and outcomes identified in the safeguarding Children and Young People, Roles and Competencies for Healthcare Staff Intercollegiate Document. It is important to note however, that in times of financial constraint, a sustained and uncompromising focus on training uptake and quality is required.

How did we make a difference?
Well trained staff, in motivated teams, make a positive difference to the quality of services we provide.

Lessons learned from reviews: What did we do?
We have continued to undertake Root Cause Analysis (RCA) reviews for all Serious Incidents in the Trust, and have shared these with the LSCB and partner agencies to form the basis of the condensed SCIE review processes that are taking place across the city. We have ensured representation at the LSCB 'Learning from SCRs: Implications for Practice' sessions. We also shared this session with our Brighton Safeguarding Link Practitioners Groups. Two of our staff are trained in the SCIE methodology and have actively participate in the learning reviews

How well did we do it?
The test in relation to how well we did this is in how well the lessons learned are recognised and understood in the longer term. We continue to monitor this. Information is shared with both clinical practitioners and with managers, with a view to covering those in both strategic and clinical roles

How did we make a difference?
Understanding the complexities and common themes that compromise safety helps attune staff to these issues in real time way of interagency working.

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Sussex Community NHS Trust

What have we done ?
Sussex Community Trust have appointed a substantive new Chief Nurse with Board level responsibilities for Safeguarding children who has commissioned an independent review of Safeguarding Children & adults .

The Annual Safeguarding Children Report 2013-2014 and Safeguarding Children Plan 2014 -2015 was approved by the Sussex Community Trust Quality Committee in July 2014. The purpose of the report was to provide both assurance and evidence to the Board that the Trust is fulfilling its statutory responsibilities to safeguard children and to summarise achievements and challenges against last years plan.

The Section 11 Audit was completed and signed off by the Chief Nurse in March 2014 and SCT attended and participated in the LSCB scrutiny event. An action plan is in place to address the Amber/red areas and is being monitored at the Trust wide Safeguarding Children group which meets regularly.

SCT Named Nurse and Doctor have continued to play an active role in the LSCB by attending the Board meeting as professional advisors to the Chief Nurse and being involved in a number of the subcommittees and short term working groups including the Monitoring & Evaluation Subcommittee, the Child Protection Liaison Group , the Learning & Development Subcommittee , the Child Sexual Exploitation and the Multi Agency Safeguarding Hub (MASH) working group.

Both SCT Named Nurse and Doctor have undertaken the Social Care Institute for Excellence (SCIE) learning together training and the Named Nurse has been an active member of the review team on both a SCIE Learning Review and a Serious Case Review.

How well have we done it :
In accordance with the SCT Safeguarding Children Training & Development Strategy & the Intercollegiate Document (RCPCH 2013) staff groups have received the appropriate level of training for their role . There has been an improvement in provision for Brighton & Hove staff to undertake safeguarding children training and at levels 1 and 2 resulting in 1022 staff equating to 75% and 92% were trained at Level 3

The delivery of regular safeguarding children supervision continues to be a priority. As a consequence 97% Health Visitors , 95% School Nurses and 100% of Managers seconded into Brighton & Hove Children & Family Services under a section 75 received supervision in the appropriate timeframe . A Safeguarding Children Supervision audit was completed in Children Centre Teams which demonstrates that Health Visitors receive regular supervision of a quality that meets their needs in terms of working with cases of concern

Single audits that were completed included the following: An audit to demonstrate implementation of NICE Guidance CG89 When to Suspect Child Maltreatment which gave assurance that 100% of the staff seconded into Brighton & Hove Children & Family Services under a section 75 were compliant. An audit of Child Protection Process in Children's Centres, the result being to improve outcome based planning by introducing a Family Action Plan Template which will be re audited in 2015 and a new Safeguarding Children Supervision procedure. A Child Abuse Single Agency Audit which recommended to request Achieving Best Evidence interviews prior to Child Sexual Abuse medicals.

Improved organisational communication was achieved in relation to "What to do if you suspect a child is being abused "by development of an SCT poster and leaflets which were distributed during training and throughout staff premises.

What difference has it made:
The Section 11 audit has evidenced that Sussex Community Trust continues to have safe and effective arrangements in place to safeguard and promote the welfare of children. Audit activity demonstrates that 100% of staff know who to contact if they had a concern about a child and that supervision arrangements that are in place are robustly supporting staff. An increased number of staff have received safeguarding children training at the appropriate level in accordance with the Safeguarding Children Training and Development Strategy. There is a high level of effective multiagency working through case reviews and multiagency groups which has resulted in changes to practice like the development of the Bruise/Unusual Mark Pathway and Leaflet for Parents.

Update on Priority area of the LSCB business plan

1. Child Sexual abuse – Named Professionals were involved in the multiagency audit in addition to the single audit . The action plan is currently being developed and will include SCT Named professionals being involved in a weekly multiagency meeting at the MASH commencing Ist September 2014 which will build on the meetings already established in ACAS by the Named Doctor and will involve training to the Child in Need Team . The Named Doctor is involved in the development of the Paediatric Sexual Assault Referral Centre (SARC). The Designated Doctor is the Board lead for Child Sexual Abuse.
2. Neglect – Named Professionals have been involved in a multi agency neglect working group which has involved a multiagency neglect audit . Currently the Named Nurse, who is also the Board lead for neglect, is leading a pilot with the Principal Social Worker on developing Quality of Care tool for practitioners .
3. Child Sexual Exploitation – SCT Named Professionals and Clinical Staff are involved in the Strategic and operational multiagency groups .Awareness of Child Sexual exploitation has been incorporated into all SCT safeguarding children training programs level 1,2 & 3 for year 2014/2015.

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Community Voluntary Service (CVS) Sector

Brighton & Hove has a vibrant, active and diverse Voluntary and Community Sector (CVS) which plays a major role in providing a range of (usually) free, high quality services in communities. The last Taking Account Survey 2014 showed that there are at least 2,300 CVS organisations and groups in the city of which 11% (253) define their main activity as working with children & young people.

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

These locally based organisations often play a key role in safeguarding children and young people in communities and it is therefore crucial that they have appropriate arrangements in place and are confident in managing their safeguarding responsibilities. For most CVS organisations the responsibility for safeguarding lies with their management committee or Board of Trustees.

Brighton & Hove has a well-established infrastructure organisation, Community Works, which provides a mechanism for bringing together the voice and concerns of the Third sector. The Children & Young People's Network operates under the umbrella of Community Works to provide a forum for organisations across the city who are providing services and support to children, young people and families. Following recommendations from the Section 11 audit, Community Works will be amending its membership requirements to include questions about safeguarding practice to those groups and organisations working with children, young people, families and vulnerable adults. Safeguarding is a standing item at the quarterly meetings and safeguarding information is regularly circulated to groups via the Community Works e-list. Larger organisations in the CVS may also have their own safeguarding forums in place.

Safety Net and Community Works are also promoting the NSPCC/Children England Safe Network site which provides a range of resources for community and voluntary sector groups as well as the Safe Network standards which groups can self-assess against. Safety Net, a local children's charity is a Safe Network ambassador for Brighton & Hove and also provides safeguarding information and support to many CVS organisations across the city through its Let's Protect Project which includes:

- Safeguarding support to individuals and organisations
- A rolling programme of child protection training for community and voluntary sector organisations, delivered in community venues across the city.
- The 'Simple Quality Protects' quality assurance which provides a framework for organisations to create, review and develop their safeguarding policies and procedures and share good practice, and be supported and assessed by Safety Net to achieve their Bronze, Silver & Gold awards.
- A DBS checking service and support

CVS Organisations and groups access child protection training from a range of sources including: in-house (for larger organisations), E-safeguarding courses provided by external providers, for example Educare as well as from Safety Net.

We have been involved this year with SQP: Simple Quality Protects which is an excellent way of ensuring operational order for TOYBOX Crèche in respect of Child Protection. Staff and volunteers have made good use of the completed file during periods of induction as the file clearly explains core policy statements that support Child Protection and Safeguarding. The file is a useful reference document for any OFSTED inspection due to the way in which the information is collated. TOYBOX received an OFSTED inspection in February of this year and was graded 'GOOD'.
Brighton Women's Centre

Over the last year Safety Net has provided Level 1 Safeguarding training to workers and volunteers from over 100 different organisations. 133 staff from CVS Early Years settings have received training, 215 staff and volunteers from community organisations have accessed free general safeguarding courses and 870 individuals have received training in their own settings. A further 107 attendees have accessed additional safeguarding courses relating to safeguarding teenagers, safer recruitment, safeguarding for trustees, online safety and safeguarding for children with disabilities delivered by Safety Net in partnership with other CVS organisations and the National Safe Network.

A Number of larger organisations have quality assurance marks from national schemes such as PQASSO, MATRIX and Investors in People. Locally, the Simple Quality Protects Scheme provides a simple 3 level model of quality assurance standards, bronze, silver and gold to enable groups to evidence that they meet standards of practice in a range of area, including safeguarding. This scheme was developed by Slough CVS as a means of smaller groups evidencing safe practice and standards. Over the last 2 years 30 organisations have undertaken the Simple Quality Protects scheme, with 13 achieving bronze level, 10 silver and 7 gold. A further 17 organisations are undertaking the scheme in 2014.

The CVS continues to be an active member of the LSCB. Terri Fletcher from Safety Net is the current elected representative; her role has included membership of the LSCB full board, the Participation & Engagement, and Learning & Development Subcommittees, and the Early Help development group, as well as taking on the role of chair for the newly formed Vulnerable Children Monitoring Subcommittee. Community Works staff and Reps continue to work with Children's Services staff and the LSCB around the Early Help and Mash developments, and have been regularly updated through attendance by BHCC staff at the Community Works conference. Local CVS organisations RISE and Sussex Central YMCA also deliver specialist courses as part of the LSCB training offer around "Domestic Violence & Abuse: the Impact on Children & Young People" and "Preventing & Disrupting the Sexual Exploitation of Children & Young People" respectively.

The Brighton & Hove Violence Against Women & Girls Forum acts as the multi-agency forum for Brighton and Hove in raising awareness of the effects of Violence Against Women & Girls, responding to these issues and promoting joint working, co-operation and mutual support. The chair of the Violence Against Women & Girls Forum is Gail Gray, the CEO of RISE. The chair of the Forum attends the LSCB to promote effective communication between the LSCB and Violence Against Women & Girls Forum. An update from Gail on behalf of the Violence Against Women & Girls Forum is on page 65.

Sussex Police

Although all police officers have a duty to protect life and property, safeguard children and bring offenders to justice, the specialist provision for protecting children from harm and abuse is the responsibility of the officers from the Brighton & Hove Child Protection Team (CPT). This is one of 5 such teams located across the Sussex Police area.

Officers within these teams are all trained detectives who have received additional specialist national training to be accredited child abuse investigators, and joint training with colleagues from Children's Social Care. The quality and effectiveness of investigations is managed locally by Detective Sergeants under the direction of a Detective Inspector using IT systems that include mandatory reviews of all cases under current investigation.

The Protecting Vulnerable People Branch (PVPB) is responsible for providing the Force-wide strategic lead for a number of portfolios including child protection, with a role which includes the development of policy, audit and review, and representation at the LSCB.

What did we do?

- The findings from a number of serious case reviews have related to trying to improve the collation of the large amount of information Sussex Police receives about children that is located within a number of IT systems. During the year the introduction of a new IT system has enabled a better collation of information, and the introduction of electronic child protection family files.

- We have continued to work has with partners to introduce a Multi Agency Safeguard Hub (MASH), which will bring agencies together in one location to receive and assess referrals with immediate access to information from those agencies involved.

- At a Force-wide level the PVPB have continued to focus on several complex historical child sexual abuse investigations involving members of the clergy

- Considered of how investigations into neglect might be improved

- Continued the ongoing development in our response to Child Sexual Exploitation (CSE)

How did we do?

- Electronic family files are now replacing paper versions. As this process develops staff will have easier access to information across the whole Force area rather than just from within their own team. This will help ensure more accurate information is available when commencing joint investigations with Children's Social Care, especially in cases where families are transient. More informed investigations give better opportunities to achieve a positive outcome for a child following an investigation.

- The MASH project is continuing towards a proposed implementation during 2014

- In relation to the historical abuse investigations a number of convictions have been achieved during the year. At a local level this has helped raise the profile of this area of abuse, and given the opportunity for many victims to be listened to and believed, and see justice achieved in relation to those responsible for their abuse.

- The threshold for police intervention in neglect referrals often remains relatively high, given the wide spectrum of neglect that can exist, from poor parenting through to deliberate neglect causing harm where a criminal threshold is reached. Officers from the CPT have been briefing uniformed colleagues on this issue and encouraging officers to use their body worn video to record evidence of potential neglect at premises they attend as part of their day to day duties. This has been helpful in collecting potential evidence and assessing the scale of any neglect seen by the officers.

- In addition to undertaking a complex abuse criminal investigation, the police have completed a strategic assessment of CSE across the Force area. Training has been provided to front line staff in the recognition of CSE and how to respond, and CSE incorporated into the roles of the Missing Person coordinators. Vulnerable children who go missing or who at risk of CSE are discussed at a monthly multi-agency meeting.

How did we make a difference to children?

The above initiatives continue to contribute towards improving the way the police respond to their statutory duty to safeguard children from abuse and neglect. The year ahead will see a significant restructure in the way child protection and other specialist crime areas are delivered, including joint working with Surrey Police. The LSCB will be kept informed of developments as the restructure progresses.

www.sussex.police.uk @sussex_police

Sussex & Surrey Probation Trust

Surrey & Sussex Probation Trust

Probation services are primarily engaged with adults to reduce reoffending and protect the public. This includes a duty to protect children and young people and there are policies and procedures in place to ensure this happens. Surrey and Sussex Probation Trust (SSPT) were responsible for the delivery of probation services in Brighton & Hove until the 1st June 2014 when a new system for the management and rehabilitation of offenders in the community was introduced. A new public sector National Probation Service (NPS) is responsible for the management of those offenders who pose the highest risk of serious harm and have committed the most serious crimes. The Kent Surrey and Sussex Community Rehabilitation Company Ltd (KSSCRC) manages offenders who are assessed as presenting a low or medium risk of harm and delivers interventions which include Unpaid Work.

What did we do?

Probation staff continue to discharge their safeguarding responsibilities to children through activities which include information sharing, risk assessment and risk management. All operational staff have received training to make them aware of factors that may indicate a risk. These may relate directly to offending against children for example, violence and/or sexual offending. However staff are also made aware of other risk factors that may be present in cases where those we supervise are parents or carers, particularly domestic violence, substance misuse and mental health. In the case of the latter staff are trained to recognise that child neglect may be a more significant issue.

Systems are in place to identify those children and young people who are at risk of harm from offenders. Staff are encouraged and supported to work in partnership with other agencies in order to manage the risks posed. Current partnerships include those with substance misuse and accommodation providers through our Integrated Offender Management Scheme, the Safer families Stronger communities programme and Inspire women's programme.

All operational staff are subject to a quality assurance audit of their risk assessments. Middle managers are required to regularly monitor in supervision, all known safeguarding cases assessed as posing a medium risk of harm to children. Cases identified as fulfilling the criteria for inclusion in MAAPA are subject to rigorous internal and external audit processes.

A designated Safeguarding lead has responsibility for strategy and professional practice. In SSPT the post was held by the CEO. In the NPS there is a regional Director lead for Safeguarding as well as a local Assistant Director who represents the NPS on the LSCB. The Director of Operations in the KSSCRC holds the strategic and professional lead for the CRC. Safeguarding is a priority for strategic managers and there is strong representation at the LSCB and associated sub groups. From June representation was split to include a senior representative from both organisations. A number of probation staff participated in a recent Serious Case Review, the learning from which will be used to inform future practice.

How well did we do it?
Offender managers are required to carry out two types of assessment, one of offender needs and contributory factors to their offending behaviour and the other the risk of harm they pose to others. The overall quality of these assessments is monitored and has achieved a good overall standard this year. We know however that we need to improve our recording to include easier identification of 'current and active' risk of harm cases involving a child or known adult. This will be an immediate focus of work for both new probation organisations.

Our training records show that 90-95% of the offender facing staff have attended child protection training in 2013/14. Much of this was delivered through in house training, in particular the 'Developing Professional Curiosity' workshops which were mandatory for all front line staff. New staff attended introductory 'Working Together' events. Overall attendance at LSCB events was low. We will seek to improve attendance at relevant LSCB events in the coming year.

Senior Management attendance at the LSCB and representation at associated subgroups was good. A KSSCRC middle manager was trained in the SCIE Serious Case Review methodology and will be available to undertake reviews in Sussex.

How did we make a difference to the lives of children?
There are numerous examples of good practice in relation to the assessment and management of offenders who are at risk from and/or have contact with children. The contribution of Probation to MAPPA, MARAC and to formal joint child protection work is strong. We are mindful that there is further room for improvement and will be studying closely the recommendations in the recent inspection report 'An Inspection of the Work of Probation Trusts and Youth Offending Teams to Protect Children and Young People' HM Inspectorate of Probation August 2014, to make the outcome of effective protection of children more likely in every relevant case.

Leighe Rogers former Director SSPT. Current Director of Operations KSSCRC
August 2014

www.ksscrc.co.uk @KSSCRC

Children & Family Court Advisory and Support Service (CAFCASS)

Cafcass is a non-departmental public body, sponsored as of April 2014 by the Ministry of Justice. Its principal functions are to safeguard and promote the welfare of children who are subject to family proceedings, and to provide advice to the family courts. It employs about 1870 staff, over 90% of whom are frontline.

What did we do?

In 13/14 a total of 9,680 care applications (public law) were received, which is a decrease of 12% compared with the number received in 12/13. Similarly there has also been a decrease in private law cases where a total of 42,888 applications were received in 2013/14 - a 7% decrease compared to 12/13. Shorter case durations (within s31 cases), together with proportionate working and more efficient working practices have led to the stock of open cases reducing in both private and public law.

How well did we do it?

The following are examples of activities undertaken by Cafcass in 13/14 to improve practice, better safeguard children and make a positive contribution to family justice reform:

- Working with partners in family justice e.g. the Family Justice Board, Local Family Justice Boards (11 of which are chaired by Cafcass), judges; the Family Justice Young People's Board; and the ADCS, to promote family justice reform in preparation for the implementation of the Children and Families Act (April 2014).
- Contributing to the development of the Public Law Outline and Child Arrangements Programme (Practice Directions 12A and 12B respectively); and working with partners to reduce the duration of care cases (35 weeks as of quarter 3).
- Setting up demonstration projects designed to accelerate family justice reform e.g. a telephone helpline service in the North-East to divert from court cases where there are no safeguarding issues.
- Strengthening the workforce through a number of measures including: the talent management strategy; MyWork (a mechanism by which staff can understand and regulate their own performance); development of a health and wellbeing strategy.

- Revising the Child Protection Policy, Operating Framework and Complaints and Compliments Policy.
- Drafting service user minimum standards which will be joined with our workstream on child outcomes.
- Undertaking a number of pieces of research into the work of Cafcass and family justice including research into: expert witnesses in s31 cases; the work of the Children's Guardian; learning derived from Cafcass submissions to serious case reviews (Cafcass having contributed to 30 such reviews in 13/14).

How did we make a difference to the lives of children?

The National Ofsted inspection took place in February and March 2014. Both private law and public law practice were judged to be good as was the management of local services. National leadership was judged to be outstanding.

All of the Key Performance indicators, relating to the allocation of work and filing of reports, have been met, which will have made a difference to the lives of children we work with and contributed to a more timely resolution of children's matters in the courts

East Sussex Fire & Rescue Service

What have we done?
ESFRS improved its monitoring of child protection and safeguarding practices set within its policy and procedures. Staff across ESFRS continued to report all Safeguarding concerns to the Safeguarding Co-ordinator(s) located within the Community Risk Management Department and information has been shared with statutory and voluntary agencies appropriately. The strategic overview of safeguarding continues through a refined Safeguarding Panel, chaired by the ESFRS Designated Officer, the Director of Prevention & Protection.

An internal audit was undertaken in 2013/14 by the Community Safety Lead Support at the request of the ESFRS Safeguarding Panel to assure itself that the Fire Authority was meeting its statutory requirements.

Dedicated pages on the ESFRS intranet have been made available to provide access for all staff to central information and guidance on safeguarding. This includes links to external agency information and staff support.

How well did we do it?
The Audit undertaken confirmed that all files contained a full audit trail of relevant reports, subsequent actions and feedback from organisations taking referrals from ESFRS.

230 staff completed the online Safeguarding Children KWANGO course in 2013/14, which is an increase on last year's figures. ESFRS new starters now complete the KWANGO online course as part of their induction; however, ESFRS continued to train supervisory managers, LIFE Instructors and Firesetter Intervention Scheme Advisors at the Advanced level training; over 120 staff has completed the Advance Safeguarding training in 2013/14. ESFRS recognises that awareness training on child sexual exploitation (CSE) is needed for all staff.

How did we make a difference to the lives of children?
The audit has confirmed that referrals are actioned in a timely manner and referred to the correct agency. The number of staff receiving training is having a positive impact on numbers of referrals made and the completion of accurate records ensuring that children are protected from harm at the earliest indication that there is a concern.

There continues to be effective arrangements in place to protect children from abuse and harm at the earliest opportunity. Overall, the quality of Safeguarding work is robust although there is a requirement for additional training in some key areas.
www.esfrs.org @EastSussexFRS

Conclusion and Challenges for 2014/15

This report has provided an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children. It has evidenced that safeguarding activity is progressing well in the area and that Brighton & Hove LSCB has a clear consensus on the strategic priorities achieved and what actions will follow over the coming year. The LSCB is aware of, and working to fulfil, its statutory functions under the revised Working Together to Safeguard Children (2013). Statutory and non-statutory members are consistently participating towards the same goals in partnership and within their individual agencies.

Our child protection policies and procedures to keep children safe are well embedded, regularly reviewed and ensure agencies have a clear reference point to undertake single and multi-agency work. We are confident that these ensure children are best protected from harm and their families offered the right support when they most need it. Our local policies and procedures also enable the right decisions to be made about the safe recruitment, induction and supervision of frontline staff, as well as respond to allegations against staff.

Challenges:

- Whilst we have tried to promote the direct **participation** and input of **children** and **young people** in the work of Brighton & Hove LSCB at a strategic and operational level this remains an area of challenge for the Board.
- We need to improve the breadth of our lay membership to ensure that the Board and agencies receive challenge from a reprehensive section of our communities. We are undertaking a recruitment exercise which will see a Lay Member Sub Group reporting in to and represented on the board.
- Performance management and analysis needs further development within the Board. We are working to improve our **multi-agency data set** so that it drives an embedded culture of rigorous performance management, which transforms the standards of practice.
- The LSCB **multi-agency training programme** was an area that needed attention previously. Throughout 2013/14 urgent action was taken to reinvigorate the Training, now the Learning & Development Subcommittee. A new chair implemented Terms of Reference, which ensures regular and well-engaged meetings and that the group has a clear work plan linked with the LSCB's priorities. This needs to be driven forward
- We are looking to consider our capacity to deliver more regular and focused SCIE Learning Together training appropriate to different levels and **engagements in SCRs**, for example, training for the 'Case Group,' not just training for Lead Reviewers.

- The development of a Multi-Agency Safeguarding Hub (MASH) and local approach to Early Help were implemented on 1 September 2014 . We will be making sure certain arrangements are communicated effectively, understood, and consistently implemented across the partnership to **promote appropriate referrals** and support safeguarding of children and young people.
- LSCB newsletters and the adoption of the SCIE Learning Together approach to Serious Case Reviews, has helped to raise the profile of Brighton & Hove LSCB with frontline staff and raise awareness of what is being done locally. However, we need to continue to strive to raise the Board's profile with members of the public and we need to consider how we can better **engage the public in safeguarding children.**
- The **economic** situation and **organisational** change affecting public services continues to be a **challenge** for the Board and we must ensure the safety of children is not compromised.
- We need to strengthen our approach to **online safety** as the advancements in social media technology have created new opportunities for children and young people to be harmed.
- We need to better understand the reach and impact of our training, learning from case reviews and outcome of audit so as to be assured they are improving the lives of children

Messages for Readers

Board Members

Identify and act on child protection concerns

Work effectively to share information appropriately

Collectively make decisions about how best to intervene in children's lives where their welfare is being compromised, and collectively monitor the effectiveness of those arrangements.

Staff working in Board partner agencies

Book onto LSCB Multi agency training and learning events pertinent to your role

Be familiar with the Pan Sussex Safeguarding Procedures

Be familiar with the Threshold document to ensure an appropriate response to children and families

Use your agency representative (you can see who this is on page 102) to make sure the voices of the workforce, children and young people are heard

Chief Executives & Directors

Show Brighton & Hove LSCB that your agency is committed to a culture of safeguarding

Ensure your workforce contributes to the provision of LSCB multi agency safeguarding training

To have an open dialogue about any barriers that may impact on your organisations ability to safeguard children and young people

The Community

You are in the best place to look out for children and young people and to report any of your concerns

Safeguarding children and keeping them free from harm is everyone's responsibility, if you are worried about a child or young person please follow the steps on Brighton & Hove LSCB's website:

www.brightonandhovelscb.org.uk

Local Politicians

Help Brighton & Hove LSCB respond to the voices of vulnerable children and families in your ward. For 2013/14 Councillor Sue Shanks was lead member for children and families, making sure their voices are heard by the LSCB

Keep the protection of children and young people at the forefront of thinking when scrutinising and challenging any plans for Brighton & Hove

Commissioners

Scrutinise and challenge governance and planning arrangements by your providers for children, young people and their families in Brighton & Hove

Discharge safeguarding responsibilities fully to ensure services are commissioned for the most vulnerable children

Monitor how information is shared across and between your providers

Children and Young People

You are at the heart of the child protection system.

We want to make sure that your voices are heard and that we know how you are experiencing the services in our Board partner agencies. If you would like to know more about how you can influence the work of Brighton & Hove LSCB please contact us at www.brightonandhovelscb.org.uk/contact

Appendix 1: LSCB Budget 2013-14

Detail	Original Budget £	Revised Budget £	Actual £	Budget 2014/15 £	Forecast 2014/15 £
Staffing:					
Training Manager	30700	30700	**30797**	31050	31196
Business Manager	49700	49700	**75028**	50450	47519
Admin Officer	19800	19800	**16574**	22900	22497
Nurse		15000	**9817**	15100	6510
Independent Chair	20000	20000	**22331**	20000	20000
Other Costs:					
Contingency for SCR Panels	10000	10000	**12400**	10100	21878
Venue Hire	1000	1000	**758**	1000	1000
Staff advertising	0	0	**400**		
Training	0	0	**11025**	15740	15740
Insurance				80	80
Transport Costs	200	200	**0**	200	200
Printing	2000	2000	**251**	2000	2000
Office Stationery	100	100	**0**	100	100
Telephony	300	300	**239**	300	300
Computer Costs	200	200	**0**	200	200
Chronolater	2300	2300	**2030**	2300	2300
Communications	2000	2000	**1800**	2000	2000
Conferences	1000	1000	**0**	1000	1000
CWDC	15000	15000	**0**		
Hospitality	200	200	**202**	200	200
Child Death Review Panel		10000	**10000**	10000	10000
Pan Sussex Safeguarding Procedures Manual	2000	2000	**1955**	2200	2200
Other fees		0	**244**		
Total LSCB Expenditure	**156500**	**181500**	**195850**	**186920**	**186920**

Funded By:					
B&H City Council - Core Funding	85500	85500	**85500**	124680	124680
B&H City Council - Extra Funding	8400	35400	**35400**		
B&H City Council - Balance of Carry Forward	15000	15000	**15000**		
Contrib. from NHS Brighton & Hove CCG	32000	32000	**32000**	43780	43780
Surrey & Sussex Probation Trust	4000	4000	**6000**	5572	5572
The Police and Crime Commissioner for Sussex	9000	9000	**9000**	12338	12338
CAFCASS	600	600	**550**	550	550
Total Funding	**154500**	**181500**	**183450**	**186920**	**186920**
Overspend			**12400**		**0**

Breakdown of extra funding received in year

Nurse		15000
Child Death Review Panel		10000
Admin Post		8400
Procedures manual		2000
	Total	35400

Appendix 2: Local Safeguarding Children Board Members as of March 2014

Statutory Members:
Graham Bartlett, Independent Chair of LSCB

Brighton & Hove City Council (BHCC):
Pinaki Ghoshal, Director of Children's Services
Helen Gulvin, Acting Assistant Director Children's Services: Children's Health, Safeguarding & Care
Jo Lyons (Dr), Assistant Director Children's Services: Education & Inclusion
Linda Beanlands, Head of Community Safety

Sussex Police
Paul Furnell (D/Supt)

Sussex & Surrey Probation Trust
Leighe Rogers, Director, Brighton & East Sussex Local Delivery Unit

Youth Offending Service
Anna Gianfrancesco, Head of Service

CAFCASS
Nigel Nash, Service Manager

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

Lay Members
Andrew Melrose (Professor)
Gabraella Howard-Lovell

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

NHS England
Katrina Lake (Dr)

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

Schools
Wendy Harkness, Head Teacher, West Hove Infants
Haydn Stride, Head Teacher, Longhill Secondary
Wendy King, Head Teacher, Bevendean Primary School

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

Community & Voluntary Sector
Terri Fletcher, Director, Safety Net

Advisors:

Ann White (Dr)	Named Doctor, SCT/BHCC
Carwyn Hughes (DCI)	Protecting Vulnerable People Branch, Sussex Police
Deb Austin	Head of Safeguarding, BHCC
Debi Fillery	Named Nurse BSUH, NHS Trust
Eddie Hick	Child Protection and Safeguarding Manager, Sussex Police
Helen Davies	Independent Safeguarding Consultant, Chair LSCB Monitoring & Evaluation Sub Committee
Leonie Perera (Dr)	Named Doctor, BSUH, NHS Trust
Mia Brown	Brighton & Hove LSCB Business Manager
Natasha Watson	Managing Principal Lawyer, BHCC
Sue Shanks (Cllr)	Lead Member, BHCC Children's Services
Tom Scanlon	Director of Public Health
Yvette Queffurus	Named Nurse – Safeguarding, SCT/BHCC
Zo Payne	Named Nurse, Sussex Partnership NHS Trust

Agency	Number of Statutory Members	Representation at LSCB Meetings 2013-14[7]
Brighton & Hove City Council	4	80%
Sussex Police	1	100%
Sussex & Surrey Probation Trust	1	80%
Youth Offending Service	1	40%
CAFCASS	1	40%
East Sussex Fire & Rescue Service	1	60%
Lay Members	2	20%
Brighton & Hove CCG	4	80%
Brighton & Sussex University Hospitals	1	80%
Sussex Community NHS Trust	1	80%
Sussex Partnership NHS Foundation Trust	1	20%
SECAMB	1	0%
Schools	3	66%
Brighton & Hove Domestic Violence Forum	1	60%
Community & Voluntary Sector	1	80%

[7] Average of statutory members from the agency attending or sending an appropriate delegate to all five LSCB meetings during 2013-14

Appendix 3: Brighton & Hove LSCB Training: Mission Statement

Our full Training & Development Strategy can be read on our website. Our mission is to provide high quality, up-to-date training on safeguarding. This training will enable frontline practitioners working with children and families living in Brighton & Hove to keep safeguarding and promoting the welfare of children at the centre of their work.

Our multi-agency training enables staff and volunteers to work effectively across boundaries and organisation. This takes into account the individual rights of both participants and the children and families served with regards to race, culture, gender, experience of disability, language, sexuality and sexual orientation.

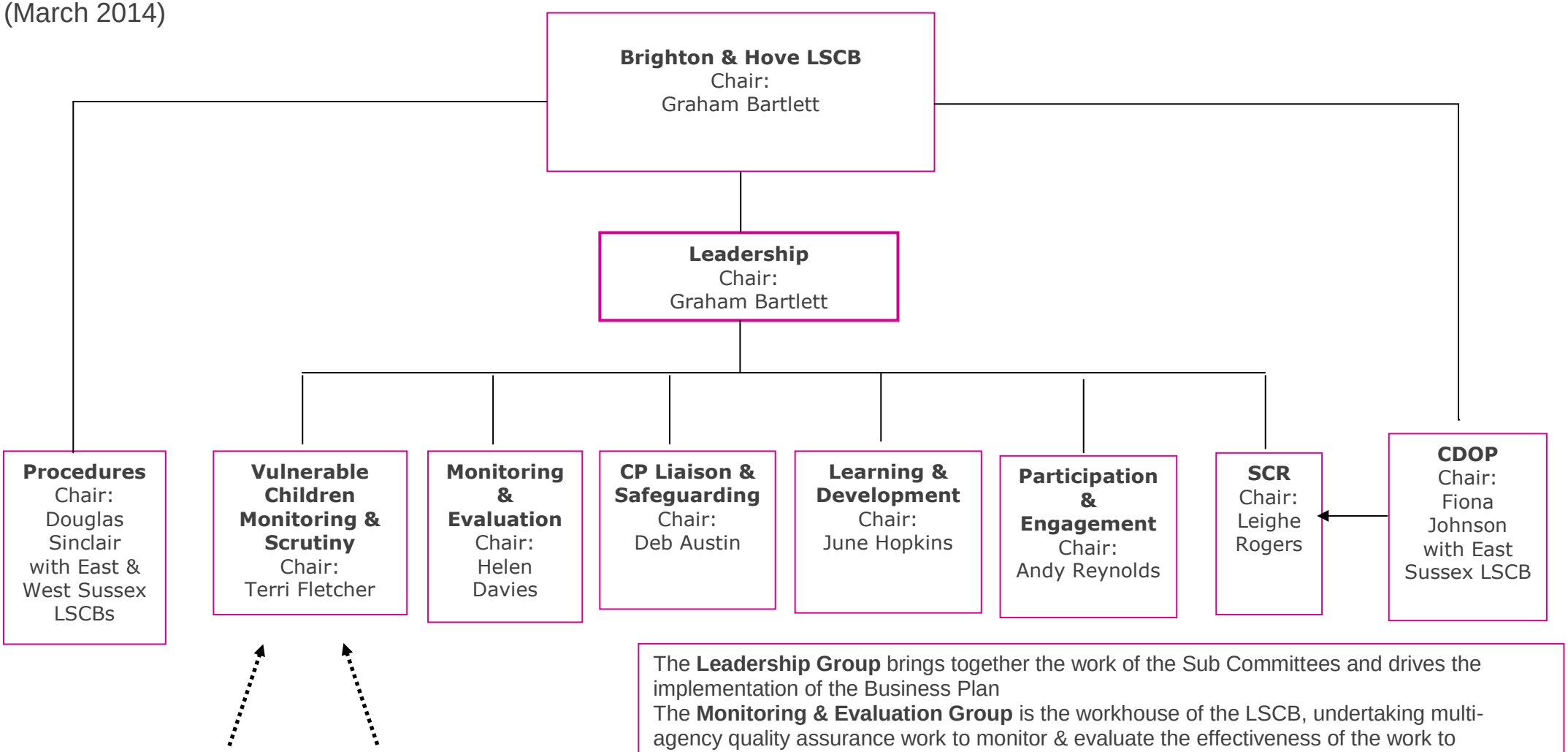
Brighton & Hove Local Safeguarding Children Board's Training Programme is based upon the following principles that will underpin all training events:

- All training is child focussed ensuring the voice of the child and the child's welfare remain paramount
- Training is delivered by trainers who are experts in safeguarding, child protection and promoting welfare.
- Training is informed by current evidence based research, lessons from serious case reviews, child deaths, practice developments and national and local policy

Evaluation and feedback is integral to the continued development of the LSCB training programme, and we will ask you to comment on the course & content at the end of the day. We also suggest that you reflect on how this learning effects your practice during supervision with your manager, and we will contact you around three months after the course with a short online survey to assess how you have been able to put the training into action, You may also be contacted to request a quick telephone consultation, or to become part of a focus group, and your cooperation with this is truly valued.

Appendix 4: Brighton & Hove LSCB Subcommittee Structure Chart

(March 2014)



The **Leadership Group** brings together the work of the Sub Committees and drives the implementation of the Business Plan

The **Monitoring & Evaluation Group** is the workhouse of the LSCB, undertaking multi-agency quality assurance work to monitor & evaluate the effectiveness of the work to safeguard & promote the welfare of children in Brighton & Hove.

The **SCR Group** commission case reviews & leads on the local learning & improvement framework

The **Learning & Development** & the **Participation & Engagement Group** are closely linked to all sub groups, and work to raise awareness of safeguarding issues & foster good multi agency working.

The **CPLG Group** is an operational group that discusses cases & acts upon the issues to improve multi agency working relationships.

The **VCMS Group** monitors and scrutinises at a strategic level the multi-agency operational groups that work with vulnerable children – focusing on missing and CSE.

Brighton & Hove LSCB

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