Brighton & Hove Local Safeguarding Children Board

Annual Report 2017-18

Contents

Forward by Independent Chair - Chris Robson

I am pleased to introduce the Brighton & Hove Safeguarding Children Board (LSCB) annual report. This is my first annual report as the Independent Chairperson, a role I took over in December 2017. The LSCB is required to publish a report each year on the effectiveness of safeguarding in our area. This should include an assessment of local safeguarding arrangements, achievements made and the challenges that remain.

Throughout the year, building on the work done by the previous chair, the Board has continued to grow in the way partners challenge and hold each other to account, both at full board and at our subcommittee meetings.

Progress against our priorities has been promising; you will see the detail in the report from page 15.

Our quality assurance activity has highlighted some real strength in the multi-agency safeguarding response to children with disabilities. Our audit on recognition and response to intra-familial child sexual abuse has helped provide a focus on areas of practice that could and will be improved.

This year saw the Early Help Hub, Family Information Service and the Multi-Agency Safeguarding Hub came together to form a single point for all contacts related to supporting and safeguarding children known locally as the Front Door for Families. Whilst it is too early to evaluate its impact, the service has been carefully designed to ensure a range of professionals with different areas of expertise are bought together to assess, decide and coordinate how best to support children, young people and their families where there are concerns.

Two serious case reviews have been published this year. One concerned the death of a 17 year old boy and led us to evaluate the safeguarding response to children as they approach adulthood. The other concerned two siblings who are suspected to have died whilst involved in conflict abroad. This was a large scale and complex review highlighting some good practice and areas for development in supporting children and young people who are vulnerable to exploitation through radicalisation. You can read more about these reviews from page 26.

Child protection and safeguarding in the multi-agency world is complex and quick solutions are not always available. Our priorities are designed to drive whole system change and service improvement which, if carried out correctly, should lead to improved outcomes for the children and young people of Brighton & Hove who need them most. Towards the latter end of the year the LSCB has been aware of emerging threats and risks of county lines activity. Whereby local children and young people are being criminally exploited to run drugs and money into rural areas of the county. Whilst criminal exploitation was not identified as a priority for the LSCB when our business plan was drawn up in 2016, we have responded swiftly and robustly to this new safeguarding risk. It is important that we do not to shy away from trying to understand and tackle such difficult issues.

Our multi-agency training has continued to thrive. I am very pleased to announce that our Learning and Development Officer was nominated for “Child Protection Trainer of the Year”, which demonstrates that we are providing a relevant, up-to-date and beneficial programme to promote the ongoing safeguarding of our children and young people across the city.

This will be the last annual report of the LSCB as we begin the transition to new safeguarding partnership arrangements bought about by the enactment of the Children and Social Work Act. I thank the members of the LSCB for their professionalism, challenge and rigour and the business team for all their work during the year. I must conclude by thanking the frontline practitioners for their dedicated work in safeguarding our children and young people.

Introduction

This annual report covers the period 1 April 2017 to 31 March 2018.

Who we are and what we do

Brighton & Hove LSCB is made up of senior representatives from statutory and non-statutory agencies and organisations in Brighton & Hove with a responsibility for keeping children safe. This includes, for example, the City Council, the Police, Health partners, Probation Partners and the Community and Voluntary Sector.

Essentially, Brighton & Hove LSCB has a co-ordination role.

We coordinate local work by:

- Delivering a multi-agency Business Plan, which outlines how we intend to tackle priority safeguarding issues together
- Developing robust policies and procedures
- Delivering multi-agency training

We ensure the effectiveness of local work by:

- Monitoring and scrutinising what is done by our partner agencies to safeguard and promote the welfare of children
- Undertaking serious case reviews and other multi-agency learning reviews, audits and qualitative reviews and sharing learning opportunities
- Collecting and analysing information about child deaths
- Drawing evidence from the testimony of children, young people and frontline professionals
- Publishing this annual report

Summary of Achievements

- We have held six briefings in the last year, reaching over 100 frontline practitioners and their line managers. Through these sessions we have promoted the purpose and work of the board and focused on sharing the learning themes from our serious care reviews and our multi-agency audit work.
- There continues to be a strong focus on understanding the picture of child sexual exploitation locally and an increasing focus on prevention.
- A Multi-Agency Child Sexual Abuse Strategy and action plan and Neglect Strategy has been developed.
- As a result of LSCB audit work a Multi-Agency Child Neglect Consultation Group has been established which offers a reflective space to practitioners and their managers to bring complex and stuck cases where neglect of children is considered to be a primary issue.
- Through the work of the LSCB there are now more effective communication channels in place when children are placed out of county (this relates to both Children's Social Work and Police)
- The LSCB has influenced to ensure that strategic and operational responses to sexual harm and violence are informed by voices of children who have experienced this type of abuse.
- We have revised the LSCB Threshold Document and Early Help strategy to ensure it is more accessible for practitioners.
- We have agreed a strategy on Whole Family Working – A Strategy for Early Help which recognises that all partners share responsibility for intervening as early as possible.
- The Board has satisfied itself that processes in Brighton & Hove follow national Chanel Panel guidelines.

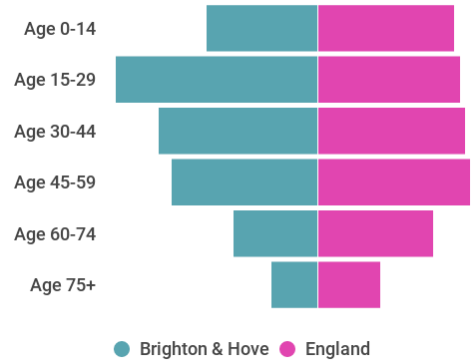
Summary of Challenges

- For the second year in a row we have struggled to implement the Quality of Care Tool. This is an assessment tool that supports practitioners in neglect cases where there is drift and delay to identify action required. This is a national licenced product which cannot be viewed until purchased. We have been trying to work with the provider to ensure this is fit for local purpose before purchase.
- As reported last year we have still not be able to locally implement Operation Encompass1. It is hoped this will be in place by September 2018.
- Whilst we have made some efforts to ensure that all partners are listening to the voices of children and young people and their families, and are achieving a positive impact on children's lives as a result of their own quality assurance processes, this focus needs to remain a priority.
- Management information from key safeguarding agencies still needs to be embedded.
- The LSCB hasn't fulfilled its aims of better engaging with Brighton & Hove's children's and young people's forums to review how the voice of the child should be better integrated into the work of the LSCB.
- Due to a number of public facing campaigns already being developed by partners in the City, we were not able to run the city - wide campaign highlighting the risks of all forms of exploitation and on-line grooming of children that we had planned this year.

Local Background and Context

Population

2016 population estimates show there are 51,281 children aged 0-17 in Brighton & Hove



In 2011, 19.5% or 1 in 5 residents identified as belonging to a minority ethnic group, an increase from 12% in 2001.

Neighbourhoods

The city has a population density 7 times the average for the South East, and includes most densely populated area in the South East. BAME communities are mostly concentrated in city centre wards, student population in wards around Lewes Road, and single person households in the city centre wards. Families are predominantly found to the east and north of the city

As at 31 March, 157 children are allocated to children's disability team

Languages

For one in 12 residents aged over three years (21,833 or 8.3 per cent) English is not their main or preferred language. Arabic is the most widely spoken language in the city after English, with 0.8 per cent of residents (2,226 people) using it as their main or preferred language. (2011 Census)

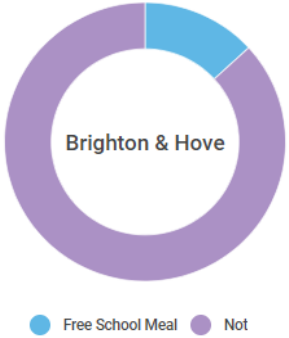
4.9% of city households have no household members who speak English as main language, compared to 4.4% across England.

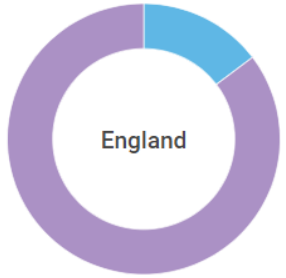
Deprivation

Deprivation is more acute in the city than in neighbouring counties. On Income Deprivation Affecting Children, Brighton & Hove ranks 95th most deprived (East 99th, West 128th) of 152 Upper tier Local Authorities

Latest figures made available to the LSCB showed that 18.1% of the total population of children and young people under the age of twenty in the city were living in families on less than 60% of median national income. 2013 estimates show 12% of households were living in fuel poverty, putting older and younger residents at risk of ill health during the colder months.

In January 2018, 13.2% of Brighton and Hove pupils from Reception year to year 11 (aged 4 to 16) had applied for and had been deemed eligible for free school meals. This is below the national figure of 14.7% (January 2017).





Outcomes for Brighton & Hove Children

This section provides more detail of the progress being made to keep children in Brighton & Hove safe from harm.

Early Help

There were **7105** contacts to the Front Door for Families in 17/18, of which **918** resulted in a referral to Early Help **(13%).** **April & May includes referrals to the Early Help Hub (now closed).*

Top 3 Agencies Making Early Help Referrals

26% by School Staff

19% by the Police

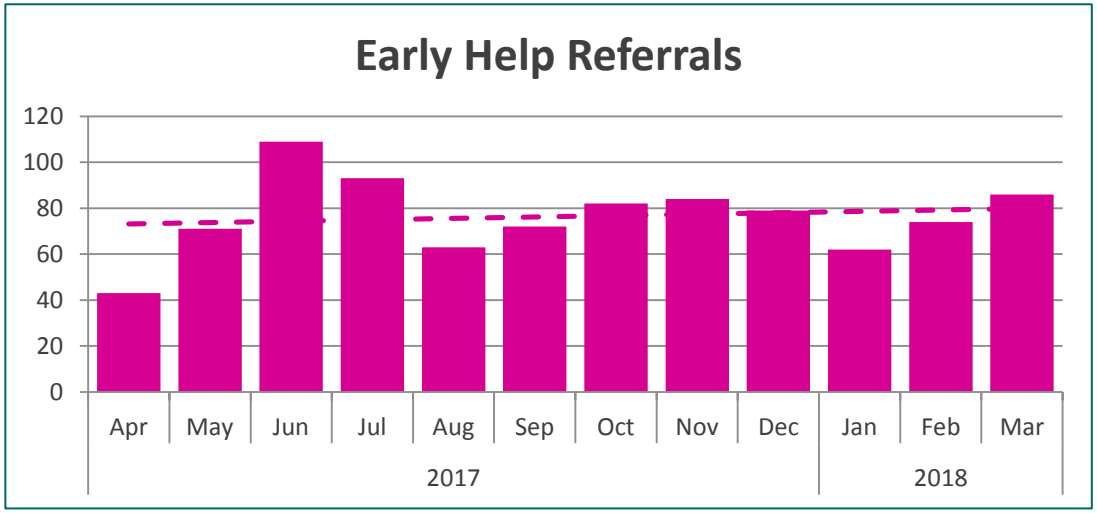
10% by Health Visitors

Top 3 Factors (type of need) identified in Early Help Referrals

16% Socially Unacceptable Behaviour

16% Parental Mental Health

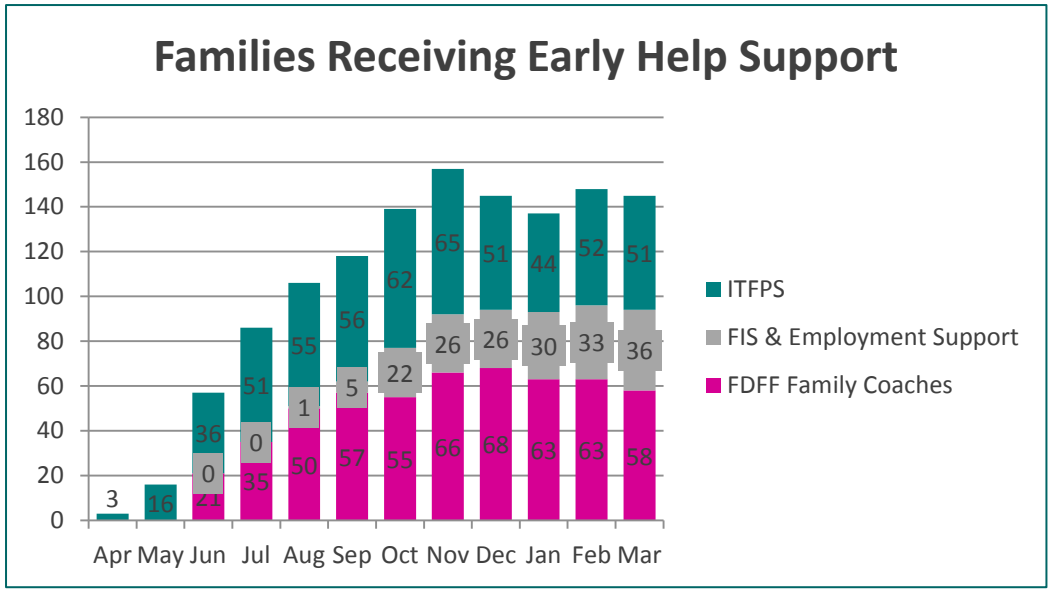
11% Child Mental Health



Early Help Team Activity (Carefirst users only)

Council Early Help teams began to move their casework to the Carefirst case management system from May 2017, following the closure of the Early Help Hub. All teams were consistently recording on Carefirst by November 2017

- The number of families receiving Early Help support in 2017/18 where their casework was recorded on Carefirst was **478.**
- The average number of families open to Early Help on Carefirst each month was **105.**
- As full casework migration was not completed until November 2017, numbers are expected to be higher in 2018/19. The November'17 to March'18 average is **146** families accessing Early Help support each month.



ITFPS – Integrated Team for Families and Parenting Service
FIS – Family Information Service
FDFF – Front Door for Families

Top 3 Factors (type of need) identified in Early Help Assessments

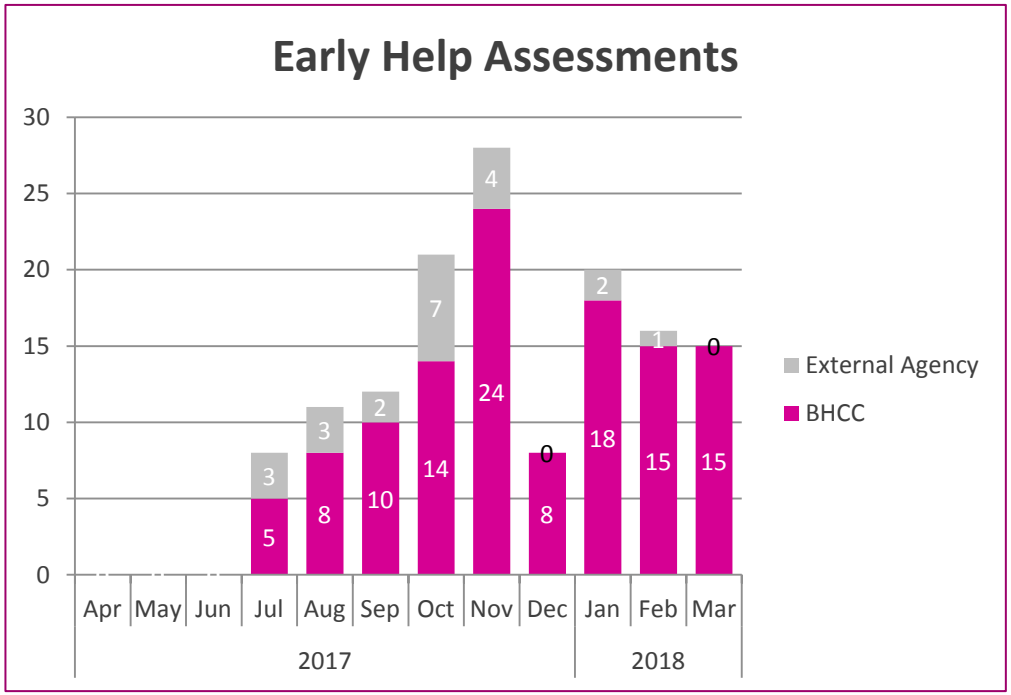
62% Parental Mental Health
57% Child Mental Health
38% Parental Physical Health

Early Help Assessments

There were **139** Early Help Assessments completed on Carefirst in 17/18, an average of 12 per month.

The November to March average is **17** per month. External agencies include schools and health visiting (part of Sussex Community NHS Foundation Trust).

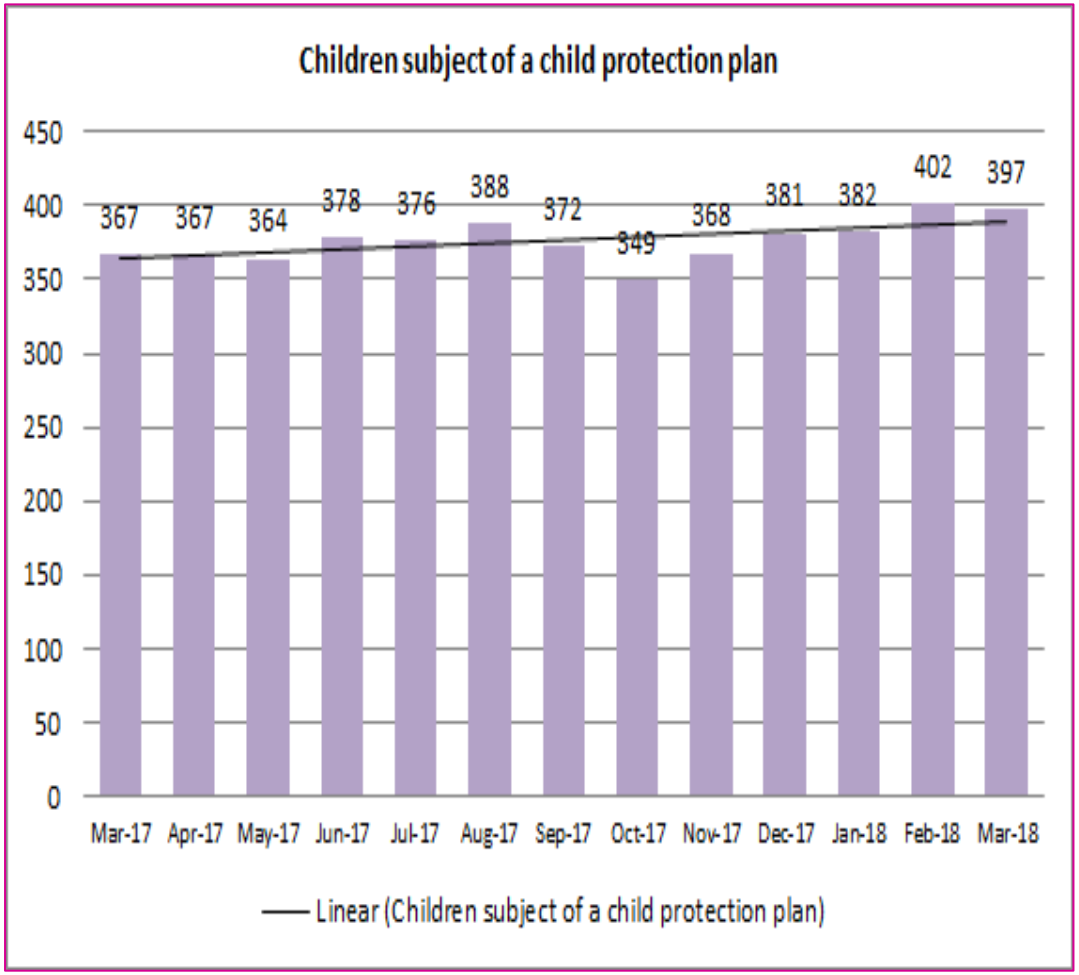
A priority for 2018/19 is to improve the recording of external Early Help assessments and plans.



Child Protection

Over the year, the number of children with child protection plans has **increased**. This year there are currently **397** children with a child protection plan at 31st March 2018, up from **367** at March 2017. This is higher than similar areas. Statistics published by the National Society for the Prevention of Cruelty to Children (NSPCC) show that the numbers of children in the child protection system are increasing.

Figure 1



Children are receiving the help they need in a timely way.

87% of initial child protection conferences are held within 15 days, above the 2016/17 England average of **77.2%.**

89% of Strengthening Family Assessments are completed within 45 days, above the England average of **82.9%.** This is a stronger position than was reported last year.

In October 2015 the Brighton & Hove City Council's Social Work service reconfigured into 16 Pods, who are now responsible for overseeing an assessment and the accompanying safeguarding response, from start to finish.

The overall improving picture in respect of Strengthening Family Assessment performance is a positive sign that this system change is contributing to improved service delivery, particularly in relation to seeing children and assessing their needs in a timely way. The monitoring of the timescales around these assessments requires constant vigilance in order to sustain performance.

The average duration of these assessments is **reducing**, which indicates that the assessment of children's needs is happening in a timely way and that social workers are not taking the full possible 45 days to conclude their assessments and plans for children moving forward.

Re-referrals and repeat Child Protection Plans

Both are **higher** than last year and are **higher** than England averages, Figures 2 and 3.

Re-referrals: **24%** for year ending Mar 18 compared to the 2016/17 England average: **21.9%.**

Repeat Child Protection Plans: **23.8%** for the year ending March 2018 compared to the 2016/17 England average of **18.7%.**

This means that children are still being exposed to risk for a second or third time, which calls into question the effectiveness of the intervention already undertaken and the effectiveness of the continuum of need and how families are escalated through it.

Figure 2.

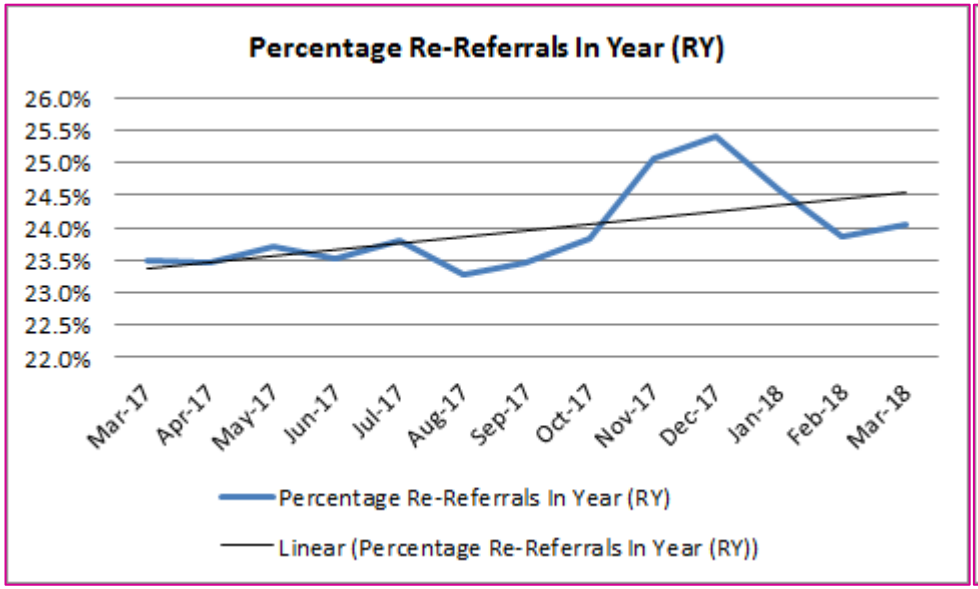
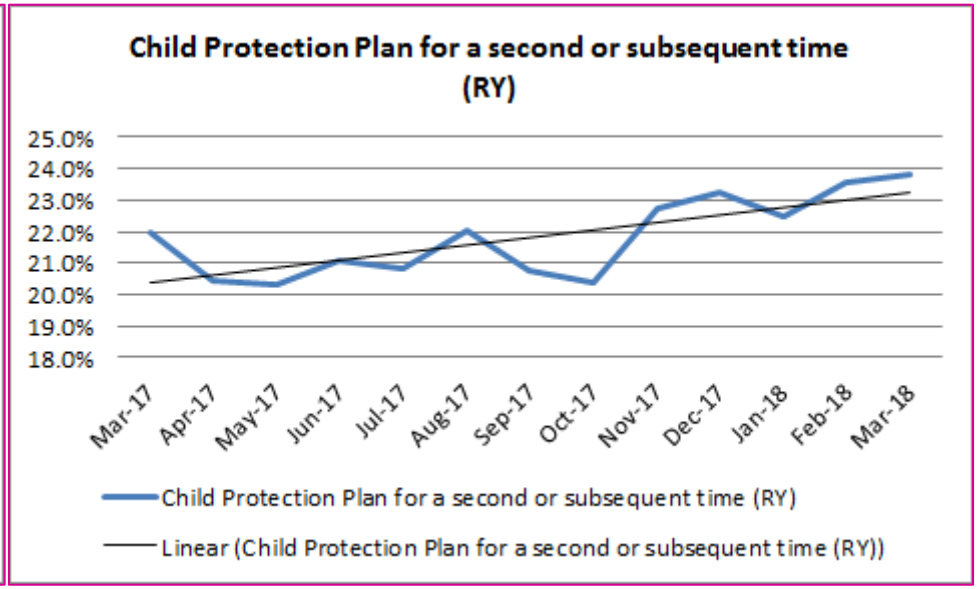


Figure 3.



Of the **394** children who ceased to be the subject of a child protection plan during the year, **30 (7.6%)** of these had been the subject of a child protection plan for two years or more when the plan ended. This percentage is **above** the national average of **3.4%.**

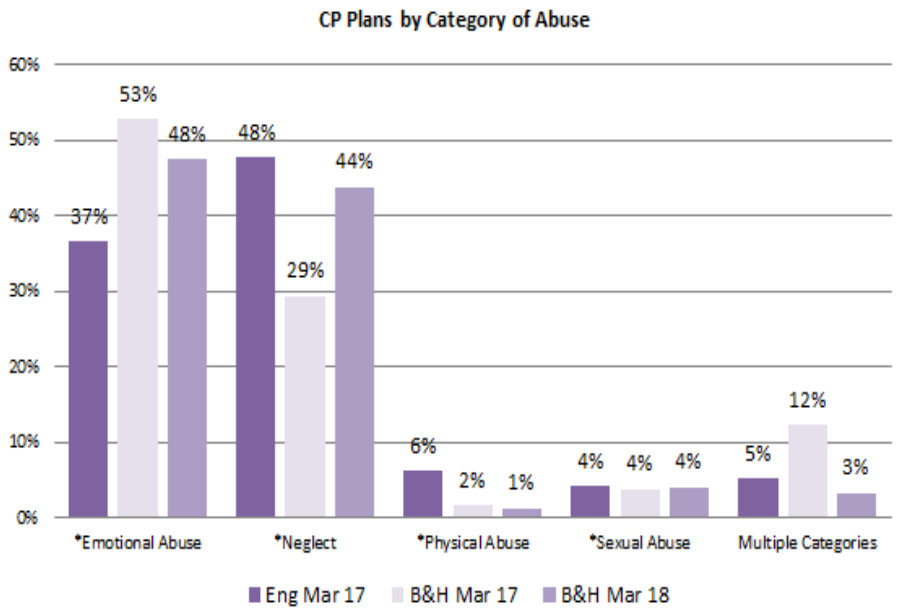
Neglect & Emotional Harm

For the last three years between **41.5%** (Oct 17) and **55.6%** (Apr 16) of children on child protection plans have been primarily described as suffering from **emotional abuse.**

There was a problem with reporting factors last year. The CIN Census shows that **34** episodes had a factor of neglect out of **1,458** episodes with factor information for the year ending 31st March 2017, which would rank Brighton & Hove 150th out of 151 LAs with published data. We know this isn't accurate.

Of the **397** children who have a child protection plan recorded at 31 March 2018, **174 (43.8%)** had neglect recorded as the latest category of abuse, this is below the national average of **47.8%,** however Brighton & Hove has a higher percentage of children who have a child protection plan in place as a result of emotional abuse (of which neglect is a component), **47.6%** compared to **36.7%** nationally.

Figure 4.



According to the NSPCC, neglect is the main concern in 48% of child protection plans in England. In analysis of Serious Case Reviews (SCRs) neglect was a factor in two-thirds of the non-fatal SCRs and over half of the fatal cases. Of this number only 12% of children had a child protection plan with neglect being by far the most common category (a further 12% had been on a CP plan in the past). Read page 15 to see how the Board have been tackling neglect this year.

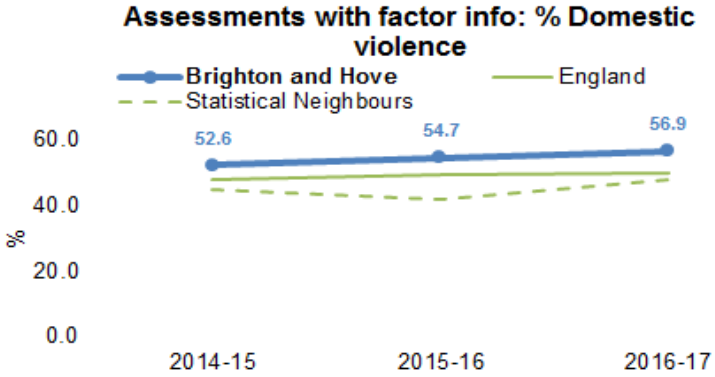
Children in Need

There are **1,976** open Children in Need cases at 31st March 2018, (**1,112** excluding children subject of a Child Protection Plan and Children in Care). As reported in last year's annual report the Brighton & Hove City Council's Families, Children & Learning Directorate (FCL) approached the Local Government Association to coordinate a safeguarding Peer Review. This identified some drift in Child In Need cases. This year it has remained a priority for FCL to monitor this on an ongoing basis to prevent case work drifting.

Domestic violence

56.9% of Children in Need at 31st March 2017, had domestic violence recorded as a factor, **above** the England average of **49.9%.**

	2014-15	2015-16	2016-17	% change from '15-16 to 16-17	
	%	%	%		
Brighton and Hove	**52.6**	**54.7**	**56.9**	**Up**	**4%**
Statistical Neighbours	45.0	42.1	48.1	Up	14%
England	48.2	49.6	49.9	Up	1%
South East	46.1	50.1	50.1	Up	0%



Looked after Children

There are **418** children in care (CiC) at 31st March 2018. The peak CIC number since 2010 was 515 in November 2011 and the lowest number was 409 at January 2018.

The aim is to reduce children in care to 416 (81 per 10,000 children), which is the average for our 10 nearest authorities in terms of contextual factors based on Public Health analysis of deprivation, alcohol, drugs and mental health.

The CIC rate per 10,000 is **81.6** at March 2018, down from 89 per 10,000 at 31st March 2017. This is in-line with the March 2017 contextual neighbour average (82), and above the national average (62) and statistical neighbour average (63).

The health care offer to looked after children continues as always to be a focus for partners. **83%** of looked after children have a completed health assessment. The Brighton & Hove Clinical Commissioning Group (CCG) monitor consistency of the statutory health assessments and care plans of looked after children. The education of looked after children is also a key area of interest for the Board.

Child Sexual Abuse (CSA)

This year we have undertaken a lot of work to combat child sexual abuse. You can read more about this work on page 17.

There are currently **16** children on child protection plans under the category of child sexual abuse, representing **4%** of all children subject of a child protection plan – in line with the national average of **4.2%** at 31st March 2018.

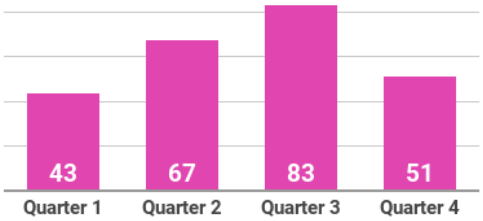
Sussex Police has recorded **38** sexual communication with a child offences between September 2017-March 2018. The majority of these offences relate to online activity in chatrooms and through social media.

Missing children

Going missing increases children's vulnerability to abuse and exploitation.

17% or 4 of the 24 children who went missing from care between 1st January and the 31st of March went missing 3 or more times. The 4 children who went missing three or more times, accounted for 22 Or **43%** of the 51 individual missing episodes recorded in the quarter

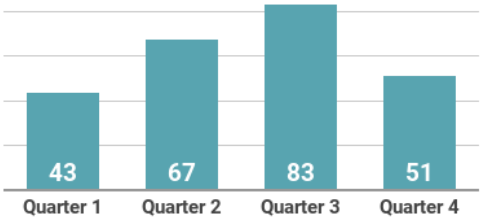
This chart shows the quarterly trend for missing episodes from care.



Missing from Home

13% or 3 of the 23 children who went missing from home between 1st January and the 31st of March went missing 3 or more times. These 3 children accounted for 18 or **46%** of the 39 individual missing episodes recorded in the quarter.

This chart shows the quarterly trend for missing episodes from home.



Child Sexual Exploitation (CSE)

As at 31 March 2018 **31** children have a CSE classification who are open to Social Care**.** Multi-agency meetings are held regularly to review the level of risk that the child is currently exposed to (Red-Amber-Green), and a multi-agency plan is created to protect the child.

Last year we undertook a multi-agency audit to test the effectiveness of multi-agency working with children who were being, or at risk of being, sexually exploited. From this work we gained assurance that CSE was being identified appropriately and as early as possible. This form of abuse remains a key strategic priority for the LSCB reflecting its national and local status.

Crime and young people

The total of recorded crime where victims are children has **risen;** this is in line with the force average within the county.

The most common reason for police protection powers being used is involvement with crime, missing episodes, CSE and neglect.

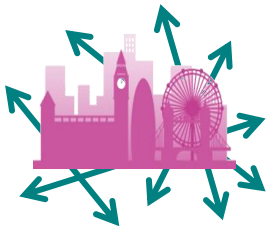
There were **239** first time entrants to the Youth Justice System in Sussex (**24** in Brighton) in the year 2017/2018

There were **329** in 2016/2017, **37** in Brighton & Hove 2016/2017.

3 young people from Brighton & Hove were sentenced to custody sentenced to custody this year.

County lines

Towards the end of the year the Safeguarding Boards, along with the Community Safety Partnership (CSP) Board, started to look closely at the delivery of services for a particularly vulnerable group of people. This is a small but important group who are vulnerable to and involved in criminal activity connected to the transportation of drugs. The true scale of County Lines activity is difficult to determine with accuracy as its nature is fluid and the intelligence surrounding the threat is not always clear, nor is it recorded consistently.



There are an estimated **720** lines across England and Wales - actual number may be considerably higher, as many of these areas are likely to have more than one line and county lines networks are increasingly operating from more than one phone number.

At least **283** lines originating in London (conservative estimate). County Lines originating from London predominantly impact forces in the south and east but some also affect forces further north. The police and Brighton & Hove City Council have closed down over **20 premises** in the past two years using Closure Orders under the 2014 Anti-Social Behaviour Policing and Crime Act. There have been incidents of violence associated with these addresses with knives and other weapons reportedly being used.

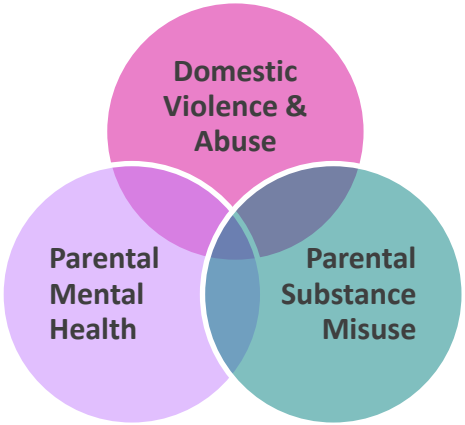
Adolescent Mental Health

We have been worried about the numbers of children self-harming so we have been keeping an eye on this and hearing from Public Health about all their work with local schools to support children and families with this issue. We have also published a Self-Harm and Suicidal Behaviour procedure with colleagues across Sussex to help professionals respond appropriately. You can read this here: **Self-Harm and Suicidal Behaviour**

Throughout the year the Sussex Clinical Commissioning Groups' have been re-designing the specialist child and adolescent mental health service. This has included; an extension of outreach models, development of mental health support in social care for vulnerable children and young people as well as training in an integrated approach to working with the most hard to reach adolescents with severe complex mental health needs. We routinely receive updates on progress.

Priority Area 1: Neglect & Emotional Harm
(Domestic Violence & Abuse, Parental Mental Health & Substance Misuse)

What we want for children: Children in households where neglect is a feature are helped and when necessary protected.



There is considerable national research and local evidence which demonstrates the damage to infants, children and adolescents living in situations where their needs are neglected. Here's what we have been up to this year to tackle neglect.

Neglect Strategy

Professionals working with children and their families have developed a neglect strategy. This sets out how the city's services work together to reduce and mitigate the risks of child neglect. You can read this **HERE .**

Neglect Strategy Action Plan

Alongside the neglect strategy sits an action plan to keep us focused. As a result of this plan the safeguarding data presented to the LSCB has been fine tuned.

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Multi-Agency Neglect Audit

Last year, through looking at a number of local cases, we examined the effectiveness of arrangements to safeguard children who experience neglect.
This showed us that risks were appropriately assessed and acted upon in four cases (44%). We didn't think this was good enough and have been committed to addressing areas of weakness. One such area concerned the inconsistent use of multi-agency chronologies. A chronological record of significant events in a case, if managed properly, can help build a picture of the child's history and the risks posed to them. Since this audit chronologies are better used to inform assessments and plans as a routine part of safeguarding practice across all agencies. Next year we will encourage the safeguarding partners to look for evidence that these are being consistently used to assist case planning.

Multi-Agency Child Neglect Consultation Group

This multi-agency group was established as a consequence of the aforementioned audit. It meets every two months to offer a reflective space to practitioners and their managers to bring complex and stuck cases where neglect of children is considered to be a primary issue. This supports a more timely response to neglect by reducing drift and delay which can have serious consequences for children, resulting in them continuing to be exposed to neglect.

Neglect Learning Review

As reported in last year's annual report the LSCB undertook a learning review which concerned a family with five children where there were child welfare concerns over a period of over ten years. This year we have completed all the actions from this review. We have undertaken a full review and update of local practice guidance for children left unsupervised and provided training to local interpreters in the complexities of safeguarding and legal procedures.

Pan Sussex Neglect Conference

In November 2017 we co-hosted a pan Sussex LSCB conference looking at the issues of neglect. The day, attended by over 100 professionals was opened by Dr Jenny Molloy, author of Hackney Child, who gave us an insight into the lived experience of a neglected child and "the reality of being invisible." This was a great reminder about the importance of keeping the child and their wishes at the centre of all that we do. We also examined national data from a longitudinal study by Research in Practice, looking at how we can respond effectively to neglect. Phil Jones, Workplace dynamics specialist, presented on "disguised compliance" and how families want to present the best of themselves but we must consider what day to day life for the child is really like.

Neglect training

Throughout the year we have raised awareness about the risk and impact of neglect with all partners and agencies, including adult services. Learning from our neglect review and multi-agency audit has informed our neglect training which has been accessed by professionals from across the safeguarding partnership. We also, for the first time, rolled out some neglect eLearning. Professionals have also received training to understand the impact of parental substance misuse on children and young people.

Conclusion

Previous good progress on this priority has continued. There is evidence that learning from the previous multi-agency audit and learning review is embedded in practice. The creation of the Multi-Agency Child Neglect Consultation Group has been a fantastic step forward and has led to improved outcomes for children and young people living in the City. One area that still needs to be progressed is ensuring that there is robust management oversight of neglect cases so that drift and delay are identified and appropriate remedial action is taken.

Priority Area 2: Sexual harm and violence towards children (Child Sexual Exploitation and Child Sexual Abuse)

What we want for children: Children and young people in Brighton & Hove are protected from sexual harm and violence.

Sexual harm and violence can have a devastating impact on the lives of children and may have far reaching consequences for their families and our communities. It is not limited to any particular gender, geographic area or social background but it is clear from the increased awareness arising from a number of high profile media cases that it remains prevalent throughout the UK.

LSCB Child Sexual Abuse Strategy

This strategy sets out the vision, commitment and approach of the LSCB to ensure arrangements to safeguard children from sexual abuse are effective. It builds on what we have learned, both locally and more widely. The strategy outlines how agencies work together on cases when potential child sexual abuse concerns are reported, and details continuing plans to disrupt this kind of activity and prosecute the people who perpetrate this crime. It also talks to peer on peer abuse, harmful sexual behaviours and harmful practices. An action plan to accompany the strategy is in development as at 31 March 2018.

Learning seminar focussed on case planning and inter agency working

In February 2017 a joint learning review was undertaken between Families, Children and Learning and Sussex Police to examine the effectiveness of their joint working arrangements to safeguard a 15 year old female looked after by Brighton & Hove Local Authority who was at risk of sexual exploitation. A seminar with frontline staff was also held to identify learning points. The case generally evidenced good inter agency working with clear evidence of a multi-disciplinary team who knew the child well and who all agreed on the level of risk posed to her. The main issue related to gaps in communication between social work and police which led to police not being fully updated on case planning discussions and the legal context.

Intra-familial Sexual Abuse audit

Intra-familial sexual abuse is where a family member involves a child in (or exposes a child to) sexual behaviours or activities. The family member need not be a blood relative, but could be someone who is considered “part of the family,” such as a godparent or very close friend. This year we have been finalising plans to undertake a quality assurance activity to evaluate how effectively current multi-agency practice protects children where concerns have been raised that sexual abuse may be occurring within a family. Results are pending as at 31 March 2018.

Peer on Peer Abuse

Peer on peer abuse occurs when a young person is harmed by their peers. ‘Peer-on-peer’ abuse can relate to various forms of abuse and can be harmful to the child perpetrator as well as the victim. In 2017 the government issued new guidance for schools around dealing with **Sexual violence and sexual harassment between children in schools and colleges.** Since publication local schools have been supported to update their working practices. Next year safeguarding partners should seek assurance about the effectinvess of arrangements to safeguard against this type of abuse.

Child Sexual Abuse Referral Centre (CSARC)

Over the year the CSARC team continued to run regular training sessions. This included open days to highlight child sexual abuse and demonstrate how the team works with all professionals to give the best service to children and families. The 2017 service review by NHS England rated the Sussex CSARC as Outstanding in many areas. The team regularly collects feedback from all users and works to continually improve the service. Additionally the service successfully applied for two research / evaluation grants from the Centre of Expertise for Child Sexual Abuse. These grants have been used to review and improve services in particular for children in care.

"They were really nice and kind"

Child Sexual Exploitation (CSE) Audit

From audit work carried out in the previous year we know that on the whole the responses to CSE are effective with evidence to suggest agencies work well together to reduce risk but that there were some areas that needed tightening up. The audit highlighted examples where support services quickly withdrew when the young person who was at risk of CSE refused to meet in clinical settings. This isn't the first time the LSCB have been made aware of this issue and we have continued to work with commissioning colleagues to ensure service provision is flexible enough to meet the needs of people who find attending clinic based appointments daunting.

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Vulnerability to exploitation

This year we reviewed the effectiveness of our subcommittees which hold responsibility for overseeing the tactical and strategic response to child sexual exploitation. Both groups now focus on the vulnerability to all forms of exploitation, including Child Criminal Exploitation (CCE), Child Sexual Exploitation (CSE) (including Trafficking), and Missing & Radicalisation. This has helped the LSCB to remain alert to emerging risks and issues. The latter end of the year saw us becoming aware of a new and emerging threat for the partnership; the risk of drug gangs exploiting young people to transport drugs around the city and county.

Learning and Development

LSCB learning & development offers around sexual violence and harm to children have continued throughout the year. During the 'Safeguarding the City' event, experts from the Clermont Unit[1] delivered presentations on supporting young people who display harmful sexual behaviours. Colleagues at the WISE Project[2] ran a session looking at the particular issues for boys and young men experiencing or at risk of sexual exploitation. There was also a workshop around the issues of consent, promoting conversations about those young people who may not understand that they are being forced or coerced into some form of sexual activity.

Return Home Interviews

Statutory guidance on children who run away or go missing states that when a child is found they should be offered an independent return interview (DfE, 2014:14). The key benefits of return interviews are to identify people at risk; understand the risks and issues faced whilst missing; reduce the risks of future episodes of missing or running away; and equip people with the resources and knowledge of how to stay safe if they do choose to run away again (DfE, 2014: 15-16). Since April 2016 Missing People have been commissioned locally to provide return home interviews. In June 2017 they presented their annual report. At this time we were advised that the accuracy of reporting for Brighton & Hove children could not be guaranteed due to double recording and some system issues. At the beginning of the year across Sussex it was noted that there was a decrease in the timeliness of Return Home Interviews. Sussex wide performance improved significantly by September 2017 when **50%** were completed within 72 hours, and **90%** were completed within 7 days, exceeding their target. As at 31 March 2018 the LA continues to seek assurance from the provider that the service offered to Brighton & Hove children is satisfactory.

Conclusion

We have consistently delivered well in relation to this priority. There is evidence of significant changes to ways of working that have improved outcomes for children and young people. Services are focused on supporting victims as well as acting to find and stop would be perpetrators. The LSCB has influenced to ensure that strategic and operational responses to sexual harm and violence are informed by voices of children who have experienced this type of abuse. However, there is still work to do. Whilst there is evidence that the response to missing children is improving more work is needed to understand the patterns and learn how to reduce repeat episodes in a child focused way.

[1] The Clermont Family Assessment Centre is a joint agency, specialist child protection unit with a multi-disciplinary team of experienced professionals. The Unit provides specialist risk assessments for the courts and in child protection procedures. Other work includes individual, group and family therapy, treatment programmes and consultation and training for professionals.

[2] YMCA WiSE works across Brighton and Hove, Surrey and East Sussex to support children and young people to stay safe in their relationships

Priority Area 3: Early Help, Pathways, Thresholds and Assessments

What we want for children: Emerging problems and potential unmet needs are identified so that families and children receive the right support at the right time.

Early help is an approach rather than a discrete service. It involves all partners sharing responsibility for intervening as early as possible to help children, young people and families at risk of poor outcomes. Effective early help relies upon partners working together to:

- identify children and families who would benefit from early help
- undertake an assessment of the need for early help
- provide services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child and family.

Front Door for Families

This service brought together the Early Help Hub and the Multi-Agency Safeguarding Hub to create a single front door for both early help and safeguarding referrals. The Front Door for Families is made up of professionals with different areas of expertise who work together to assess, decide and coordinate how best to support children, young people and their families where there are concerns. Over the past year these professionals have worked with families and agencies to help decide the level of need and appropriate plan of support for the child and family. After discussion at one of our Board meetings a specialist mental health nurse has since joined the team at the Front Door. Amongst others, they join;, Social Workers who make decisions about levels of need, Referral Officers who receive calls, accept e-mails and on line notifications and provide information, advice and guidance for professionals and the public, Police Officers who assess information and notifications about children and young people coming to the attention of the Police and Family Coaches who examine any contacts that meet the threshold for targeted

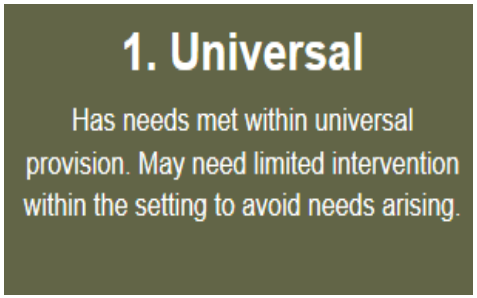
Early Help and Parenting Support and assist partner agencies in setting up Team around the Family meetings and plans.

Threshold Document

In September 2017 work began on a review of the LSCB Threshold Document and Early Help strategy. These tools provide a framework for professionals who are working with children, young people and families. It aims to help identify when a child may need additional support to achieve their full potential. We recognise that children and their families do not always easily fit into a category or a tick box and that a child's circumstances can change quickly and over time and a child may move across the levels of need dependent on a number of different variables that are present at any one time. The revised can be printed as an **A3 poster** for reference, or can be viewed as an **interactive thresholds framework** .

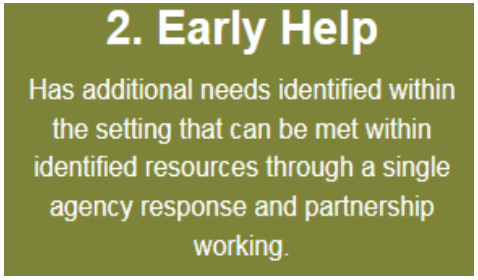
Transforming services to whole family working

For families with multiple problems an integrated "whole family" approach that recognises and deals with their interconnected problems is most effective. Whole family working means transforming services from a number of unconnected professionals with their own assessments, thresholds and measures to integrated, family-focussed, outcome based working. In light of this we have developed a Whole Family Working Strategy, a strategy for early help and this complements the revised Threshold Document. The strategy emphasises the joint commitment to whole family working and providing help and support as early as possible to prevent risk and vulnerabilities from escalating. You can read this **HERE**. Going forward we advise the safeguarding partners to test how the revised Threshold Document and Whole Family Working Strategy has improved outcomes for children and their families.



Early Help Strengthening Families Assessment

This year the Early Help Assessment has been replaced by a simplified document. The Strengthening Families assessment and planning model is now used across level 3 (Early Help Partnership Plus) and level 4 (Specialist Services) levels of need. The assessment travels with a family through the different services. The form is available **online** for professionals in all settings to use. Agencies use their own form of assessment to identify the level 2 early help level of need. The priority for 2018/19 is to expand the use and recording of Early Help Strengthening Assessments and Plans by agencies.

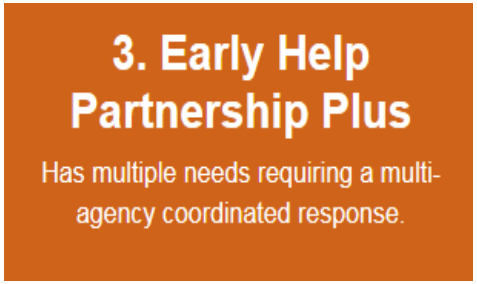


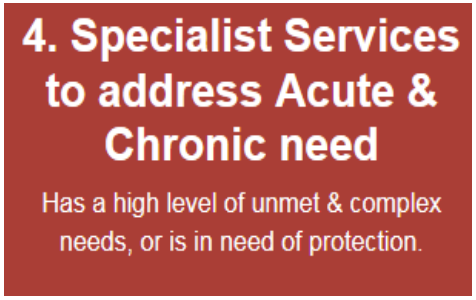
Conclusion

We have continued with our commitment to early help.

This year we have clarified the thresholds for early help and agreed a strategy for how agencies can work together to better support the needs of the whole family.

We hope that audit work next year will evidence positive and lasting outcomes for children and families.





Priority area 4: Governance, Quality Assurance & LSCB Scrutiny

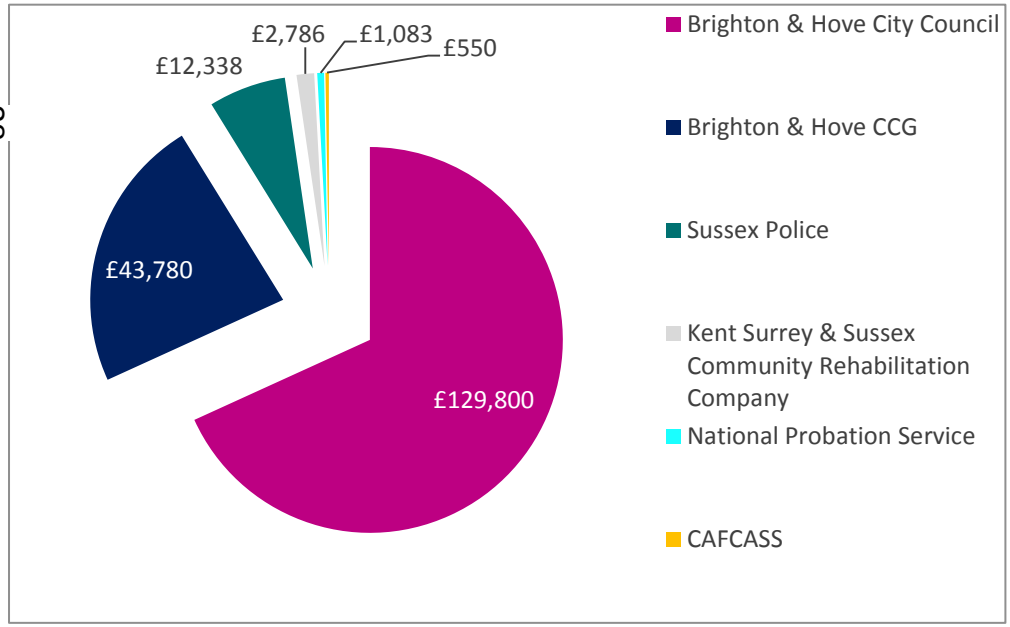
What we want for children: Board business is coordinated and ensures the effectiveness of what is done by partner agencies thereby improving the lives of children and young people.

Over the year we have continued to challenge each other to improve systems to keep children and young people safe in Brighton & Hove.

LSCB Finances

In financial year 2017/18 the actual expenditure was £**224,400.** There was an underspend of £**53.** Partner agencies have contributed to the operation of the Board. All agencies contribute by chairing or vice-chairing meetings or providing use of their buildings and facilities and hosting learning events. The training programme has self-generated £**34,010** income

Income – Total, Inc. training £224,347



Expenditure £224,400

Staffing	139,099
SCRs/LRs	21,205
CDOP	12,500
Training Expenses	11,733
Transport	557
Venue Hire	918
Insurance	100
M&E Chair	1,800
Printing	2,751
Conferences	361
Website	2,125
Computer Costs	880
Telephony	311
Misc.	460
Support Services, e.g. Legal	29600

Performance information

Our Management Information continues to direct where we put our focus. This year we have continued to review our performance measures to ensure they are closely aligned with our priorities and focused on assessing outcomes for children. Again we have worked to make this a truly multi-agency dataset to support us to make better informed decisions about where future work is needed.

Quality Assurance

Our multi-agency audit programme has continued to thrive. Our audits have highlighted weaknesses in existing systems and processes. They have also made recommendations for action leading to improvement and these have been robustly monitored for implementation, progress and impact, by the Monitoring & Evaluation Subcommittee. We have heard about how well our partner's quality assure their own safeguarding activity.

Section 11

This year we have revisited and planned for next year's Section 11[3]. This self-assessment is carried out every two years. New standards have been added this year following serious case reviews across Sussex. Going forward the Section 11 will also ask partners to assess their own safeguarding arrangements as they relate to faith and culture and hard to engage families.

Conclusion

Our quality assurance activity is robust; it has helped us truly understand how effective safeguarding services are in the city. Summaries of findings from audits have been shared with staff in briefings and a strong tracking system is in place to oversee progress on all actions arising from our audits and learning reviews. However, there is still much to do, especially in ensuring that all agencies are listening to the voices of children, young people and their families, and are achieving a positive impact on children's lives as a result of their own quality assurance processes.

[3] *Working Together to Safeguard Children (2015)* requires all LSCBs to gather this information to assess whether partners are meeting their statutory obligations as outlined in Section 11 of the Children's Act (2004).

Priority area 5: Participation & Engagement

What we want for children: Learning from LSCB reviews is known, understood and influences the practice of staff across the partnership and learning and improvement is informed by feedback from those who access and deliver safeguarding and child protection services in Brighton & Hove.

Regulation 5 of the Local Safeguarding Children Boards regulations 2006 provides that LSCBs are responsible for "communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so". We believe it is important that our work is communicated across our target audiences so that they feel informed about work we do to improve safeguarding in Brighton & Hove.

Voice of the child

Our multi-agency audits evidence active engagement by our partners with children, families and staff to understand their perspective of service delivery, service support and interventions.

This year we have undertaken work with our partners to determine how they evidence; what is being done to obtain the voice of the child, how children and young people's voices are being used in the development of practice and setting of priorities, how this is making a difference and how they know this.

All our training is child focussed, ensuring the voice of the child and the child's welfare remains paramount. This year we have been able to gain the view and voice of people using services with service users inputting into our "Impact of Substance Misuse" and "Safeguarding Adolescents training. This year has also seen the return of "The Child's World: Reflections in Practice" co-delivered by a young care leaver.

Throughout 2017-18 the LSCB has continued its work with Safety Net to produce a parent newsletter, Safety Rocks. This year we have shared advice from Child Safety Week on preventing accidents, provided some hints and tips on moving up to secondary school and dealing with change, and information for parents on Fortnight and age-restrictions on using social media. The Safety Rocks Secondary School Newsletter: Summer 2018 contained some tips to help manage exam stress and anxiety, information on the worrying use of Xanax as a recreational drug, and shared some signs that could indicate a young person may be caught up in “County Lines”.

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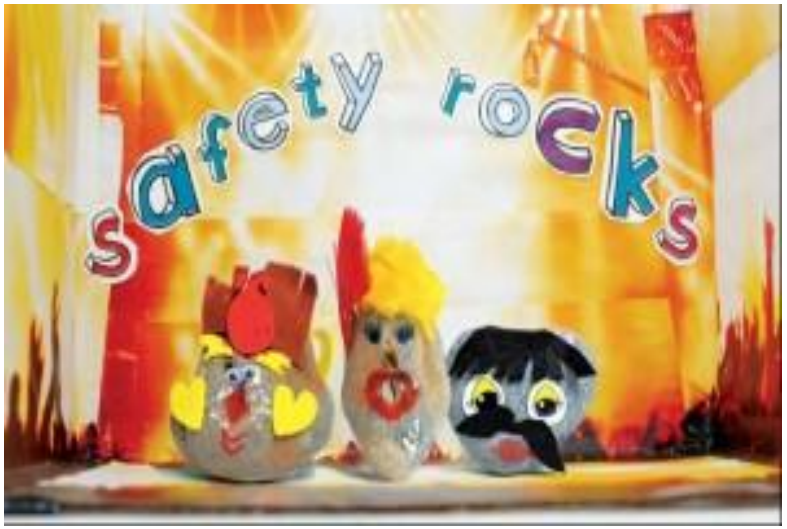
The **LSCB Board Briefing** continues to be hosted on the LSCB website following our quarterly Board meetings to support parents, carers and members of the public to have an improved understanding of the values and statutory function of the LSCB partnership.

The LSCB Website and our Twitter have gone some way to supporting the public to understand the role and remit of the LSCB. As at year end we have 1,895 followers which is considerably more than our closest statistical neighbour/s.

The LSCB has continued to cascade learning from Case Reviews, child deaths and quality assurance activity through professional learning events to help professionals understand what is required to improve safeguarding and child protection systems – such events are always well attended and well evaluated.



Conclusion

We have continued our commitment to sharing learning from LSCB activity and we can see how this has influenced the practice of staff across the partnership.

Where possible we have sought assurance that feedback from those who access and deliver safeguarding and child protection services in Brighton & Hove is taken into consideration in the formation of service delivery.

The safeguarding partners should continue efforts.

Serious Case Reviews

SCR Child A - June 2017

This review was commissioned following the tragic death of 17 year old, A. A was subject to a Care Order to Brighton & Hove City Council and had been in care since 2004. After a number of unsuccessful foster placements A was placed in a residential therapeutic unit in a neighbouring county in and remained there until his death. You can read the full report, the Board response and a short summary of the findings **June 2017: Child A SCR**

The review identified a number of strengths in service delivery, but also highlighted areas of sub-optimal practice.

One of the issues was an overreliance on the residential therapeutic unit to meet all of A's needs. The unit, accredited by the Royal College of Psychiatry, showed competence and confidence when working with A and there was a presumption amongst social work staff that the unit had sufficient expertise. This meant the need to seek additional (including psychiatric) opinion about A and his prognosis was not considered. Since publication social work staff have been reminded that if there are planned out of area placements, liaison must take place with relevant providers in the to ensure all the welfare needs of individual children are met.

As a result of this review;

- Health assessments, including mental health assessments, for looked after children have been reviewed for robustness and assurances have since been provided to the LSCB.

- All social work staff were reminded of the importance of providing carers with written information when making placements for children in care, as per Care Planning Regulations 2010, and reminded to ensure that children are fully briefed about the information shared.

- As at March 2017 the LSCB are seeking assurance that all Care and Placement Plans (as a priority those recognised to be high risk) include a clear contingency position in the event of placement breakdown. Next year Children, Families and Learning will be undertaking an audit to seek assurance that children in therapeutic placements are receiving appropriate support as well as exploring whether young people are now routinely informed about the information given to prospective carers about them. A staff bulletin and workshop on the theme of professional differences is also in development at the time of writing. This will draw on lessons learnt from this review regarding the importance of all practitioners feeling confident to professionally express concerns and challenge any aspect of care planning.

SCR W and X - July 2017

This report was commissioned to evaluate multi-agency responses to vulnerable young people at risk of exploitation through radicalisation. It followed the reported deaths of two brothers, 'W' and 'X,' in Syria in 2014. The siblings and their family had received services from local agencies in Brighton & Hove. Whilst the mandatory criteria for a Serious Case Review were not fully met, the Chairperson felt such an approach would provide a robust framework by which to maximise learning. It was a complex and large-scale review. This was a tragic case, which has had a major impact on our understanding of the risks posed to children of exploitation through radicalisation. You can read the full report, the Board response and a short summary of the findings **July 2017: Siblings W&X**

The heart of this review examined the siblings and their family's experiences. This included their experience of being subjected to racist and religiously motivated abuse and attacks, domestic abuse and physical abuse. The review also considered the youngest four siblings' involvement in anti-social and criminal activities. It evaluated the professional practice and services offered to the family.

The review identified **13** findings, which were grouped into four priority areas. The review found a 'striking' response following the discovery that the two siblings and another young person had gone missing. It recognised changes to processes, practice and working relationships to help prevent other young people at risk of radicalisation and travelling to Syria.

Working with children vulnerable to radicalisation

A core issue explored in meetings with local community members was around the need for all children to have positive self-esteem. In this case, early experiences of racism in nursery schools and primary schools were described as leading to the children becoming alienated and, as a consequence, more vulnerable to searching for ways to feel better about themselves through other means. There was concern expressed by community members that schools were not able to protect Muslim children sufficiently from racism. In December 2017 the Board heard how local schools record and respond to the experiences of Muslim pupils and what training has been provided to schools to support them to identify and challenge bullying and prejudiced based incidents, including those which are racist and religiously motivated.

Counter Terrorism Policing South East have formally responded to the review's findings. They have provided clarity around how police officers resolve potential conflicts between the security of the state and the safeguarding of children involved in such investigations. They have since invested in developing further guidance around safeguarding. Safeguarding is now a standing item in their daily operational meeting and Counter Terrorism Policing have also committed to attempting to recruit more officers with a public protection background.

Working with high risk adolescents

The review emphasised learning from a serious case review published last year **(September 2016: Child E SCR)** that systems to collect and share data about young people who come to police attention did not consistently provide all relevant information to practitioners to support assessing, identifying an addressing safeguarding needs. As a result Sussex Police, in consultation with other agencies, have undertaken work to review the circumstances in which a SCARF[4] should be completed have been updating Force Policy accordingly.

Working with minority ethnic groups

This review asked us to reflect on whether the local safeguarding system has the resources and strategies available to help abused women and children from minority cultural backgrounds. As a result the LSCB requested the Safe in the City Partnership Board to review the extent to which the current infrastructure of domestic abuse services meets the specific needs of the Black Asian Minority Ethnic communities in Brighton & Hove. We have also updated our training, Domestic Abuse: Impact on Children, to better support professionals to have an understanding of the long-lasting trauma in families of domestic abuse. It also led us to question whether local practitioners have sufficient curiosity, knowledge, and skills to explore the role of culture, identity, religion, beliefs and potential divided loyalties experienced by some children and families. The review also highlight that our statutory agencies had insufficient knowledge about, and understanding of, local minority ethnic and faith community groups and how best to work together to safeguard children, including those at risk of exploitation of local children into radicalisation.

Working with Trauma

Childhood trauma is an important public health concern, with adverse childhood experiences being one of the strongest predictors for difficulties in future life. Throughout the year the Board have been exploring how the safeguarding partnership collectively intervenes to provide coordinated and responsive therapeutic support to children who have experienced, or who are at risk of experiencing, trauma. This work is ongoing. The Learning & Development Officer has also been working on developing multi-agency training to support the understanding of the impact of childhood trauma, including Post Traumatic Stress Disorder, and the understanding the neuro-developmental implications of abuse, neglect and trauma on brain development.

[4] Single Combined Assessment of Risk Form – the form that notified professionals when police have had contact with a child/ family member

Assuring the quality of safeguarding practice

Under Working Together to Safeguard Children (2015) LSCBs must quality assure practice, including through joint audits of case files involving practitioners, to identify lessons to be learned. This year we have undertaken the following two audits.

Children with Disabilities Multi-Agency Audit

Research has found that disabled children are three to four times more likely to be abused and neglected than non-disabled children (Jones et al 2012; Sullivan & Knutson 2000). The LSCB completed a multi-agency audit in October 2017 to examine whether a robust and timely service is provided to disabled children who are in need of protection and whether we are making a difference.

Examples of what is working well

There is a good awareness and understanding of safeguarding by staff working with children with disabilities in their identification and response to child protection concerns. It is also clear that thresholds for child protection are understood.

Child protection concerns are identified early and there is a prompt response by the professional network.

Assessments take into account the impact of the child's disability on their siblings and overall family functioning. There is good analysis of the family situation and appropriate consideration is given to historical information and previous concerns.

Five out of six parents rated the help that they have received as 'good' and felt that things had improved for them and their children.

Examples of what needs to be improved

In 3 cases not all of the appropriate agencies contributed to the strategy discussion.

In 3 cases Core Group/Network meetings were not held within prescribed timescales

In one case where there were 31 professionals listed in the Initial Child Protection Conference as being involved with the child and their family leading to some confusion about who is attending the Core Group, with professionals assuming that someone else from their agency was working the case.

Wide variation in how well the voice of the child is heard.

Recommendations

In cases where numerous health professionals are involved with the child and family, a lead paediatrician is required to provide an oversight of all of the medical conditions, interventions and outcomes and to prepare a robust health report for the CP Conference.

Staff to be reminded that the social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion.

All agencies to ensure that the voice of the child is heard (as evidenced through direct work, communication and/or observation, or through discussion with those that know the child well).

Read more about this audit here **Children with Disabilities Audit: Staff Briefing**

Intra Familial Child Sexual Abuse Audit

This multi-agency audit was undertaken to evaluate how effectively current multi-agency practice protects children where concerns have been raised that sexual abuse may be occurring within a family.

Examples of what needs to be improved

- Whenever a referral is received by Front Door for Families regarding CSA, the Children's SARC needs to be automatically involved in the strategy discussion
- Awareness needs to be raised with all professionals about the children's CSA/ SARC pathway.

Examples of what is working well

- Where referrals were made to MASH/Front Door for Families and the Police, concerns were clearly recognised and dealt with early enough.
- Where a safeguarding investigation was required, they were completed in a timely way, and the outcome was appropriate and demonstrated sound decision making in all but one case.
- In all but one case, there was evidence of the child being engaged in the process at all stages, with some very good examples of the individual needs and circumstances of the child being taken into account
- The therapeutic needs of the child and family were fully addressed in all cases.

Recommendations

- All agencies to ensure that the Strategy discussion involves the relevant agencies in particular health and including the SARC.
- A reminder to staff that once strategy discussions are recorded it is important that all agencies have a copy for their own records
- It is important that safeguarding processes involving children in care are properly followed and recorded even though the children are safe.

Single Agency Audits / Other Multi Agency Audits

This year all agencies have shared their safeguarding children audit schedules. This helps to assure the LSCB that partners are quality assuring their own safeguarding practice.

To support agencies with this the LSCB developed 'good practice for agencies when conducting single agency audits' document.

Throughout the year we have considered audit information from the National Probation Service, Kent Surrey & Sussex Community Rehabilitation Company (CRC), the CSARC, and CAFCASS.

We expressed concern that no safeguarding specific audits were undertaken by Sussex Police.

During the year, the Children's Social Work Service has shared several single agency audits with the subcommittee on re-referrals, Child Sexual Abuse, pod workloads, and pathway plans for care leavers.

Following the Child E SCR (published September, 2016) Families, Children and Learning were asked to provide an update on the systems in place to ensure that life story work is maintained for all children in care. This will be addressed in summer 2018.

Safeguarding training

It has been another busy and productive year for LSCB Learning and Development. In line with local initiatives and emerging issues, the training programme has been tailored to meet the needs for multi-agency professionals working to better safeguard the children and young people of Brighton and Hove.

This year **338** practitioners from across the city have attended the level 2 core training courses and another **606** have attended the more specialised (level 3) courses and briefings. This gives a total attendance figure of **944** who have attended events from the LSCB programme this year. See Appendix 3 for more information about training attendance.

Training Pool

There remains a very strong working relationship between the Learning and Development Subcommittee, and the team providing our multi-agency training, led by the Learning and Development Officer. The solid, multi-talented training pool continues to offer support around delivery, and the comprehensive programme would be impossible to deliver without them.

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Learning & Development Subcommittee

Attendance at the subcommittee has maintained a good representation from the majority of Board partners. New representation from Sussex Partnership NHS Foundation Trust, RISE and the Sussex Police this year has brought a new dynamic to the group as a whole. Meeting frequency has been reduced to ease the time and extraction of staff who attend.

Training Programme

The training programme continues to offer the essential core “working together to safeguard children” aimed at those new to role, from any of the partner agencies. This year the training programme has developed more specialised safeguarding training to encompass emerging risks and issues facing the children and young people of Brighton and Hove. In particular we have added and updated the training around **Safeguarding Adolescents**; training has also been commissioned from Sussex University to deliver presentations around **Trauma Informed Practice**, the training in relation to **Exploitation** has also been reviewed and recommissioned to incorporate all aspects of exploitation, including criminal, radicalisation, sexual and drug related “county lines” exploitation of young people.

Practice Points

The LSCB has maintained its commitment to keeping practitioners informed of local and national learning from serious case reviews. As is standard practice in the LSCB we have achieved this via face to face briefing session and the use of the **Practice Points Training Scenarios** it is understood from colleague's feedback, these have been used in group supervision and team meetings to good effect

Training Partnerships

The Learning and Development Officer has continued to liaise and coordinate with the other local authorities in Sussex to reduce duplication of training offers that exist across the county and make better use of training that is offered by the same provider, e.g. Multi-Agency Public Protection Arrangements training. We have also undertaken a joint project with partners and provided a successful Pan Sussex Training Day, around the subject of Perplexing Cases (Fabricated, Induced, Illnesses), this was in response to a recognised need across the county, and was well received.

We have continued our collaborative work with our local partner colleagues from the Safe in the City team particularly issues of Harmful Practice (Female Genital Mutilation, Forced Marriage, and Honour Based Violence).

The LSCB Learning & Development Officer now also attends the quarterly Learning & Development Subgroup meeting of the Safeguarding Adults Board to explore training opportunities across both boards.

Working Together to Safeguard the City Week

The week provided a series of events, including talks on young people displaying harmful sexual behaviours, working with families with poor mental health as well as staff briefings in relation to the serious case review following the reported deaths of local siblings W & X. There were also open days at Safety Net, and a workshop around supporting people experiencing homelessness. The week culminated with a conference organised by colleagues from the Safeguarding Adults Board.

#SafeguardingSussex

Training Evaluation

Very informative training. Expertly delivered
(County Lines)

Evaluation and feedback is integral to the continuing development of the LSCB training programme. Staff are asked to comment on the course and content at the end of the every training session, both verbally and also by completion of an electronic evaluation. We also recommend that attendees reflect with their line mangers on how training has impacted their practice. There is also the opportunity to follow up with an on line questionnaire three months after a particular training event. The Learning and Development Officer has also constructed a standalone survey, which is sent via mail chimp to encourage a better response to the requests for evaluation.

Around **70%** of attendees are completing the electronic evaluations, and this will be further explored to see if we can promote better use of this.

Training in development for 2018/19

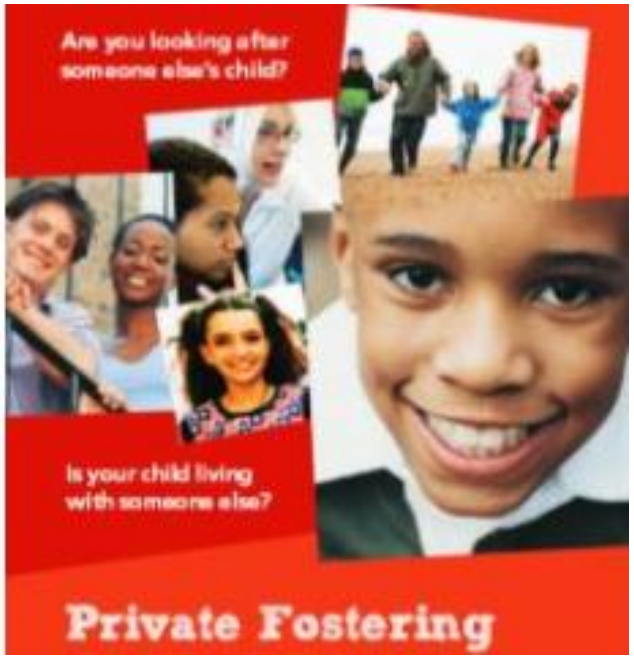
As a result of the W and X Serious Case Review and local intelligence on child criminal exploitation, we have been in discussions with partners from WISE, who have historically delivered our training around the subject of child sexual exploitation. Training is currently being developed to cover recognition and response to all forms of exploitation to provide a more comprehensive training offer.

The Learning Development Officer continues to work closely with the training pool to develop and update the core safeguarding training, in line with the new whole family approach and also to encompass the new Threshold documentation.

Safeguarding training for faith organisations will be a key area for development next year as well as training on child neglect for the city's workforce.

The draft revision to Working Together to Safeguard Children 2018 includes the need for safeguarding partners to continue to ensure learning is promoted and embedded. The LSCB have encouraged partners to continue learning and development arrangements and suggest that they resume attempts to evaluate the impact and effectiveness of multi-agency safeguarding training on outcomes for children, young people and their families.

Private Fostering



Arrangements to raise awareness about Private Fostering

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

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

In 2017-18 a number of initiatives were undertaken to highlight the notification arrangements to existing and potential private foster carers, voluntary and statutory agencies, and members of the public:

Private fostering training, as part of the LSCB Session on "Hidden Children", was delivered in February 2018.

Information about Private Fostering has been shared by the LSCB with professionals and members of the public via social media as part of Private Fostering Awareness Week (3-10 July 2017).

Information about private fostering has been included in the primary and secondary school admissions booklets 2017-18. Brighton & Hove City Council continues to raise awareness about the private fostering regulations with Language Schools and Guardianship Agencies.

Monitoring Compliance with Duties and Functions

- The Private Fostering procedures **Brighton & Hove Children's Services Procedure Manual** were reviewed and updated in Aug 2017
- The Carefirst Private Fostering reports were reviewed and updated July 2017
- An audit of Private Fostering cases was undertaken in March 2018.

The number of children living in Private Fostering Arrangements in 2017-18 is **30** compared to **33** in 2016-17. During the year, **24** new notifications were received and 19 were confirmed as being private fostering. All new notifications received an initial visit, with **88%** taking place within 7 working days. Nineteen arrangements ended during the year, leaving a total of **11** children living in Private Fostering arrangements at 31 March 2018.

Child Death Overview Panel (CDOP)

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

Between April 2017 and March 2018, the CDOP was notified of 8 deaths of children who were resident in Brighton & Hove which is a continued decrease in numbers of deaths since last year. The CDOP met 6 times during the year to discuss child deaths in Brighton & Hove with one meeting to discuss neonatal deaths. The CDOP has reviewed 9 deaths from Brighton & Hove during this period, (there will always be a delay between the date of a child's death and the CDOP review being held).

Of the reviews completed in 2017/18, 3 (**33%**) were completed within six months with the remaining six being completed within the year.

Age profile of deaths notified to CDOP

Over the 10-year period April 2008 – March 2018 CDOP were notified of **152** deaths.

On average, **15** deaths per year are notified to CDOP for Brighton & Hove.

During the 10-year period around 3 in 5 deaths **(55%)** notified for Brighton and Hove were for babies aged under 28 days compared with the average in England which is **43%.**

The reasons for this are not known. There are no significant differences in the rates of deaths for the other age groups

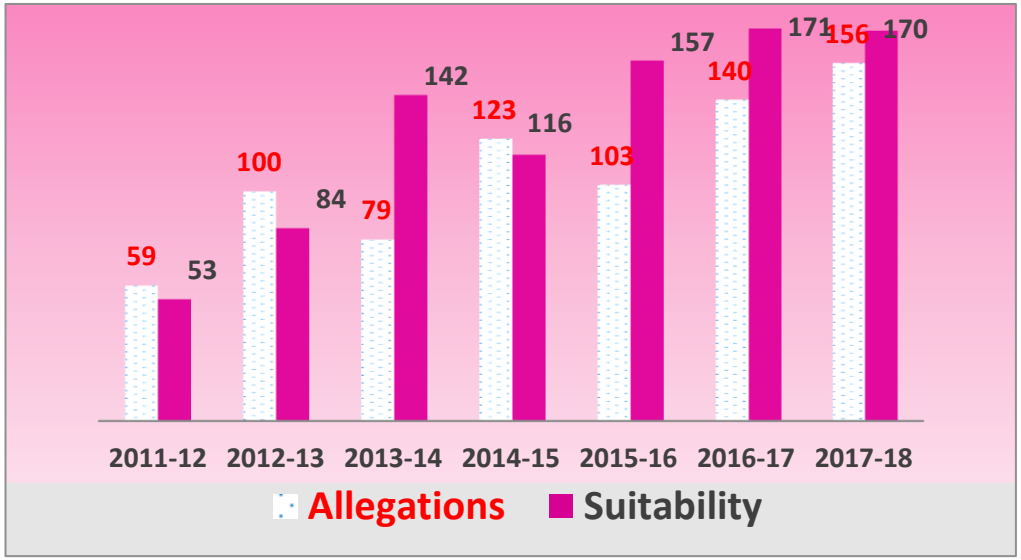
Local Developments, Challenges and Achievements

During the last year the CDOP co-ordinator function has been fulfilled by the CDOP co-ordinator for West Sussex CDOP. This has been a positive development and currently the three LSCBs are considering whether there could be closer working arrangements in the future which would enable all three areas to meet the requirements of the new national guidance for CDOPs. An example of improved joint working across the three LSCBs has been the work undertaken in the last year on deaths from suicide. As all three LSCBs had experienced a number of such deaths, some of which have required serious case reviews, there was some co-ordinated work across the three LSCBs. All areas felt there was merit in better linking work on children and young people to improve our learning about risk and preventative factors.

Local Authority Designated Officer (LADO)

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

There were **336** referrals to the LADO in 2017-18, which is **15 more** than in the previous year. The total increase is proportionately less than in previous years. The graph below highlights the continuing increase in referrals regarding allegations since 2011.



Schools remains the highest employment sector and the proportion of allegations remains relatively consistent at **46.4%** in 2016-17, and **43.3%** this year. The proportion of schools referrals appears to be affected by any significant increase/decrease in other sectors.

A significant variation is the **increase** in allegations within the Early Years sector up from **9** in 2016-17 to **21** in 2017-18. This resulting in their percentage increase from **6.5%** (joint fourth highest) to the second highest at **13.4%.** Allegations regarding the **voluntary sector** remains low, there has been an increase overall; in 2016-17 there were **5** including Suitability, this year there have been **12.**

Use of Restraint

The number of allegations regarding Maintained schools saw a decrease of **3** from the previous year. The allegations spread across a number of schools with no identifying pattern. Allegations involving Non Maintained teaching staff again saw a marked decrease from last year's **8** to **3**, while allegations involving Non Maintained Non-Teaching Staff rose from **2** to **7** this year. Of the **22** referrals, only two were deemed substantiated, leading to suspension and disciplinary investigations. The outcomes included both individual and organisational learning. In respect of schools, of the **18** referrals none led to suspension.

Timescales

The **80**% and **90**% targets have nearly been met, **77**% and **88.5**% respectively. As previously reported, ongoing cases reflect lengthy police investigations, court cases and disciplinary procedures. These cases are likely to take over a year before they are resolved.

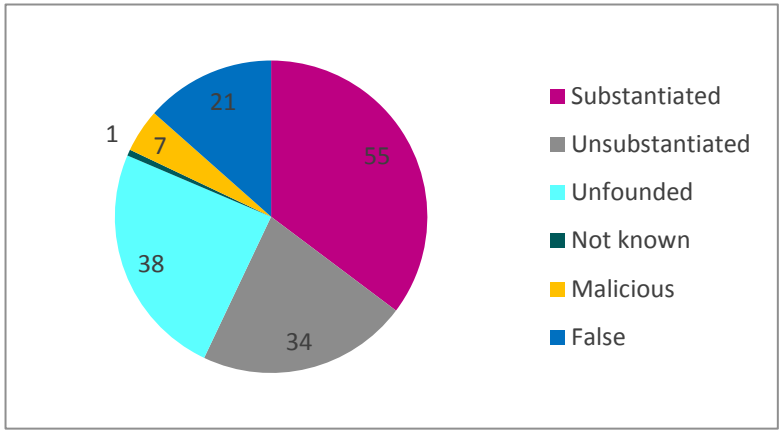
There were **32** Police investigations, **8** being historical, **5** are ongoing. It is worth noting that the ratio of police investigations to child protection (s.47) investigations is significantly higher and this may occur where an employee has no family/children or where there is no named child(ren) warranting a Strategy Discussion, with this being a single agency, police led investigation, for example involving internet sharing of Indecent Images of Children (IIOC).

There have been **3 charges** resulting in **3 convictions**.

The statistics appear to indicate that timescales of investigations have not been impacted upon with the implementation of the Policing and Crime Act 2016 and regulations regarding bail conditions which came into force in April 2017.

Outcomes

The significant proportion of substantiated, unsubstantiated and unfounded allegations, vs false and malicious, indicate that referrals to the LADO continue to be made appropriately. The number of false allegations has steadily risen the past few years; **8** in 2015-16, 17 in 2016-17 and **21** this year, all within schools and residential care settings, with no discernible pattern and only **4** of which were in relation to use of restraint.



Looking Ahead

This report has outlined the progress that has been made in improving safeguarding in Brighton & Hove.

Over the year Board partners have consistently demonstrated a genuine willingness to work together. Both multi-agency practice and individual partner audits are robust and learning from quality assurance and serious case review activity has been widely cascaded and embedded in both single and multi-agency training offers.

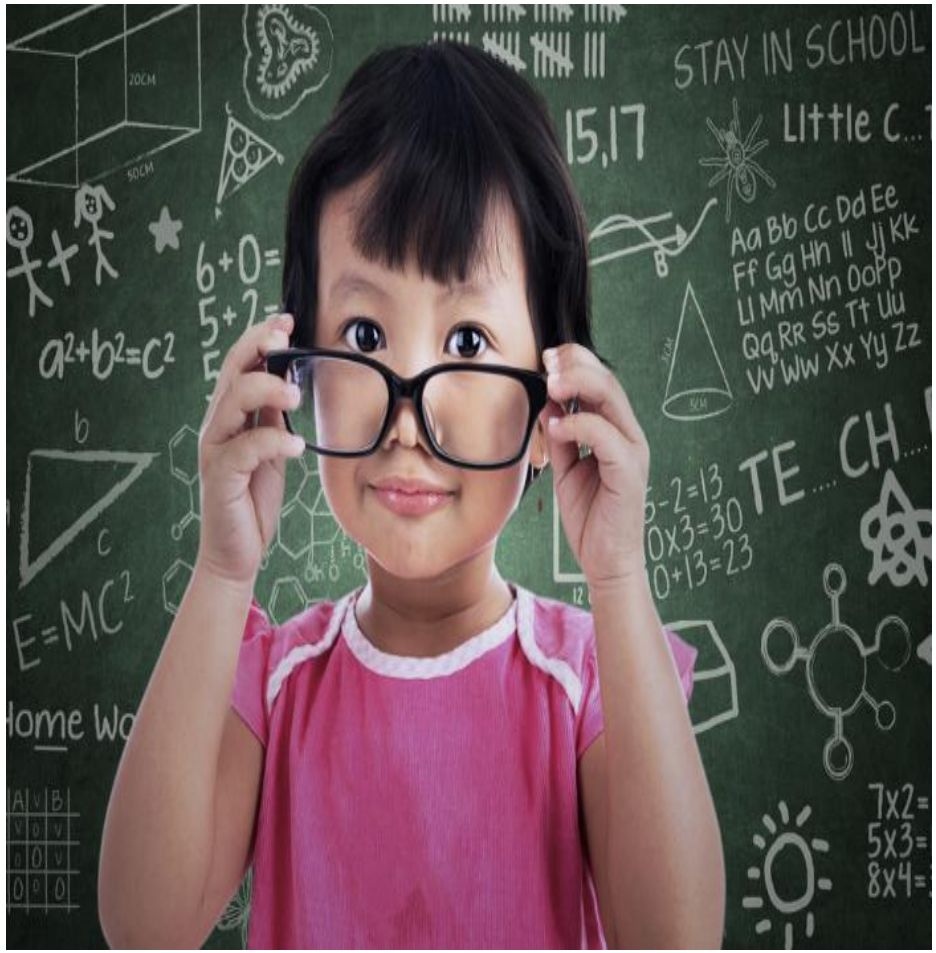
At the time of writing the Board awaits the publication of Working Together to Safeguard Children, 2018. This new legislation brings with it the opportunity to revisit the priorities we set back in 2016.

Whilst outside of the timeframe of this annual report we felt it was important to share with you an update from the Board Development half day held on 30 March 2018. We held this day to reflect on our successes and achievements and share with the safeguarding partners our thoughts on what the priorities should be as they move into the new safeguarding arrangements.

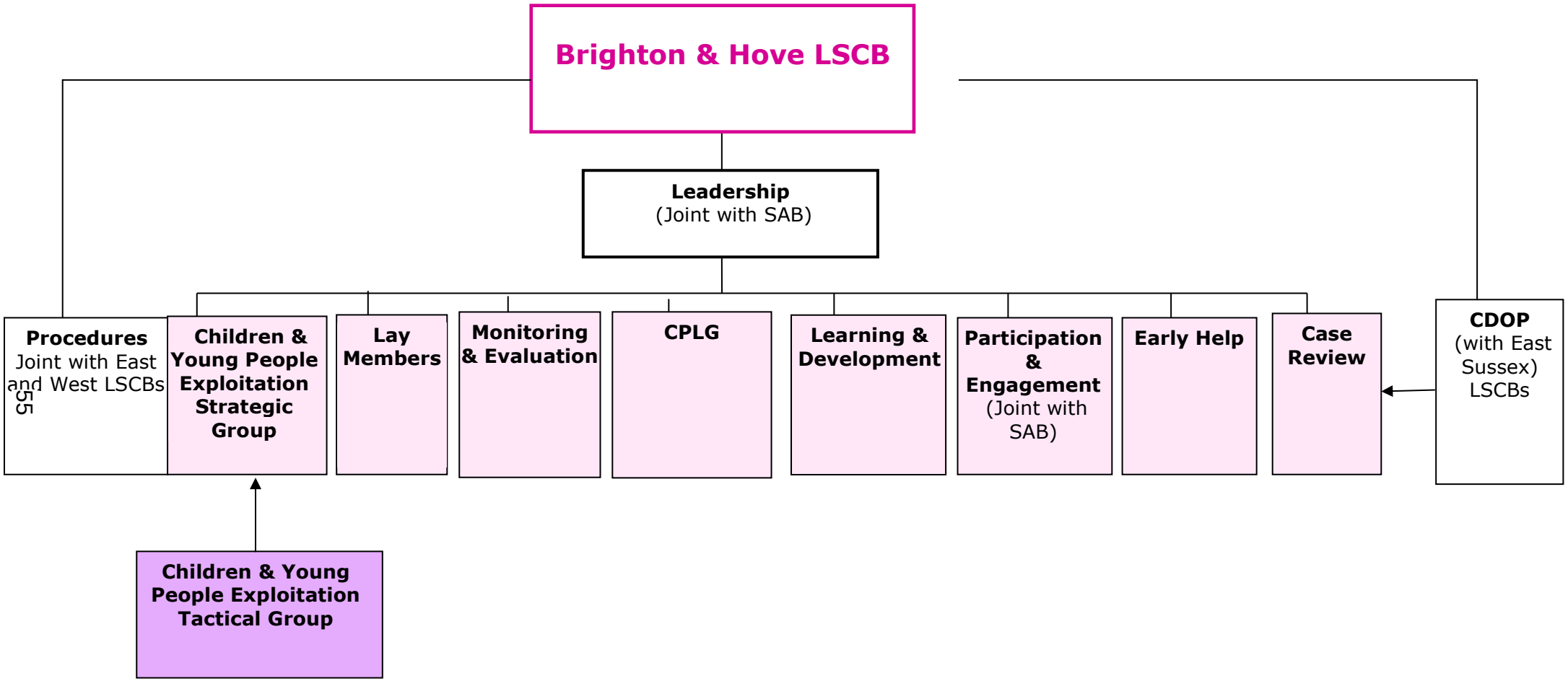
We discussed the emerging threats for our children and young people and the partnership's role in minimising the impact.

We shared our thoughts on how best to realign subcommittee responsibilities in the new arrangements. We advocated for the continuation of independent scrutiny via the appointment of an independent chairperson and continued lay member and lead member representation. We urged the safeguarding partners to take forward plans to further develop youth engagement and to continue the quality assurance functions and challenge ethos which has served the LSCB well.

The safeguarding partners will publish their safeguarding arrangements and new priorities by May 2019.



Appendix 1: Board Structure



Appendix 2: Board Membership

Statutory Members	Advisors
Chris Robson, Independent Chair of Brighton & Hove LSCB **Brighton & Hove City Council (BHCC):** Pinaki Ghoshal, Director of Families, Children & Learning, Jo Lyons (Dr), Assistant Director: Education & Skills, Peter Castleton/ Jo Player Head of Community Safety **Sussex Police** Carywn Hughes, D/Superintendent **National Probation Trust** Andrea Saunders, Director of Public Protection **Kent Surrey & Sussex Community Rehabilitation Company** Debbie Piggott, Resettlement Director **Youth Offending Service** Anna Gianfrancesco, Head of Service **CAFCASS** Nigel Nash, Service Manager **East Sussex Fire & Rescue Service** David Kemp, Head of Community Safety **Domestic Violence Forum** Jo-Anne Walsh, Chair, Brighton & Hove Domestic Violence Forum **Community & Voluntary Sector** Terri Fletcher, Director, Safety Net **Schools** Richard Chamberlin, Roedean School, Elizabeth Cody, Brighton College Ruth King, Blatchington Mill School **NHS England South (South East)** Domenica Basini, Assistant Director for Safeguarding and Quality, **Brighton & Hove Clinical Commissioning Group (CCG):** Allison Cannon, Chief Nurse, Sussex CCGs, Naomi Ellis, Jamie Carter (Dr), Designated Doctor, Jo Tomlinson, Designated Nurse Mary Flynn (Dr), Named Doctor (GP representative) **NHS Trusts** Frances Howsam, Named Dr Safeguarding Children, Brighton & Sussex University Hospitals (BSUH) Susan Marshall Chief Nurse, Sussex Community Foundation Trust (SCFT) Diane Hull, Chief Nurse, Sussex Partnership Foundation Trust (SPFT) Bethan Haskins, Chief Nurse, South East Coast Ambulance Service	Mia Brown, Brighton & Hove LSCB Business Manager David Feakes, Head of Safeguarding & Looked After Children, SCFT Helen Davies, Chair LSCB Monitoring & Evaluation Subcommittee Ann White (Dr), Named Doctor, SCFT Yvette Queffurus, Named Nurse, SCFT Debi Fillery, Named Nurse BSUH Jayne Bruce, Deputy Director of Nursing Standards and Safety, SPFT Rebecca Conroy, Principal, City College Dan Chapman (Cllr), Lead Member, BHCC Children's Services Deb Austin, Head of Safeguarding, BHCC Natasha Watson, Managing Principal Lawyer, BHCC Emma Gilbert, Head of Housing, BHCC Dr Peter Wilkinson, Acting Director of Public Health Kerry Clarke, Children, Young People and Public Health Schools Commissioner Pierre Serra, DCI - Public Protection, Sussex Police Jane Mitchell, South East Coast Ambulance Service

Appendix 3: Training Attendance

Level 2 – Core Child Protection Courses	Courses Presented	Attendance
Developing a Core Understanding	6	126
Assessment, Referral and Investigation	6	111
Child Protection Conferences and Core Groups	6	101
		338
Level 3 - Specialist Child Protection Courses		
Domestic Abuse and Violence	3	34
Child sexual exploitation - level 1 – Prevention and Disruption	2	26
Child sexual exploitation - level 2 – Working with Young People	2	11
MAPPA – Multi Agency Public Protection Arrangements	2	12
Safeguarding Children with Disabilities	1	25
Impact of Parental Substance Misuse	1	12
Neglect Training	2	27
Hidden, (Private fostering, Home education, Travellers and Migrants)	1	10
Young people displaying Sexually Harmful Behaviours - Clermont	1	20
Dealing with Child Sexual Abuse	1	17
Working with Parents who have a Learning Disability	2	19
Mental Health & Children's Services: Working Together with Families	2	25
Safeguarding Adolescents	1	20
Disguised Compliance	2	28
County Lines – Gang Exploitation	1	33
Harmful Practices – (in conjunction with VAWG)	2	58
Practice update - ABE	1	32
Childs World	1	20
Safeguarding in a Digital World	2	25
SCR Briefing – W & X	2	48
Neglect Briefing – Family C – Learning Review	2	30
Perplexing Cases (FII)	1	36
Neglect Conference	1	38
		606

Multi-agency attendance LSCB Core training (01/04/17 – 31/03/18)

Agency	Developing an Understanding	Referral, Assessment & Investigation	Case Conference & core groups
Police	0	0	1
Education	44	47	51
Health	8	8	5
CVS	10	4	4
Probation	4	5	5
BHCC	29	19	15
Early Years	*22*	*22*	15
Housing	*3*	*2*	*3*
Other/unknown	*7*	*4*	4
	124	*111*	103

Brighton & Hove City Council

NHS Brighton and Hove Clinical Commissioning Group

NHS Sussex Community NHS Foundation Trust

Sussex Partnership NHS Foundation Trust

YMCA DOWNSLINK GROUP

NHS Brighton and Sussex University Hospitals NHS Trust

Cafcass Children and Family Court Advisory and Support Service

Kent Surrey & Sussex Community Rehabilitation Company PROBATION

East Sussex Fire & Rescue Service

National Probation Service

Network Survivors Supporting survivors in Sussex for 25 years

Brighton Oasis Project

Rise Freedom from Abuse and Violence Since 1994 Sanctuary and Support in Sussex

impact INITIATIVES

The Wise Project Working to prevent the sexual exploitation of children and young people

safety net

allsorts youth project

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