KENT SAFEGUARDING CHILDREN BOARD

KSCB

SAFEGUARDING THE CHILDREN OF KENT

Annual Report 2009 -2010

Business Plan 2010-2013

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1. Introduction

The death of Peter Connelly in Haringey resulted in a heightened national focus on the safeguarding of children. Since then, Children's Trust Boards, Local Safeguarding Children Boards and their partners have been working hard to learn lessons and strengthen arrangements to keep children safe. This is being undertaken within a challenging context: there are higher expectations and standards; increased demand in many areas in the form of referrals to children's social care services and numbers of children being the subject of child protection plans; continued workforce challenges in key areas such as social work and health visiting. Added to these challenges will be the impact of public sector funding reductions which are likely to affect all agencies that contribute to the safeguarding of children.

These are all challenges that face partners and partnerships in Kent. Building on a strong track record, the commitment of partner agencies to strengthen the safeguarding of children is high. As part of this, robust review of existing safeguarding arrangements and clarity of strategic direction are even more critical in the light of the challenges being faced.

This report provides an account of the work of the KSCB during 2009/10. It sets out the strategic aims that the KSCB intends to achieve over the next three years. These aims will be achieved by the delivery of specific objectives in each year; the specific objectives for 2010/12 are set out.

These aims and objectives are based on an analysis by the KSCB of its strengths and areas needing development; local needs, issues and experience; messages from local and national Serious Case Reviews (SCR) and research; messages from national developments and statutory regulation and guidance.

2. Key strategic priorities for KSCB

2.1 From Process to Outcomes: Making a Difference

I. Evidence from the analysis of SCRs, both locally and nationally, highlights continuing concerns about fundamental safeguarding issues.

II. If, then, we are going to make real progress in safeguarding and promoting the well-being of children, Local Safeguarding Children Boards, Children's Trust Boards and the individual agencies that make up the Boards will not be able to carry on doing "business as usual". There will be a need for all involved to do some things differently: to consolidate and develop what works well, but also to think and act creatively. This will not be easy as it will mean stepping outside of comfort zones.

III. Perhaps the biggest refocusing that needs to take place is a move from process to outcome. If one considers the statutory responsibilities of LSCBs as set out in *Working Together*, then it is probably fair to say that LSCBs have concentrated on, and been most comfortable with, process type functions e.g. developing procedures, protocols, policies, delivering training programmes. Yet there is another large area of responsibility*: "Monitor and evaluate the effectiveness of what is done by the local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve" (Working Together,*

March 2010). The key word here is effectiveness; because this is asking what impact, what difference the activity of Board partners working both singly and collectively (and the Board itself) is making to the lives of children and their families. How are their lives better – in terms of concrete safeguarding and well-being outcomes being achieved?

IV. Moving to an outcomes-based approach to safeguarding is not easy. It requires coming at things differently, stepping outside of conceptual boxes, adopting and struggling with new ways of thinking. This it is not something achieved as an event, but rather a journey. But it is the right path to be on: if the safeguarding work that Board partners deliver is making a positive difference to the lives of children, then we need to know that, so we can build up, share and celebrate models of what good practice looks like (instead of trying to work from deficit models of what has gone wrong); if it is not making a difference then we also need to know that so that it can be replaced by practice that does make a difference.

V. KSCB is committed to moving towards a stronger focus on "outcomes". This will involve a constructive dialogue with individual partners, the Children's Trust Board and other key partnerships. It will impact on both the commissioning and delivery of services.

VI. "Outcomes" for children and families is the principle underpinning the framing of the Board's strategic aims and specific objectives. The review of what has been achieved in 2009/10 is largely in terms of the "quantity" and "quality" of safeguarding related activity. This is important because it is a testament of the dedication and hard work of many individuals and organisations. Future annual reviews will increasingly focus on the outcomes for children and families that have been achieved as a result of the activity.

2.2. Quality Assurance and Complexity

To find out how effective the arrangements and services designed to keep children safe and promote their well-being are, LSCBs and their partner agencies need to have in place fit-for-purpose quality assurance arrangements. What we know from the DCSF analysis of serious case reviews and local analysis is that safeguarding children is a complex business: this is because it is a fundamentally human activity; it involves working with complex individuals and families; and the work is undertaken by human beings and organisations which bring their own complexity. To make sense of what is happening will require an approach to quality assurance that recognises this complexity. This is why the development of a robust quality assurance framework is a key strategic aim. As with outcomes, it is not something that is set in place as an event; rather, it is something that is developed and built on.

2.3 Learning, Development and Supervision

Safeguarding children is about the management of risk within the context of a range of complex human relationships: relationships between professionals, relationships within families, relationships between professionals and children, relationships between professionals and parents/carers – and the internal relationships that professionals have with their own histories and experiences. If professionals are to be effective in the midst of this complexity they need the support to think clearly and imaginatively. For this

reason, learning, development and working with partners to ensure effective supervision arrangements are in place are key elements of KSCB's forward planning.

2.4 Think Family, Act Family

Children are part of family systems. In the safeguarding arena, as noted above, these are often complex family systems, with a whole range of historic and current factors interacting in a way that is detrimental to the welfare and safety of the children. Therefore, to improve the safety and well-being of children, the needs of the whole family have to be considered and addressed. This means effective partnership working and a shared approach is necessary across adults' and children's services, as well as between different children's services. This is particularly important in respect of domestic abuse, adult mental ill health, substance misuse and learning disability, and this is why they figure in KSCB's strategic planning. The aim is not just to change thinking, but for changed thinking to translate into changed ways of working and improved outcomes.

In addition, families do not exist in a vacuum. They are part of a broader community in which factors such as housing and poverty impact on family functioning and the safety and well-being of children. KSCB will need to understand such factors and identify what contribution it can make in respect of them.

2.5 Relationships that make a difference

KSCB intends to make a positive difference to the lives of children. It cannot do this on its own: it will achieve this through developing effective relationships with other strategic groups – in particular the Children's Trust Board, but also other strategic groups such as the Kent and Medway Domestic Violence Strategy Group. It will also ensure it has clear connections with the relevant governing boards and committees of partner organisations. There are particular challenges for agencies who have safeguarding responsibilities but whose core business is not safeguarding; a key role for the KSCB will be to work with such partners to ensure an appropriate balance.

David Worlock
Independent Chair

Introduction

This is the third Annual Report of the Kent Safeguarding Children Board (KSCB), covering the period of 2009/2010. The report highlights the structure of the KSCB, outlining the strategic and operational dimensions, including the various multi-agency subgroups. The report summarises the achievements of the KSCB during 2009/10, as well as those achieved by multi-agency forums, which feed into and report to the KSCB on a regular basis. It outlines the priorities set for 2010/13 in the Business Plan, with a more detailed Action Plan 2010/12.

The aim of the Annual Report is to inform the staff of the KSCB partner agencies, their service users and the public of the work of Kent Safeguarding Children Board. In addition it forms part of the accountability of the Board to those who fund and support the KSCB; Kent County Council's Lead Member for Children's Services and the agencies represented on the Kent Children's Trust Board. This report will focus not only on achievements of the Kent Safeguarding Children Board during 2009/10, but also clearly identify where more progress needs to be made through the Business Plan.

The Annual Report will be distributed and made available to all key agencies /stakeholders and is a public document. It will be accessible through the KSCB website www.kscb.org.uk

Review of Safeguarding 2009/10

Kent Safeguarding Children Board (KSCB) has now completed three full years of operation. It has worked hard to ensure that it continues to strengthen governance arrangements and that safeguarding and promoting the welfare of children and young people remains a high priority in all partner agencies.

During the year, the Board met on five separate occasions, and was chaired by Oena Windibank, the Vice Chair, and Director & Associate Director of East Kent Primary Care Trust Children and Families Services, on four of those occasions until the appointment of David Worlock, Independent Chair in January 2010.

Some of the key areas of work undertaken by the KSCB during the year are as follows:

Role and Function of Kent Safeguarding Children Board (KSCB)

Desired Outcome: An effective Local Safeguarding Children Board – with the intended outcome that the KSCB works effectively and efficiently as a Board, and in its sub-groups and effectively influences other strategic partnerships to deliver the staying safe agenda.

Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. For this reason, the Children Act 2004 requires every Local Authority to establish a Local Safeguarding Children Board (LSCB). The Kent Safeguarding Children Board was established in April 2006.
Chapter 3 of "Working Together to Safeguard Children, a guide to inter agency working to safeguard and promote the welfare of children" (2010) sets out the core objectives of a LSCB:

- Co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in Kent.

- To ensure the effectiveness of what is done by each person or body for that purpose.

Within the core objectives of the LSCB there are a number of core strategic functions that are a priority for LSCBs:

- To continue to develop and deliver inter agency policies and procedures including

    - setting out thresholds for service provision for children and young people
    - ensuring training is provided to meet local need
    - recruitment, selection and supervision of staff
    - investigating allegations against those working with children,
    - ensure the safety and welfare of children who are privately fostered,
    - co-operate with neighbouring authorities

- To ensure effective communication with children, parents, carers and professionals in relation to keeping children safe and promoting their welfare, and ensuring that the views of children and their carers contribute to the work of the Board and the services they receive.

- To ensure effective monitoring of what is done by the statutory KSCB members and other bodies, individually and collectively, to safeguard and promote the welfare of children, and advise on ways to improve.

- To actively participate in the planning and commissioning of services to ensure that they take full account of the need to safeguard and promote the welfare of children.

- To ensure that there is effective single and multi-agency training of staff for the development of a safe and skilled workforce to safeguard and promote the welfare of children.

- To ensure that lessons are learnt from the work of the KSCB under its functions related to child deaths, and any serious case reviews.

Board Structure and Membership

The membership of the KSCB has remained consistent over the past year, apart from a few changes due to colleagues leaving Kent. There is a new Director of Children Services and a new Lead Member. One significant change in membership has been the change in chairing arrangements for the Board.

It was agreed by the members of the Board in May 2009 that an independent chair should be appointed. David Worlock was successfully appointed by members of the Board and a Panel of Young People. The previous chair of the KSCB, Oena Windibank, Operations Director & Associate Director of East Kent PCT Children & Families Services, stepped down in January 2010. In line with requirements of the Laming Report recommendations the KSCB will look to recruit lay members next year.

The core members of the KSCB are those who are designated as statutory members under S.13(3) of the Children Act 2004. Associate members have been established and ensure robust links with key stakeholders. The KSCB also secures the involvement in its work with the Kent & Kent Domestic Violence Strategy Group, the Multi-Agency Public Protection Arrangements, Housing, and Drug Action Team via existing forums and sub-groups.

All core members and associate members of the KSCB have been provided with a written statement of their roles and responsibilities and their organisation has confirmed that they are able to:

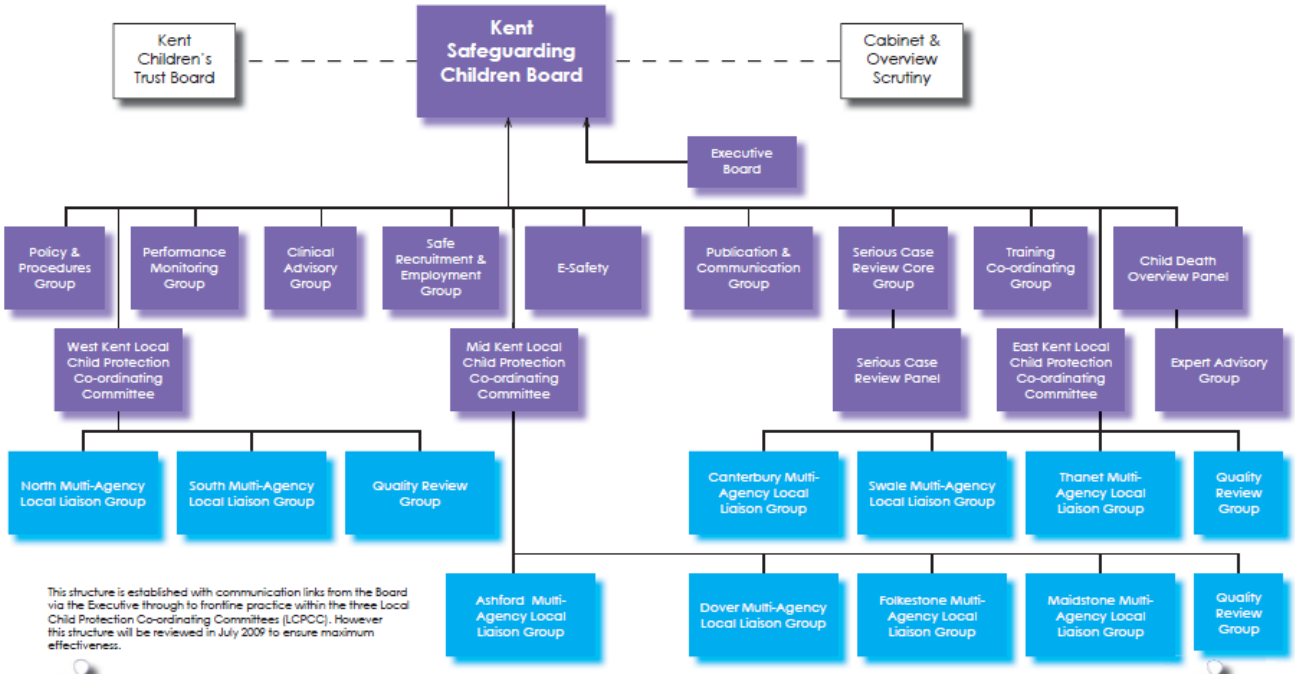
- Speak for their organisation with authority
- Commit their organisation on policy and practice matters
- Hold their organisation to account (in matters of safeguarding children).

A written constitution and terms of reference have been established for the KSCB, and terms of reference established for each subgroup are available via www.kscb.org.uk. This will be reviewed over the next coming months in light of the new Working Together guidance, published in March 2010.

In order to discharge its roles and responsibilities KSCB has established the following structure of sub-groups in order to progress the detailed work of the strategic aims of the Board (see over the page).

The sub-groups of the Board are key to its operation as they bring together professionals from all agencies to use their considerable knowledge and experience to ensure the work streams, identified in the Annual Business Plan, are achieved to the highest possible standard. The work undertaken in these multi-agency forums ensures that changes and improvements are made which positively impact on the lives of children and young people in Kent.

The Board and its associated sub-groups are administered by the KSCB Administrators and supported by the KSCB Manager, KSCB Development Officer and the Learning & Development Officer.



Governance Arrangements

The Kent Safeguarding Children Board is accountable to the Director of Children's Service and the Lead Member for Children's Services who have a particular focus on how the Local Authority and partner agencies are fulfilling their responsibilities to safeguard and promote the welfare of children and young people.

The KSCB has a clear and distinct identity within Kent Children's Trust Board. The Chair of the KSCB is a member of the Children's Trust Board, and holds that Board to account for ensuring that safeguarding is central to all its activities.

Whilst the KSCB plays the key role in co-ordinating and ensuring the effectiveness of local individuals' and organisations' work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partners retains its own existing lines of accountability for safeguarding and promoting the welfare of children by its services. The KSCB does not have a power to direct other organisations but will advise the Local Authority and Board partners on ways to improve. When there are concerns about the work of partners and these cannot be addressed locally, the Chair of the KSCB will report these to the most senior individual in the partner organisation, to the relevant Inspectorate, and, if necessary, to the relevant Government department.

Critical challenge and holding partner agencies to account for their safeguarding activity is a key function of KSCB, which has been strengthened by the new legislation.

The relationship between the KSCB and the Children's Trust Board (CTB) has continued to be strengthened and stronger links are established between the work of the KSCB and the CTB.

- The Chair of the KSCB is a member of the Kent Children's Trust Board
- Both Boards are continuing to develop and maintain a clear and distinct identity within the governance arrangements.

- The KSCB annually reports formally to the Children's Champion Board and Kent County Council on the work of the Board and the current position regarding the safeguarding the of children and young people in the County.

- The KSCB will provide comment to the Kent Children's Trust Board during the review and refresh of the Children and Young People's Plan

- The KSCB Manager links to the Children's Trust Manager

Recognising the need to measure effectiveness and to ensure that the Board had clarity on its strategic objectives, the KSCB organised a half day workshop in November 2009. Members used a Self Assessment and Improvement Tool to evaluate progress, strengths and weaknesses in areas which are judged to be crucial for achieving effective cooperation at strategic and practice levels that both safeguard and achieve better outcomes for children:

- a shared strategic vision;
- effective governance arrangements; and,
- systems, structures and capacity.

As a result of this workshop the Kent Safeguarding Children Board identified four key strategic priorities:

1. Creation of measurable child/young person focussed outcomes; for the Board collectively and all agencies individually to be performance managed against evidence of 'making a difference'.
2. Performance monitoring as a Board and individual agencies, through a performance framework.
3. Involvement strategy, including the third sector, communities, children and young people and families/carers.
4. Practice development and improvement strategy, through comprehensive training strategy, learning from events/SCRs, front line practice learning and subgroup function to support Board effectiveness. Agreement of Board accountabilities and engagement of members and their agencies, of collective responsibility of outcomes/priorities, active involvement of all members, collective prioritisation of strategic objectives, resource allocation.

During 2010, Kent County Council's (KCC) Internal Audit Team carried out a Governance of Partnerships audit regarding KSCB to provide assurance on the governance arrangements within partnerships that Kent County Council is involved in. Based on the findings in this audit, the conclusion drawn was there is substantial assurance that risks, which could prevent achievement of business objectives pertaining to the audited system, are managed effectively. The audit team also concluded that there was high reassurance accountability regarding partners' roles and responsibilities.

Review of the KSCB Objectives

Performance Monitoring & Evaluation

Desired Outcome: All partners demonstrate compliance with s11 requirements

The requirement for KSCB to monitor whether or not work to safeguard children is effective, is a challenging one as it involves collecting and evaluating performance information across each member agency.

The Performance Monitoring Sub-group is chaired by Oena Windibank, Director & Associate Director of East Kent PCT Children & Families Services and Vice Chair of the KSCB. The group meets on a quarterly basis to monitor multi-agency safeguarding performance and to develop ways of assessing effectiveness and competence of services to undertake their safeguarding children responsibilities.

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

Following the death in 2008 of Peter Connolly (Baby P), the Secretary of State ordered an urgent review of safeguarding arrangements by Lord Laming. Lord Laming published his report "The Protection of Children in England: A Progress Report" in early 2009. All of his recommendations were accepted by the Government.

Following this publication, the KSCB commissioned Kent Children Services, Kent Police and East and West Kent PCT to conduct self-audits against the Laming and Victoria Climbie recommendations. The results were good with a high degree of compliance, and action plans have been drawn up to ensure that there is full compliance.

Additionally, the KSCB in partnership with Canterbury Christchurch University produced a self-audit tool for organisations that work with children's providers to assist them in monitoring their compliance with the requirements of Section 11 of the Children Act 2004. The audit tool aimed to assess each audit standard for: the clarity of its description, the details of evidence, the achievement of the standard and the provision of an action plan where the standard was not met.

Twenty seven organisations across Kent were required and completed the self-audit tool and the information provided was evaluated to better estimate whether the Section 11 requirements were presented as met.

All twenty-seven organisations stated the explicit provisions they made to comply with KSCB standards and provided action plans to achieve unmet standards. Every organisation showed a high level of compliance. Four audit forms showed full compliance and provided clearly identifiable examples of good practice. These were provided by Children's Social Services, Canterbury City Council, Kent Police and Connexions. These organisations provided clear and detailed evidence for policies and procedures that accommodated most of the KCSB standards and also provided detailed and feasible action plans for implementing further organisational developments that would ensure children's safeguarding.

Specific examples of good practice included: undertaking 'action learning' from case studies (Kent County Council, Education), completing action plans following serious case reviews (East Kent Hospitals Foundation Trust), reporting near misses and examining them (NHS Eastern and Coastal Kent Community Services), utilising Viewpoint software to collect the views of service users (Kent Young Offenders Service), whistle blowing system being in operation where all staff members can make anonymous referrals to the

Professional Standards Department (Kent Police), obtaining Stonewall membership to promote equality and diversity in the workplace (South East Coast Ambulance Service NHS Trust), pursuing ISO27001 accredited for information management (Kent Probation Service), senior officers attending mandatory training at Canterbury Christchurch University as well as maintaining an annual safeguarding action plan to ensure continuous improvement and establishing a Quality Assurance and Performance group to monitor child protection matters (Connexions).

What difference did we make?

There continues to be a strong commitment to partnership working and the ongoing development of good practice within the multi-agency teams that are working to support children, young people and their families. These audits show robust governance arrangements are in place in all partner agencies. More work needs to be done to further embed the following good practice and understanding between agencies:

- The rule of optimism held by some practitioners needs to be challenged by line managers in supervision and the escalation procedures used effectively

- Understanding of thresholds between different agencies needs to be improved so that we are able to support each other and the child/young people more effectively

The KSCB will be using the findings from these self-audits to inform the business planning for 2010/12. This will allow the Board to set objectives and indicators to improve outcomes in the coming year.

The evaluation of local practice is one element of the Kent Safeguarding Children Board's monitoring and evaluation programme. In Kent there are 3 Local Child Protection Co-ordinating Committees. These bring together partners working in the districts, including local authority children's social services, schools, early years settings, police, health and the voluntary/community/faith sector.

The Quality Review Groups have focused on the effectiveness of information sharing, and children and young people who present with 'risk taking behaviour'.

What do we do next?

- The Independent Chair will take over the chair of the Performance Monitoring Sub-group in June 2010. There will also be a review of the group's membership.

- Develop a quality assurance framework based on key priorities identified by the Kent Safeguarding Children Board. This will include elements of understanding needs, outcomes are analysed and evaluated, stakeholders' views, including those of agencies, parents, children and young people , are taken into account and form an important plank of evidence, All of this will assist in the Board having a quality assurance system which is relevant, manageable, children and young people focused, transparent and evidence based.

- Continuing to strengthen scrutiny of performance and implementing good quality assurance systems across agencies.

- Develop and implement a programme of continuous sampling and qualitative audits of case files across agencies focusing on the effectiveness of multi agency child protection practice.

- The establishment of a clear dissemination process to share the learning from these activities, working with relevant subgroup and existing processes.

Improving and Promoting Best Safeguarding Practice and Procedures

Policies and Procedures

Desired Outcome: Processes are fit for purpose and promoting positive outcomes for vulnerable children

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

The Policy and Procedure Sub-group has started to review the contents of the Kent and Medway Safeguarding Children Procedures 2007.

A number of new Procedures and Protocols were introduced during the year, namely;

- The KSCB worked alongside the London Safeguarding Children Board to support the London-wide Trafficking Children Project.
- Updated procedure for children in whom illness is fabricated or induced, in line with recent DCSF guidance.
- Toolkit for Individual Management Reports in Serious Case Reviews
- Procedures and Practice Guidance for the Review of Child Deaths
- Procedures for the Rapid Response Process
- Joint working protocols between Adult Services and Children's Services
- Fire Safety Practice Guidance and supporting leaflets and posters
- Safeguarding Children in Custodial Settings
- Safer Practice in use of Technology for Adults Working with Children

All of these have been widely disseminated and are available to view or download from the Kent Safeguarding Children Board website: www.kscb.org.uk

During the year, the KSCB received briefings and/or was actively involved in consultations on the following areas:

- Independent Vetting and Barring Scheme
- Children and Young People's Plan
- Missing Children
- "Together we can end violence against women and girls"
- Consultation on the new statutory draft guidance for Children's Trusts
- Handling Allegations of Abuse made against Adults who Work with Children and Young People
- Serious Case Review Consultation
- Working Together Consultation

What difference did we make?

There are clear protocols in place to clarify roles and responsibilities to safeguard children in Kent.

Information about strengths and weaknesses and lessons from serious case reviews are fed back to Board representatives to promote accountability and drive up best practice.

What will we do next?

The "missing children" procedure is currently being revised to encompass children missing from home and to update sections covering children missing from education and children missing from care.

A second edition of the Kent and Medway Safeguarding Children Procedures will be published in the third quarter of the next financial year and will reflect the new national statutory guidance Working Together which was issued on the 17th March 2010. This will be a joint venture between the both the Kent and Medway Safeguarding Children Boards and will ensure consistency in policy and practice across the area.

Safer Recruitment & Employment

Desired outcome: The Kent children's workforce is competent and safe.

The statutory guidance Working Together to Safeguard Children places a duty on the KSCB to have effective arrangements in place to deal properly and quickly with all allegations of harm made against professionals who work with children. It should coordinate the investigations into these allegations and ensure that safer recruitment practices are established.

The framework for managing cases where allegations have been made against people who work with children is wider than those situations where there is a reasonable cause to believe that a child is suffering, or is likely to suffer significant harm. It also caters for cases of allegations that might indicate that a perpetrator is unsuitable to continue to work with children in his or her present position, or in any capacity. The procedures are adhered to in those cases where it is alleged that a person who works with children has:

- 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 in a way that indicates that he/she is unsuitable to work with children

It is essential that procedures are followed and timescales are adhered to. Therefore it is a requirement that all agencies are familiar with what to do should they become aware, or suspect, that a professional has abused a child.

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

All member organisations of the Safeguarding Board have a named senior officer with responsibility for dealing with allegations. In addition, the Local Authority Designated Officers (LADOs) manage and oversee all individual cases. The LADOs provides advice and guidance in relation to allegations as well as monitoring the progress of cases to ensure that they are dealt with as quickly and consistently as possible. The LADO role within Kent County Council is currently performed by two officers within the Policy & Performance Unit at Kent County Council.

The Local Authority Designated Officers (LADOs) received 474 allegations/ concerns in relation to people who work with children between 1st April 2009 and the 31st March 2010.

These staff worked in a variety of different roles across a number of agencies, including schools, childcare, foster care, children's services, the police and voluntary sector.

The allegations/concerns related to the following categories:-

Physical Abuse (Including inappropriate restraint)	264
Sexual Abuse (including Internet abuse and abuse of trust)	107
Emotional	22
Neglect	2
Risk by association	12
Other Conduct Concerns	67

There have been 5 referrals of historical abuse (4 sexual, 1 physical) reported by Kent Police to the Social Care LADO during the year, equating to a 500% increase.
Three cases were risk by association, all sexual and all related to internet misuse. There has been a significant increase in internet abuse activity. The offences included being in possession or making indecent images of children.

It is evident that many of the allegations and complaints of a physical nature emanated from a child's perception of a situation when staff had intervened appropriately and in line with approved behaviour management policies to keep a situation safe. It is also clear however that many teachers, unqualified support staff and residential care workers do not have the necessary experience or training to deal with increasingly challenging behaviours presented by young people in some settings.

During 2009, partner agencies continued to deliver its programmes to staff regarding best practice for safer recruitment and employment.

Following the launch of the Independent Safeguarding Authority and the new Vetting and Barring Scheme on 12 October 2009, the KSCB produced a briefing paper aimed at raising awareness amongst partners about new statutory requirements which come into effect in summer/autumn 2010. This was distributed to all board partners, and is available on the Kent Safeguarding Children Board website.

What difference did we make?

Sir Michael Bichard's recommendation on safer recruitment has led to training being developed in this area for all agencies and the wider workforce by the Child Workforce Development Council (DWDC).. The requirement for schools to have completed this training becomes mandatory in January 2010. KSCB will be encouraging partner agencies to use this training resource throughout 2010/ 2011.

Awareness of abuse and harm is improved amongst the Kent workforce which is critical as they are ideally placed to identify and support children at risk. Reports from the Local Authority Designated Officers LADOs indicate that partner agencies are referring allegations against staff appropriately and in a timely fashion. Investigations being completed within timescales remain a challenge.

What will we do next?

Ensure that vetting and barring protocols, procedures and guidance are in place across the all agencies in line with the Independent Safeguarding Authority's (ISA) Vetting and Barring Scheme.

Child Death Review Processes

Desired outcome: KSCB is compliant with statutory requirements and multi-agency collaboration reduces preventable child deaths in Kent

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

Child Death Reviews have been a statutory requirement since April 1st 2008 as part of the Local Safeguarding Children Board Regulations 2006. LSCBs are required to review the circumstances of all child deaths (up to the age of 18 years). This is because a fuller understanding about why children die may help reduce overall child deaths. Research has shown that parents want the death of their children to be investigated so that they may understand why this happened to their family.

In line with Chapter 7 of *Working Together to Safeguard Children*, the Kent Child Death Overview Panel has oversight of the processes, ensuring:

- That reviews occur in a timely fashion.
- That the information, support and investigation of each death is appropriate and compassionate.
- That there is appropriate investigation or referral of any deaths where there are safeguarding or criminal issues.
- That where issues or lessons emerge that have broader relevance, or public health implications, they are effectively disseminated.
- That deaths are monitored so that trends or apparent associations can be identified and where appropriate investigated.
- That information is appropriately collated and reported to the DCSF.

The Child Death Overview Panel (CDOP) consists of senior managers in those organisations which regularly have contact and care of children, who provide scrutiny and transparency. The Panel Chair is Oena Windibank.

This year the CDOP has met four times and considered the conclusions from the Expert Advisory Group (EAG). The Expert Advisory Group consists of a group of practitioners who review all cases in detail and have met on 12 occasions throughout the year.

There were a total of 95 deaths of children normally resident in Kent. Of that total, 70 cases were reviewed and 54 deaths were considered to be unexpected and 41 expected. 2 were deemed to be preventable, 8 potentially preventable and 59 to be not preventable. In one case there was insufficient information to make a decision on preventability. The remainder of the cases are awaiting inquests, criminal proceedings, SCRs or have yet to be reviewed.

One case considered by the child death process was referred to the SCR core panel, this case was accepted as an SCR, and a review undertaken.

The review of these child deaths have considered the appropriateness of professionals' responses to each unexpected death of a child, their involvement before the death and any relevant environmental, social, health and cultural aspects, to ensure a thorough consideration of how such deaths might be prevented in the future.

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

- The Single Point Of Contact (SPOC) process has been established and is embedded well and an efficient secure process has been established around the notification process and collation of information.

- The improved gathering of information in terms of detail and from a wider spectrum of agencies has enabled the groups to consider far more information when considering the cases. Attendance by paediatricians has improved and the EAG has co- opted specialists such as a Neonatologist, Head of the Police Serious Crash Investigation Unit to attend EAG meetings when considering thematic issues such as neonatal deaths and road traffic crashes.

- Procedures for the Child Death Review Process and the Unexpected Death of a Child produced and ratified by the KSCB.

- Three designated doctors for Child Deaths (with protected time) have been recruited in the Eastern & Coastal PCT and two in West Kent PCT through its commissioning arrangements.

- Specialist nurses have also been appointed by both PCTs. These staff co-ordinate the health response to all child deaths in the area including the initial stages of the rapid response.

- A database has been established by the KSCB.

- There are now agreed information sharing channels with Kent Coroners.

- Ten members of the Child Death Overview Panel and Expert Advisory Group have been funded by the KSCB to attend the three day advanced training course The Warwick Advanced Course in the Management of Unexpected Childhood Deaths to facilitate improved management of unexpected childhood death across Kent in line with recognised good practice and with the statutory guidance from DCSF. In addition the PCTs have funded all their designated doctors and nurses who roles cover the child death process. To attend.

- Leaflets have been designed for Parents and Carers regarding the Child Death Review Process and home visits that are conducted when a child dies.

- Annual Report 2008/9 published.

- The average time between death and review is about 3 months unless the case is subject to inquest, SCR or criminal proceedings.

- The KSCB Development Officer with Lead Responsibility for Child Deaths was appointed in August 2009.

- A Child Death Training Strategy has been written and agreed by CDOP.

- Two intermediate training days have been held where 61 supervisors from the key agencies have attended. These courses have been led by the KSCB assisted by CDOP/EAG members. Training sessions for the Kent Registration Service, Coroner's Officers and Designated Child Protection Coordinators (schools) have also been held. Presentations on the CDOP and rapid response process have been given to all three local child protection co-ordinating committees.

- Reflective sessions delivered by the Child Bereavement Charity for the administrative staff involved in the CDOP process and members of the EAG and CDOP have been arranged.

- The KSCB procedures for child death investigation have been re written in light of Working Together 2010.

What difference did we make?

The KSCB Development Officer with a lead for child deaths will be producing an overview report containing the findings of the second year of the child death review processes later this year; this will identify the number of deaths across the county, themes and trends arising from these deaths and action taken to address areas highlighted.

The Panel is still in its infancy and it is still too early to identify local patterns and trends in child deaths from birth to aged 18 years. However, there are some themes that are beginning to emerge in relation to a number of deaths. These include the need to raise awareness in respect of co-sleeping arrangements and safe places to sleep. However, given the relatively small numbers of child deaths involved, the Board will feed in the information gathered to regional and national data and from this more reliable conclusions can be drawn

What will we do next?

- Developing more thematic reviews.

- West Kent PCT currently does not have permanent designated doctors in post for CDOP. Work is ongoing to finalise the person specification and job description to ensure the designated paediatrician's posts can be recruited to.

- Deaths of Kent children that occur overseas will continue to be difficult to investigate properly particularly in countries where infrastructure is limited.

- The reporting requirements from DCSF are still unclear.

- Further CDOP & Rapid Response Development sessions to be held.
- E Learning Package to be developed.

- Review existing policy and procedure in light of the revised Working Together guidance.

- Develop effective communication/involvement of parents in the CDOP process.

- Translate learning from CDOP into prevention activity.

- Improve the completeness of the data set and in a timely way.
- Develop a system to monitor the support families are offered/ receive following the death of a child.
- Enhance local safeguarding children board cross boundary working.
- Produce an information leaflet for professionals about Child Death Overview Panel.
- Identify any potentially contributory recurrent themes, circumstances.
- Identify possible limitations to service provision by agencies.
- Develop local recommendations to help reduce childhood deaths and where appropriate, specific ad hoc recommendations e.g dealing with particular road or environmental factors.
- Feed into the regional and national reports on the Child Death Review process – to produce more generalised sets of recommendations aimed at reducing child deaths.
- Roll out the programme of 6 basic courses lasting 2 hours between July to January.
- Develop improved links between KSCB and the Coroners, Registration Service, tertiary centres outside of Kent, hospices and other CDOP coordinators in the region and London have been developed.
- The panel has identified a trend of 6 incidents of co-sleeping deaths of infants which are being considered further to identify what action if any can be taken to reduce this category of death. The further analysis will examine any common factors and issues to assist the panel in deciding what action to take.
- Setting up of an audit trail for recommendations/actions arising from the CDOP panel to monitor all recommendations and ensure ownership and accountability.
- Evaluate the routinely collected data on the deaths of all children, identifying lessons to be learned, issues of concern, patterns or trends, with a particular focus on inter agency working to promote the welfare of all children.

Serious Case Reviews (SCRs)

Desired Outcome: SCR recommendations are effectively implemented to improve child safety, with reviews completed within time and judged to be of good quality.

Local Safeguarding Children Boards are required to consider holding a serious case review when a child dies and abuse or neglect is known or suspected to be a factor in the death. In addition, Local Safeguarding Children Boards should always consider whether a serious case review should be conducted where:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or

- a child has been subjected to particularly serious sexual abuse; or
- a parent has been murdered and a homicide review is being initiated;
- or a child has been killed by a parent with a mental illness; or
- the case gives rise to concerns about Multi-agency working to protect children from harm.

What is the purpose of a serious case review?

The purpose of a serious case review is to:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguarding and promote the welfare of children
- identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result; and
- as a consequence, improve Multi-agency working and better safeguard and promote the welfare of children.

Serious case reviews are not inquiries into how a child died, or who is culpable, that is a matter for Coroners and criminal courts, to determine as appropriate.

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

During 2009/10 four SCRs have been undertaken. One review was undertaken jointly with a London LSCB.

Independent Consultants were commissioned to write all the overview reports and in all cases the parents were offered the opportunity to contribute to the report.
Action plans have been drawn up from the frequently. These are monitored regularly by the KSCB.

All of the serious case reviews have been evaluated by Ofsted and all have been awarded a rating of 'good'. This reflects the commitment and hard work shown by agencies and organisations to this challenging but necessary work. Action plans drawn up from the recommendations have been implemented and are regularly monitored with a view to carry out audits to track progress.
Key themes arising from the SCRs undertaken during 09/10 were:

- Understanding the significance of hard to reach individuals and families
- Assessment and engagement with families with multiple and chronic difficulties
- Information sharing
- Compliance with procedures

Abigail

Over a period of ten months when Abigail was 11 years old she was seriously sexually abused by a 48 year old man who was a friend of the family. This culminated in Abigail

becoming pregnant. The family friend then arranged for her to have a termination of pregnancy at a private clinic.

KSCB decided to undertake a discretionary serious case review because Abigail had sustained serious impairment of her health and development through abuse and the case gives rise to concerns about the way in which local services work together to safeguard the welfare of children.

The serious case review was assessed against the criteria for conducting reviews as set out in '*Working Together to Safeguard Children'* (Chapter 8) by Ofsted, who evaluated the review as 'good' overall.

Ofsted stated that there were strong terms of reference and there was a good focus on the child in the majority of the individual management reviews. Six individual management reviews were judged good, two were judged adequate and three judged inadequate. The overview report gave careful consideration to the child's disability and considered how this was addressed through practice. Issues of race and culture were considered and there was good involvement of the child and her immediate family in the review process. The recommendations were assessed as adequate and Ofsted felt there were adequate arrangements in place for monitoring the overview report and action plan.

Brooke

Brooke, a three week old white British girl, died as the result of serious head injuries. She was the only child of the relationship between her mother and her father. The father has another daughter who is now aged five and who lives with her paternal grandmother. At the time of Brooke's death, the family was known to universal health services. The mother was previously known to Children's Social Care Services and had been the subject of a Care Order. The father became known to these services at the age of 17 years through his involvement with his then partner's child. He was arrested on suspicion of murder and subsequently convicted of Brooke's manslaughter.

This serious case review was also assessed by Ofsted, as 'good' overall. Ofsted stated that the serious case review was commissioned and completed within the agreed timescales and the terms of reference and the scope of the review was good. However, the quality of the individual management reviews was more variable. Nine were judged as good; two adequate, and one judged as inadequate. The overview report was good. The recommendations and action plans were judged as good. The executive summary was suitably anonymised and it was also assessed as good.

The report concluded appropriately that there was an overall failure on the part of health professionals to undertake a holistic assessment and a lack of multi-agency information sharing with the result that the potential risks to the child were not identified.

Caroline

Caroline, a five week old, white British, girl was discovered lifeless in her parents' bed on 17 November 2008 and pronounced dead on arrival at hospital. The mother had taken Caroline into bed to breast-feed her during the night and fell asleep with her.

The mother admitted she had drunk some alcohol the evening before and Caroline's father had also been drinking heavily.

There was a significant history of professional intervention into Caroline's family life with specific concerns around neglect of her siblings including poor conditions in the home,

siblings being left unsupervised, parental alcohol abuse and domestic violence. Prior to this incident none of the children were subject to child protection plans.

One of the key issues highlighted in this review was the importance of professionals being aware of how and when to escalate concerns regarding a case. The serious case review made a recommendation in this respect.

Agencies have been asked to remind their staff of the importance of challenging if they are dissatisfied with the actions being taken by another agency in respect of any case and ask them to re-familiarise themselves with the escalation process found in the Kent and Medway Safeguarding Children Procedures 2007. This provides clear guidance for professionals about the process that should be followed when there are disagreements regarding the management of a case.

This serious case review was also assessed by Ofsted as 'good'. Overall, six individual management reviews were judged good, one was judged adequate and two were judged inadequate. None of the individual management reviews considered the family's ethnic, cultural and religious background, and that fact was commented on in the overview report, which was judged as good. The recommendations were adequate and the action plan was good. The executive summary was judged as inadequate.

All three serious case reviews have been completed, the cases presented to and agreed by the KSCB, action plans developed and the reports circulated as required. The KSCB remains committed to learning the lessons from these reviews and will ensure that, as well as specific recommendations being carried out, lessons learned will be incorporated into future training and procedural revisions.

Other developments

- The local guidance and templates for the completion of SCRs has been completely revised to support the SCR process in line with the Ofsted Descriptors and its required explicit Quality Standards.

- Established a clear protocol with partner agencies to ensure that Individual Management Review (IMRs) are undertaken by appropriate senior managers within their agencies in accordance with the revised guidance and within the required timescales.

- A training programme for senior managers within partner agencies on the completion of IMRs to the required standard. To date this course has been delivered to over seventy five participants.

- Ensured all KSCB External Training providers are aware of the findings from SCR to promote the lessons to be learned from both the Kent SCRs and other SCRs and national research in their training

- We have developed a monitoring system for serious case review Action Plans to ensure recommendations are implemented and lessons are learnt.

The Board has maintained a focus on learning from these tragic cases and is committed to identifying how we can improve practice and sharing this across agencies. There is strong commitment from serious case review core panel members and the agencies they represent within the Serious Case Review process and in particular Individual Management Review writers have devoted a huge amount of time and resource to the completion of reviews.

We have made a number of positive changes to the whole process, including the SCR Practice Guidance and Toolkit; the challenge and decision making process within the panel and the quality of reports produced and we are looking forward to seeing a change in outcomes for children within the County

In June the KSCB commissioned the University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP) to undertake an analysis of all Serious Case Reviews (SCRs) completed since 2000. The overall purpose of the study was to obtain a profile of the children and families involved in SCRs and to provide an overview of the main practice themes arising from the reports.

The findings of this study and the serious case reviews undertaken during 2009/10 reflect many of the themes identified in national surveys of serious case reviews. Of particular interest is that many of the cases were highly individualised and although some involving long-term neglect could be considered as fairly typical of this type of case, "others contained unique and complex factors which are far less likely to be familiar to professionals". Further, they found "There was also a distinct absence of risk factors in some cases".

It has to be remembered that the majority of children who have an agreed and co-ordinated multi-disciplinary child protection plan are generally well served by the child protection processes and the services involved. There are over 1200 children in these circumstances at any one time in Kent out of the total child population of 327,000. The numbers of serious case reviews constitute, therefore, a small but significant proportion of the child population being safeguarded. Furthermore, not all will have been identified as children about whom agencies have had safeguarding concerns or been assessed as children in need under the Children Act 1989 and be in receipt of services.

However, the Kent Safeguarding Children Board is clear that there must be a continuing focus ensuring that the findings of serious case reviews are rigorously implemented, and on tackling the practice issues that this report has highlighted.

Sharing the Learning from Serious Case Reviews

On the 10th November 2009, KSCB held a conference called 'Learning Lessons from Serious Case Reviews'.

The conference was well attended with nearly 180 representatives from agencies working with children in Kent. The theme for the day was '"learning from Serious Case Reviews Nationally and locally", reminding professionals of Baby Peter and what has happened since his death and.
To help in delivering this conference the following speakers were invited:

- Hedy Cleaver – Emeritus Professor at Royal Holloway College, University of London
- Sharon Vincent – research fellow of the University of Edinburgh/NSPCC centre for UK wide learning in child protection

To help look at the different themes involved in serious case reviews the following workshops were arranged on various issues that have arisen from serious case reviews within Kent:

1. Parental Learning Disability and Children's Needs: protecting the most vulnerable
2. Parental Mental Health and Resilience
3. Information Sharing & the Law

4. MARAC, MAPPA, Domestic Homicides and SCR
5. Emotional Abuse and Neglect
6. The Serious Case Review Process
7. How to Manage Allegations Against Staff
8. Sexual Exploitation of Children and the Serious Case Review of Abigail
9. Eyewitness Theatre Group – issues arising from local serious case reviews.

What difference did we make?

The KSCB now monitors the implementation of actions arising from SCRs through the Performance Monitoring Sub-group.

The overall opinion from the conference revealed that the 95% believed the conference did help them to recognise the impact of parental mental disorders, substance misuse and domestic abuse on children.
As part of the conference, KSCB had various promotional products printed, one of which was a post it folder containing the 'golden tips for information sharing'. KSCB also contacted the DCSF for their small booklet on information sharing, which were placed in the packs for the attendees. Statistics revealed that the post it notes were indeed useful as 97% of attendees stated they would use the same.

During the year the KSCB were selected by Ofsted as one of the twelve LSCBs for a 'good practice visit' to inform their analysis of good practice in serious case reviews.

The National Safeguarding Delivery Unit are currently working on a number of projects which link to a number of issues raised by the SCR – for example, information sharing between adult and children's services, referral practices by all agencies and the Think Family Programme. The newly revised Working Together 2010 published on the 17th March, emphasises issues relating to undertaking assessments in complex circumstances; giving greater weight to parental substance misuse, adult mental health issues and domestic abuse. The work of the Board in the coming year will be focussed upon these national developments.

The conclusions drawn from both the Edinburgh study and the serious case reviews undertaken this year, continue to make a significant contribution to the wider knowledge about safeguarding children in Kent.

What will we do next?

We will continue to improve our performance in this critical area of work and provide critical, reflective analysis to improve the safeguarding of children."

Following the publication of new Chapter 8 guidance on how SCRs should be undertaken, the KSCB is re-writing its own local practice guidance which will be published later in 2010. To accompany this, the KSCB is planning to deliver a series of SCR train the trainer events.

Once an action is completed the agency concerned will be required to provide clear evidence of the changes made. This process is important to ensure that the change recommended by reviews is leading to improved outcomes for children and young people in Kent.

Complete and publish two remaining Serious Case Reviews, one with another LSCB.

Consider the new guidelines for Serious Case Reviews (update of Working Together to Safeguard Children Chapter 8) and revise the procedures and IMR Toolkit accordingly.

Continue to receive ongoing cases from all partner agencies and consider concerns and issues that may lead to decision to conduct reviews.

Continue to link with the other sub-groups of the KSCB to ensure communication is maintained and action agreed from reviews.

Draw up more formal process in Kent for disseminating 'lessons learnt' to staff across the Children's Workforce.

Multi-agency training and workforce development

Desired outcome: Ensuring that all staff serving children in public, private, voluntary and community sectors are sufficiently trained in safeguarding awareness to play their part in protecting children from the risk of significant harm.

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

The assertion that 'safeguarding the children of Kent is everybody's business' must be supported by training. Staff within agencies and organisations need the opportunity to consider what this means for them, so that they can recognise when and how to intervene whatever their role in relation to children and young people.

Throughout 2009/2010 the multi-agency safeguarding children learning and development programme has continued to be regularly delivered to ensure courses are available for this to happen. The programme covers a wide range of subjects including Raising Awareness , Keeping the Child in Focus, Advanced Course in Safeguarding Disabled Children, Supervision and Management of Complex Cases, Protection as a Need in Neglect and Emotional Abuse, Essential Children and Family Law for Non Social Workers, Lessons Learnt from Baby P; Risk: Analysis and Decision Making, Effects of Domestic Abuse on Children and Young People, Child Death Review Process and Understanding Fabricated and Induced Illness to name a few.

Since 2006 there has been a steady increase in the amount of individual training courses Kent Safeguarding Children Board (KSCB) has commissioned for the workforce within Kent. Since 2006 the amount of individual training courses that KSCB has facilitated has increased by 245%, from running 11 courses during 2006-2007 to 38 different courses during 2009-2010. During 2006-2007 the courses were only scheduled 47 times during the year, whereas during 2009-2010 the courses ran 95 times in different areas of Kent to cater for the varying needs of the workforce. Since 2008, there has been a steady and significant increase in the various training courses offered and the amount of times scheduled throughout the training year.

All available courses fall into one of three levels of training: introductory, intermediate and advanced. In total there were 95 courses delivered (an improvement upon the 41 in 2007/08) providing a possible 1,926 training places. Attendance by Communities, Kent Police, CAFCASS, Independent Fostering Agencies, Kent Community Housing Trust, the Prison Service and Probation as well as independent charities have all increased.

Additionally, bespoke training has been provided to Kent Adult Social Services on six occasions as well as specific training to local children's home and the University of Creative Arts.

During 2009-2010 five courses were cancelled due to lack of numbers. The courses this affected included Raising Awareness, Participating in Child Protection conferences and

Domestic Violence in the Workplace. Four courses were cancelled when trainers were unable to deliver planned training as planned. Where it has been possible other dates have been arranged with the trainer during the calendar year or moved over to 2010-2011.

In addition, the Education Safeguarding Unit provided 11,621 staff employed in education and early years settings with child protection training during the last academic year, including 440 Designated Staff in schools. Nearly 200 whole staff group sessions were delivered, including independent schools. Designated staff in early years settings were provided with 13 training days attended by 466 Managers. Additional sessions were provided for LA advisors, staff in settings, School Governors, Childminders, residential establishments, children's centres and Connexions.

The Kent Safeguarding Children Board has continued to work on developing the 'KSCB Training College'. This year we have trained 14 trainers to be part of the multi-agency college.

In addition we have applied for grant funding from Christchurch University to develop a package of support for KSCB trainers to enhance the quality, consistency and currency of safeguarding training. This will include setting up support meetings every 2-3 months run jointly by academic staff from the university and members of the KSCB Learning and Development Group, using an online group networking tool, annual refresher training days to provide policy, practice and training updates, and a mentoring scheme. The next stage is to develop and evaluate a course to train people to deliver multi-agency child protection awareness training. The project will have the potential to lead to further collaboration with the University and partner agencies.

The project has the potential for significant benefits to a wide range of agencies, professionals and children and families throughout Kent. The partnership between the university and KSCB will be innovative and allow for the sharing of expertise and knowledge to ensure a high quality of child protection training through the development and support of those delivering the training.

What difference did we make?

Multi-agency training is monitored through feedback forms after each event including an assessment of any changes needed to the materials and reflective feedback on the performance of facilitators/trainers.

A post course evaluation form is sent to participants three months after the course to randomly selected participants to ascertain how the training has impacted upon their practice and their organisation. This form provides the opportunity to collect data, which could inform future training and assist in evaluating whether the course was felt to have made a difference back in the workplace. The majority of the evaluation forms have revealed that the participants felt they had benefitted from change in knowledge, attitudes, skills and self-confidence attributable to the effects of the courses. As well as giving them confidence to handle the different issues which arise in their jobs and to communicate more effectively and to appreciate issues from a wider perspective.

Positive outcomes were consistently identified and these were irrespective of participants' gender, age, ethnicity, service experience or whether their attendance had been mandatory. The improvements identified were significant; meaning substantial, observable change in knowledge, attitudes, skills and self-confidence attributable to the effects of the courses.

Interagency training makes a substantial contribution to learning the skills and knowledge of the "Common Core" and therefore to the training of the children's workforce in general.

The Learning and Development sub-group is a good example of effective partnership working, with members believing that their agency's and the partnership's goals with respect to interagency training were interdependent and mutually beneficial.

Overall, the multi agency training provision is flourishing and offers a valuable source of support and development to the children's workforce in Kent and is considered good value for money.

What will we do next?

- The successes of the multi-agency training programme are set to continue into 2010/2011 as a number of new developments have been added to the training schedule – for example, e-learning.

- E-learning, will now be accessible via the KSCB website, and will be offered as part of the multi-agency safeguarding children training provision.

- Identify further members to support the KSCB training college.

- Undertake a Training Needs Analysis to inform the Learning and Development Strategy.

Challenges

Several agencies have commented that their resources are stretched and training is not viewed as a priority in the operational day to day duties and core business needs.

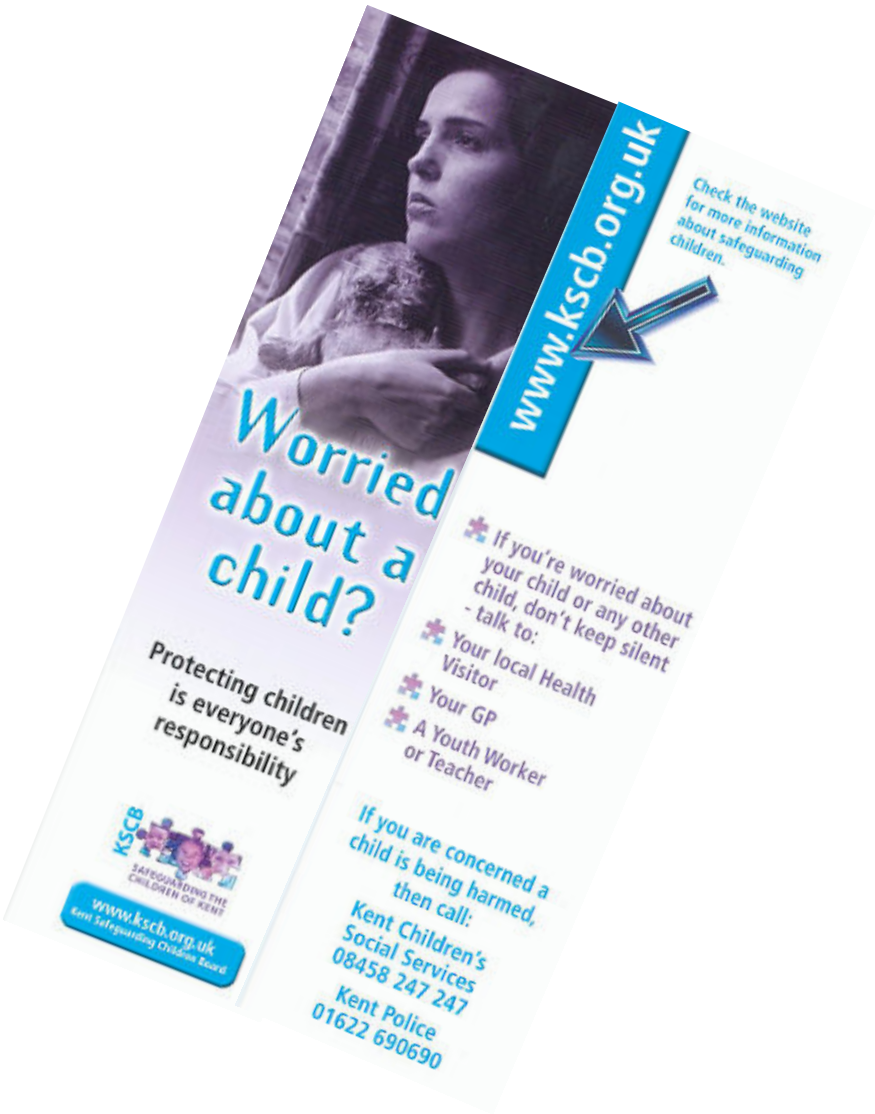
Communication and Engagement

Desired outcomes: KSCB has a high profile across all partner agency's staff and the Public

Awareness raising is an important element of the work of the KSCB. During the year a number of initiatives have been undertaken to improve knowledge and awareness and promote the safeguarding agenda.

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

The website content has been continuously updated and new information posted on a regular basis. Many encouraging comments have been made about the user-friendliness, accessibility of and wide range of information provided on the website by both professionals (both within and outside of Kent) and from members of public who have accessed the site.



The website has allowed us to communicate directly with parents, children and young people and front line professionals and it is receiving on average over 2500 hits a month. The content on the website has been reviewed and updated to reflect the ever changing context of safeguarding and child protection. Work will begin in 2010 to generate more child focussed content. This will ensure that it is accessible and relevant to children and young people.

During the last year the KSCB has commissioned the production of various merchandise, which has been distributed widely throughout the County to raise awareness about the website and the message that 'safeguarding children and young people is EVERYONE'S responsibility'. Safeguarding leaflets have been developed and updated, as has the Safer Parenting Handbook.

The various awareness raising initiatives during the year 2008/09 have included:

- Safer Parenting Handbooks updated and distributed to agencies and in public areas.
- Safeguarding pens, which have the KSCB website address - www.kscb.org.uk - on it (April 2009).

- Colourful laptop shaped bookmarks regarding safer practice on the web as the website address (as above).

- Colourful mobile phone shaped bookmarks that have the message 'U R being bullied' with the key message in text speak.

- Why is 28 important? postcards (Private Fostering).

- Child Death Overview Panel leaflets.

- The bookmark **'***Safeguarding Children is Everybody's Business'* was distributed via Kent libraries; the Kent Show and through a number of shopping centres throughout the County.

The KSCB ran four Road Shows, in Maidstone, Tunbridge Wells, Ashford and Broadstairs shopping centres to raise awareness on five different safeguarding issues:

1. Worried about a child
2. Bullying
3. Cyber-Bullying
4. Private Fostering
5. Internet Safety

These awareness campaigns included the production of 5 adverts on the areas listed above; three 60 second adverts (Worried about a Child, Private Fostering and Internet Safety) and two 30 second adverts (Bullying and Cyber bullying) to be played on a loop on 17ft screens at the shopping centres.

By placing these adverts in the various shopping centres around Kent, KSCB was able to target a wide audience in Kent. Whilst these adverts were being played on a continuous loop, KSCB staff members approached the public and asked them to complete a questionnaire on the 5 different child protection issues.

The aim of the Road Show was to engage not only adult members of the public but also children and young people to discover the general opinion held by the public concerning child protection issues.

Adults were asked questions on the following topics:

1. Internet Use
2. Private Fostering
3. If Concerned About a Child

Children and Young People were asked questions on the following topics:

1. Internet Use
2. If Concerned About a Friend

Adults seemed to believe the majority of their children were accessing the internet for gaming sites. However in actual fact the majority of children and young people stated they mainly accessed the internet for instant messaging and social networking. These results reveal that although adults are aware of the amount of time their children are spending on the internet they do not realise what sites they are accessing.

Based on the amount of children/young people that answered the questionnaire, 78% of young people who had engaged in Social networking had not proceeded to arrange face to face meetings. The results did reveal that the majority of young people did take someone with them, 87% taking a friend. However 24% of those who did agree to meet someone in the real world who they initially met online did not take anyone with them.

From the statistics, 85% of those adults who had received lessons on internet safety believed they were useful. It appeared that 59% of those adults who had not received any lessons would be interested in attending free lessons. The questionnaire showed that 56% would prefer for these lessons to be held at the child's school, with 23% answering their local community centre, 9% at the local library, 4% at the local church/faith group centre, 4% at home and 4% answering anywhere local.

The main issue that was revealed from the questions on private fostering was that the majority of adults, 77%, were not aware that if you are looking after someone else's child for 28 days or more you could be privately fostering.

Copies of the five films have been put onto DVDs which have been circulated to all Board partner agencies, to deliver the message in public arenas and relevant events. They have also been placed on U-Tube and Kent TV.

The Road Shows were also used as an opportunity to find out from the public what knowledge they already had and whether they knew what to do if they were concerned about a child and their knowledge about private fostering. With support from Subgroup members and their colleagues, the KSCB received 2129 responses from adults which was much higher than anticipated. 1465 questionnaires were completed by children and young people.

Only 2% of respondents indicated that they either did not know who to raise their concerns with, or that they would not get involved. Of the remainder, just under 30% said they would contact "Social Services". The rest identified a range of professionals and people with specific roles in the community that they felt they could consult. Many young people said they would raise their concerns with a parent, teacher or Connexions worker.

Young people were asked about whom they would go to if they had concern about a friend regarding abuse and their use of the internet. 1465 questionnaires were completed. Young people stated that if they had a concern about a friend they would report this to a family member and then to the Police.

In November 2009, a panel of children and young people were engaged in the recruitment and appointment of the new KSCB Independent chair. The appointment made was the children and young people panel's first choice.

What difference did we make?

This feedback indicates that a range of professionals and people are perceived as a useful resource to the public and consequently reinforces our objective to engage a wider range of professionals and community services in our training and multi-agency events

What will we do next?

As part of the work plan for the Board in 2010/2011, a feedback process will be developed to provide information from children and young people and their families about

how effective they feel the Board in achieving it's objectives to engage with them and raising it's profile in Kent.

Children and Young People have a Safe Environment to Grow Up In - Desired outcomes: Children in Kent are resilient, have positive self esteem and know what to do if they feel unsafe

Bullying

Desired Outcome: That children and young people feel safe from bullying and discrimination – with the intended outcome that children and young people report that they feel safer and incidents of bullying and discrimination are reduced.

The KSCB Anti-bullying Policy was approved in June 2009. This was developed following widespread consultation with the full range of partners including schools, parents and children and young people. This key document serves to strengthen the ongoing work in the County to ensure children and young people feel safe, and are able to enjoy and achieve throughout their childhood.

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

Parental and school support has been offered through a booklet "Why me? A parent's guide to helping your child deal with bullying" produced by the LA. 28,000 copies have been distributed to schools and the Children's Information Service. In addition a questionnaire for parents and carers has been made available.

There has been positive engagement by key partners and services to audit practice and plan action.

There has been an increased interest in the anti-bullying accreditation scheme and training on anti-bullying. Around 120 schools have successfully achieved accreditation and another 64 schools are going through the accreditation. In those schools that have taken part a reduction in bullying behaviour is evidenced and most pupils report that their school is good at dealing with bullying.

Young people have been involved on an ongoing basis with ensuring that any form of bullying is challenged and addressed. There has been positive feedback from schools on the use of restorative approaches to resolve conflict, including reductions in the number of days lost to exclusion and for incidents involving the wider family to be resolved.

The local authority is working with transport providers, as part of a pilot with a group of schools in Thanet, to strengthen work on 'safer travel'.

What difference did it make?

The most comprehensive data set on bullying available is collected on a regular basis through the on-line anti-bullying pupil survey[1].

The 8,475 responses to the 'Online Survey' in 2009 showed that the majority of children surveyed felt safe in their schools and when going to and from school. The same survey found that 47% of children experienced some form of bullying. In line with the national picture cyber-bullying had increased by 2% since 2007.

- A local survey of schools found that a minority (approximately 5%) of children were often or sometimes physically bullied and 8% were often or sometimes verbally bullied.
- Young people have stated they feel that bullying is recognised as an issue and feel supported in trying to address these issues in their schools and local communities.
- We have been successful in raising awareness that the issue of anti-bullying does not just manifest itself in schools but that is also evident on school transport and in communities. This has had an impact in that it has been raised as an important issue in relation to school transport and there have been meetings to look at how those concerns raised by young people and through feedback from the transport questionnaire, can be addressed.
- The anti-bullying accreditation scheme has been in place in Kent for 3 years. A reduction in bullying behaviour is evidenced and most pupils report that their school is good at dealing with bullying.

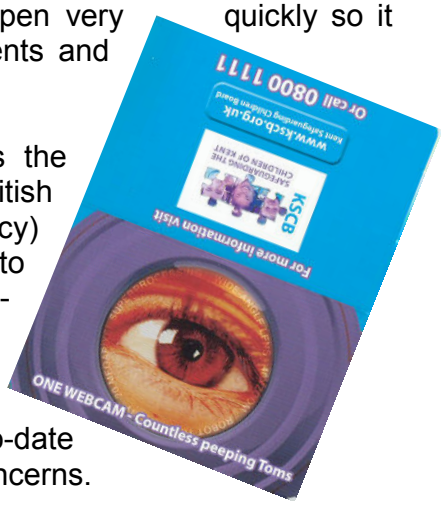
What will we do next?

KCC's Anti-bullying Strategy is coming to an end in 2010 and a new strategy will be developed. The forthcoming anti-bullying strategy will focus on school and educational settings, bullying outside of school and parental support. This will ensure that a framework is in place to direct anti-bullying work that reflects local and national policy.

[1] 6,017 pupils took part in 2006 and 8,475 pupils took part in 2009.

E-Safety

E-Safety is a major area of work for KSCB. There have also been clear recommendations from the Government and Becta that the LSCB has a subgroup due to the dynamic nature of the subject matter. Changes happen very quickly so it is essential that KSCB remain abreast of new developments and respond quickly with consistent advice across the County.



The KSCB Development Officer has been appointed as the LSCB E-Safety Champion for Kent in line with Becta (British Educational Communications and Technology Agency) National Guidance and best practice. His role is to compliment the work of the Kent County Council, Schools E-safety Officer, who provides support and advice to schools to ensure that awareness about e-safety is raised and that children and young people, parents and carers, and child care professionals, understand the issues and have up-to-date information about keeping safe on-line and how to report concerns.

Information about e-safety is available on the KSCB website and is updated regularly. The web page provides links to other useful sites for additional advice and information e.g. the Child Exploitation Online Protection (CEOP's) website. DCSF Thinkuknow; and The Internet and Children – What's the Problem?

- Training for foster carers - approx 120 attended
- 220 parents/carers attended events in schools
- e-Safety presence at Kent County Show over all 3 days
- Provided updated information about e-Safety for parents/carers online
- Distributed over 1,000 leaflets to parents/carers

Kent has number of CEOP trained Ambassadors who are able to train others and raise awareness about e-safety issues. The KSCB E-Safety Strategy sets out the plan for how training will be cascaded across the County, utilising an increased number of trained ambassadors.

Developing an e-Safety Strategy was identified as an area of priority for the E-safety subgroup using the toolkit by Becta. The e-Safety Strategy was circulated for consultation over a 2 month period and was approved by the KSCB in April 2009. An e-Safety Policy was developed alongside the strategy, for schools. This has been used as a template by a number of LSCBs nationally.

The "Safer Practise with New Technologies" document has been developed by the E-safety subgroup aimed at the Kent workforce whatever their setting.

This document discusses appropriate and safer behaviours for adults working in paid or unpaid capacities, in the context of all agencies.

This document suggests a set of real situations to enable adults to develop greater awareness of the dangers and to consider consequences of behaviour earlier in a developing situation. It is also hoped that it will reduce the number of

allegations made against staff regarding inappropriate use of digital equipment in the workplace.

Both the Kent Safeguarding Children Board Manager and the CFE e-Safety Officer have presented at conferences representing Kent Safeguarding Children. The Board Manager is also a member of the National BECTA LSCB e-Safety Expert Reference Group.

What difference did it make?

E-Safety is now considered by staff as a safeguarding and not as an IT issue.

Children, young people and their families are increasingly well informed of risks and how to deal with them.

The programme of work outlined above has been well received by national and regional bodies.

This work will be continued over the coming months as specified but new areas of concern will inevitably arise throughout the foreseeable future.

A major challenge will always be to bridge the knowledge gap between that of carers and professionals with that of children and young people.

What will we do next?

Develop packages for staff to use to support children and young people and parents/carers.

Fire Safety

Desired outcome: Children are protected from accidental injury and death – with the intended outcome that fewer children are involved in fire related incidents and other accidents/incidents at home and play.

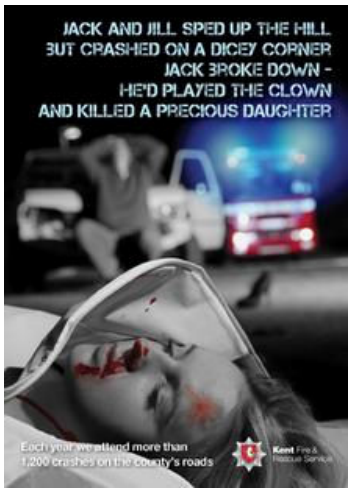
What did we do? How well did we do it?

Kent Fire and Rescue Service (KFRS) provide a broad spectrum of community safety activities which range from schools education to the reduction of deliberate fires. These activities are underpinned by the KFRS Community Safety Strategy on specific areas of community safety activity.

The KFRS have participated in the School Education programme which has ensured 72,000 children within Kent have been contacted and informed of fire safety procedures. In addition, KFRS have:

- Educated 18,000 young people with the 'Young driver road safety education programme'
- Visited 2,601 households for Home Safety Visits where there are under 5s
- 302 referrals for 'Fire Setting' have all been seen and advised
- 302 young people have attended and participated in the 'Youth Engagement' course
- 423 KFRS staff have received basic safeguarding awareness training

There has been positive feedback from both staff and students concerning the Schools Education Programmes and the Out of School road safety activity. This positivism has been reinforced through the KFRS facebook site which allows young people to make contact with our service and encourages young people to make comments about KFRS.



What difference did it make?

In the last three years there has been a 40% reduction in the number of people killed or seriously injured on the roads in Kent. Furthermore, there has been a 14% reduction in the number of fires in Kent from last year.

The KFRS make on average two referrals a month to Children's Specialist Services regarding child protection concerns. This is usually as a result of where neglect in the home has placed children at risk from a fire.

What will we do next?

KFRS intend to focus home safety activity at high risk households and have set a target of visiting 16,000 homes per year. The KFRS Community Safety Teams will be able to deliver the messages effectively and therefore, continue to reduce the number of people killed or injured in their home by fire.

It is KFRS's aim and objective to ensure all of the child protection champions receive NSPCC designated officer training thus enabling the child protection champions' role to be enhanced trained in-house experts.

KFRS take the role of safeguarding seriously and will continue to ensure all staff are trained in basic safeguarding awareness, This will ensure that all staff will have an understanding of their role with safeguarding children and therefore will be informed of what to do if there is a concern.

Road Safety

Desired Outcome: Children are protected from accidental injury and death – with the intended outcome that fewer children are involved in road traffic accidents and other accidents at home, play and employment.

Improving road safety is an essential part of the overall Kent transport strategy with the aim of meeting the national casualty reduction targets. Despite a rise in 2007 of numbers killed or seriously injured, the council is on target to meet the 40% reduction required by 2010. Work is targeted on key trunk roads and effective traffic calming measures in urban areas that have reduced child injury and death.

Missing Children

Desired Outcome: Services are effective in establishing the identity and whereabouts of all children and young people aged 0-16

Kent County Council leads the 'Missing Children Work group' which ensures close partnership working between schools, Kent Police and a wide range of children's services.

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

The government has introduced a new national indicator (NI 71), which asks local areas to assess whether appropriate systems, procedures and protocols are in place to identify the levels of running, and whether responses and services are appropriate to the needs of young people who run away. As part of the Boards performance monitoring arrangements, the chair of KSCB is required to agree the self assessment score provided by the local authority before submission to the DCSF.

The analysis of data relating to runaway and missing children now forms part of the CFE Performance Management Report. Data from this report will be used to report on a regular basis to the KSCB. A baseline report has been presented to the KSCB outlining the current position and future work to be undertaken.

Joint procedures and protocols for responding to all runaway and missing children have been developed by the Board. These include an agreed tool for the assessment of risk for differing children and circumstances. Appropriate referral and intervention strategies are included. Final consultation has been concluded in respect of the completion of Returner Interviews for children not known to Children's Social Services or meeting the criteria for statutory social work intervention. The implications of the Southwark Judgement relating to homeless 16 and 17 yr olds has also been integrated with these protocols.

Kent Police have purchased an information system which will allow information concerning all reports of runaway and missing children to be made available to the local authority for analysis.

What next?
A coordinated and outreach response to Missing Children.

Private Fostering

Desired Outcome: Private fostering arrangements are strengthened through coordination and effective implementation of statutory guidance

Private fostering occurs when a child under the age of 16yrs (or 18 yrs if a child is disabled) is cared for on a full-time basis, and provided with accommodation for more than 28 days, by an adult who is not a direct blood relative. It does not include children looked after by the local authority. It is usually arranged by the birth parent and is a private arrangement.

Examples of private fostering include:

- Child living with a family friend following family breakdown, divorce etc
- Child whose parents study or work arrangements mean they are unable to care for the child
- Teenagers staying with a friend or boyfriend/ girlfriend's family
- Asylum and refugee children
- Children brought to England by a friend of the family for the purposes of education

Anyone who is caring for a child under such an arrangements has to notify Kent County Council and that child's needs must be assessed.

If such an arrangement comes to the notice of a professional it is the responsibility of that professional to inform the carer of the need to notify the local authority and if necessary follow this up by informing Children's Social Ca

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

The KSCB has received several briefings on the development work regarding Private Fostering arrangements. This is a key area of safeguarding performance and one that the KSCB will continue to monitor closely. The Children's Social Services Private Fostering team has implemented a range of initiatives to highlight the notification arrangements to staff within Children's Services, the Council and partner agencies and the public including:

In 2008-09, raising awareness of the notification requirements was promoted in the following ways:

- Large posters placed in buildings throughout the County
- Parents and carers poster widely circulated
- Refreshed and updated dedicated page on the Council and Kent Safeguarding Children Board websites
- Publicity material has been redesigned and distributed through key points of contact such as schools, libraries one-stop shops, council offices and relevant voluntary/community groups.
- Briefing sessions to partner agencies, third sector, independent schools, children centres.
- Three designated Social Worker specifically for Private Fostering in post to undertake all assessments and subsequent welfare visits.
- Professionals and members of the public being able to access information about Private Fostering from the KCC website.
- The Fostering Team provided training to a range of professionals so that they have a clear and defined understanding of the Private Fostering Regulations and their roles and responsibilities to ensure that the Local Authority becomes aware of any Private Fostering arrangements within the area.
- Awareness raising presentations at team meetings, training events, professional forums, school events etc for professionals working with children on a regular basis.
- Guidance has been developed for services to help identify children in Private Fostering arrangements.

The KSCB has supported the awareness raising campaign that Kent County Council has in place through explaining requirements on its website and signposting potential enquiries through links on its web pages.

Throughout 2009-2010, there were a total of 69 notifications of new private fostering arrangements made during the year, of which 63 led to an assessment under the private fostering regulations. On the 31st March 2009, Kent Children, Families and Education Directorate had a total of 43 open private fostering arrangements, demonstrating an increase of 5 across the County in comparison to the previous year on 31st March 2008.

What difference did we make?

In addition to the national campaign in January 2009, private fostering was included in the series of short video scenarios commissioned and funded by KSCB and shown widely across the County in local shopping centres. The video showings were accompanied by the distribution of information leaflets about private fostering and passers-by were interviewed about their knowledge and understanding of such arrangements. The main issue that was revealed from the questions on private fostering was that the majority of adults questioned (77% of a sample of 618) were not aware that if they were looking after someone elses' child for 28 days or more this was private fostering.

In January 2009, Children's Social services contacted all independent boarding schools in the Kent by letter to raise their awareness of the nature of private fostering. In addition, an offer was extended to all the schools to meet with their governing body or senior management team to offer further advice and support in this matter. Only 2 of the 42 schools responded, both replying that they knew of no such arrangements in their schools. No independent school has requested further information about private fostering.

Private Fostering Arrangements in Kent were inspected by Ofsted in July 2008 and rated as 'good'. The Inspector assessed the service provision as strong across all aspects of the service. The inspection report for Kent identified only one recommendation in respect of improving the quality and standards of care. This being that accurate records are written to demonstrate the nature and type of information given to parents, carers and young people. This recommendation has now been implemented across the County.

Overall 2009-10 has been a good year for private fostering in Kent.

Domestic abuse

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

The Kent and Medway Domestic Violence Strategy Group was formed for the purpose of researching the multi-agency response to domestic abuse and to make recommendations for the way forward. It works towards ensuring a more co-ordinated approach is adopted by all, with a particular focus on the identification of what is both best practice and best value.

The KMDVSG 2007 – 2010 Strategy and it's associated Delivery Plan sets out a vision for effectively addressing the issue of domestic violence in the county and details the steps that will be taken to achieve this within individual agencies as well as on a multi-agency basis, with particular emphasis on the continuing need to strengthen services that assist survivors of domestic abuse throughout the county and the development of preventative initiatives.

The strategy identifies and prioritises current gaps in service delivery as well as aiming to promote and embed current effective initiatives that have already been put in place. The strategy aims to encourage all agencies and partnerships to work towards providing the highest standards in the provision of services relating to domestic abuse.

Kent has introduced Multi Agency Risk Assessment Conferences (MARAC) to discuss cases of domestic abuse where risk is escalating. These conferences identify ways to intervene and in particular safeguard children and young people who may be caught up in violent relationships.

In partnership with the Kent and Medway Safeguarding Adult Protection Committee, and the Kent and Medway Domestic Violence Strategy Group we have produced a training resource to address consistency issues and quality check the training that is delivered on domestic abuse across Kent. The training pack includes several chapters: Overview and Dynamics of DV, Children and Young People and DV, Perpetrators of DV, DV and Substance Misuse, Specialised Needs and Issues, Multi-agency Roles, Domestic Violence in the Workplace, What Health Professionals Need to Know about DV, Domestic Violence and the role of Education and Domestic Violence and Housing.

Kent and Medway Domestic Abuse Good Practice Protocols: Working with Young People in Schools and Community are aimed at agencies (voluntary and/or statutory) who are, or plan to be, working in school settings delivering lessons on domestic abuse, to promote consistency and good practice in this work across Kent and Medway. The Protocols cover a range of topics including: Definitions, Relevant Networks and Partnerships, Risk Assessment, Evaluation Measurement, Recommended Resources, Sample Lesson Plans.

What difference did we make?

The KMDVSG Annual Conference was held on the 18th November 2009 called Domestic Abuse and Substance Misuse: Making the Links. 150 people attended and generally feedback was positive and the scores came back higher than last years.

Penny Hennessey, Manager of the Kent Perpetrator Programme has won a National Award for her work on the Community Perpetrator Programme. Penny will be providing training for Kent Safeguarding Children Board over the next year.

New Independent Sexual Violence Advisor (ISVA) Service for North-West Kent. Family Matters applied to the Home Office for ISVA funding & in August and were successful in

their bid, to deliver an ISVA service across North-West Kent from August 2009 until April 2010.

Agencies contribute to reducing the risk by providing reports and participating in Multi Agency Risk Assessment Conference (MARAC). Total number of cases discussed at MARAC last year was 486. These relate to those victims assessed, by police, as at 'very high' risk of homicide.

Kent Police along with Children's Social Care operate a screening process of incidents involving all children; the purpose of which is to reduce risks to children.

Throughout Kent there is a range of innovative services designed to meet the needs of families. This includes working in partnership with housing services to provide individual refuge properties; with Kent Police who have co-located staff and ensure that victims are referred for support; information sharing has been agreed across all agencies; high risk cases are taken through the Multi-Agency Risk Assessment Conference and a fast tracking system is in place to get cases to the Magistrates Court. A range of support services is offered to families including housing, legal, personal safety, welfare benefits and child protection advice. There is a support service for children and young people. The number of repeat victims has fallen from 19% in 2005 to 14% in 2007/08.

What will we do next?

The KMDVSG have commissioned a Childrens Research Project to establish what needs to be done to better protect children affected by Domestic Violence. The report was started in mid October, and is due to report in April. The report, once finished, will provide an opportunity to make more changes to improve the support given to children and will be considered in detail by the Board.

Review the effectiveness of DV partnership working and services.

Papers to the Board during 2010 /11

- Child Death Overview Panel Procedures April 09
- Unexpected Death of A child Procedures April 09
- The Death of Baby P: Implications for Kent Safeguarding Children Board and partner agencies (April 09)
- Anti-bullying Policy (June 09)
- CAA Report (June 2009)
- Education Safeguards Annual Report (June 2009)
- Neonatal Mortality Annual Report (June 09)
- Child Deaths Annual Report 2008-09 (Sept 09)
- Private Fostering Annual Report (Sept 09)
- Statutory guidance on children who run away and go missing from home or care (Sept 09)
- Report on the Evaluation of Kent Serious Case Reviews carried out by the University of Edinburgh (Sept 09)
- CSS Activity Report (Sept 09)
- Bexley Serious Case Review Child A (Sept 09)
- Workshop on the strategic direction & operating framework of KSCB (Nov 09)
- Local Child Protection Co-ordinating Committees Annual Reports (Nov 09)
- KCC Safeguarding Review (Nov 09)
- Section 11 Audit Report (Nov 09)
- Accommodation for Vulnerable Children & Families (Nov 09)
- Serious Case Reviews 'Alfie' & 'Billy' (Nov 09)
- Ofsted SCR Evaluation Letter of Caroline (Nov 09)
- Serious Case Review Action Plans Updates (Nov 09)
- An Overview of Challenges for and Expectations of LSCB's (Feb 10)
- Strategic direction and operating framework of the KSCB (Nov 09)
- Kent Children Trust Review (Nov 09)
- The Health Economy in Kent (Nov 09)
- CAFCASS Inspection on Safeguarding (Nov 09)

Activity Report & Performance Indicators 2009/10

Safeguarding children – the national context

There are 11 million children in England. Of these:-

- 200,000 children live in households where there is a known high risk case of domestic abuse and violence
- 235,000 are 'children in need' and in receipt of support from a local authority
- 60,000 are looked after by a local authority
- 37,000 are the subject of a care order
- 29,000 are the subject of a Child Protection Plan
- 1,300 are privately fostered
- 300 are in secure children's homes

The Protection of Children in England: A Progress Report, Lord Laming

Safeguarding children – the local context

Geographically, Kent is one of the largest local authorities in the United Kingdom. The total population is currently estimated to be 1.3 million

The County displays remarkable diversity and contrasts, including ethnic and linguistic diversity and wide socio-economic disparities. Black and minority ethnic people make up 3.5% of Kent's population. 77% of Kent people live in urban areas and towns and 23% in rural areas. Although the County is affluent with income levels and property values which are significantly higher than national averages, this disguises the fact that there are pockets of high deprivation. Kent is below the regional average for skills - 28% of the working population have no qualifications. The average household income in Kent is lower than in the rest of the south east.

Overall, the local economy is thriving, but there are areas where employment is below the national average. An estimated number of at least 43,000 people do paid or voluntary work with children and young people across Kent

There are an estimated 346,810 children and young people under the age of 19 in Kent; making up 24% of the population.

Within the local arrangements for the National Performance Indicators across the Every Child Matters outcomes, the KSCB monitors the following staying safe performance indicators:-

Performance Indicators

This section of the annual report summarises Safeguarding activity in Kent between 1st April 2009 and 31st March 2010.

Data is for 2009/10 unless stated

NI 47	People killed or seriously injured in road traffic accidents *(includes young people aged 16-18, positive figure shows a reduction compared to previous period).* (2007-09)	5.6
NI 48	Children killed or seriously injured in road traffic accidents *(0-15 yr olds, positive figure shows a reduction compared to previous period)* (2007-09)	9.8
NI 59	Initial assessments for children's social care carried out within 7 working days of referral.	69.0%
NI 60	Core assessments for children's social care that were carried out within 35 working days of their commencement.	80.4%
NI 61	Timeliness of placements of looked after children for adoption (following an agency decision that the child should be placed for adoption).	76.8%
NI 62	Stability of placements for looked after children: number of moves (percentage of children looked after with 3 or more placements during the year).	8.2%
NI 63	Stability of care placements of looked after children: length of placement	72.4%
NI 64	Child Protection Plans lasting two years or more.	12.4%
NI 65	Children becoming subject of a child protection plan for a second or subsequent time	16.0%
NI 66	Looked after children cases which were reviewed within required timescales	94.6%
NI 67	Child Protection cases which were reviewed within required timescales.	97.9%
NI 68	Referrals to children's social care going onto an initial assessment.	46.4%
NI 69	Children who have experienced bullying. (2008/09)	51.7%

NI 70	Hospital admissions caused by unintentional and deliberate injuries to children and young people *(Rate per 10,000).* (2008/09)	127.1
NI 71	Children who have run away from home/care overnight *(score out of 15, higher is better).* (2008/09)	5

Financial Report

Financial Statement for 2009/10 outturn and 2010/11 budget

Income

Table 1 sets out the income for 2008, 2009, and projected income for 2010.

KSCB is funded largely from agency contributions. These contributions were established during the days of the Kent Child Protection Committee. They have not been reviewed by KSCB and the only change was in 2008 when the Youth Offending Service (YOS) agreed to provide a contribution. There has been no annual uplift to contributions during the last four years.

In addition to agency contributions, the board receives a Child Death Overview Panel (CDOP) grant from the Department for Children, Schools and Families (DCSF). It has also attracted a small amount of income through its training functions.

The EKPCT figure for 2008/09 includes a one off payment for training contractors which has not been used and has been rolled over. It is ring fenced for EKPCT use and is £39,998.

Kent Safeguarding Children Board	**No.of FTE's**	**Projected Spend 2009/10**	**Actual Spend 2009/10**	**Projected Spend 2010/11 ***
Expenditure		**£**	**£**	**£**
KSCB Staffing	8.5	222,809	132,941	330,429
Independent Chair	1	4,875	4,192	19,500
Training programme (includes conferences, meetings, seminars & expenditure as a result of Phase 2)		47,566	59,933	76,634
Serious case reviews		50,237	46,807	85,000
Child Death Overview Panel – start up costs		58,969	54,655	
Child Death Overview Panel – running costs			Nil	25,000
Printing and publications (includes training materials, conference materials and leaflets, & reports commissioned externally)		52,659	74,795	58,412
New Safeguarding Policy & procedures Manual				35,000
IT and other office equipment		29,035	24,094	8,000
Stationery		13,428	14,714	13,697
TOTAL		**479,578**	**483,827**	**651,672**

Kent Safeguarding Children Board	No.of FTE's	Projected Spend 2009/10	Actual Spend 2009/10	Projected Spend 2010/11 *
Income		**£**	**£**	**£**
CFE		241,327	241,327	241,327
CDOP Grants		95,000	95,000	185,000
EKPCT		39,664	39,664	39,664
WKPCT		50,710	50,710	50,710
Kent Police Authority		56,484	56,484	56,484
Kent Probation Service		6,276	6,276	6,276
Connexions		10,000	10,000	10,000
CAFCASS		750	750	750
YOS		8,000	8,000	8,000
Additional training income		15,197	20,512	20,000
TOTAL		**515,408**	**528,723**	**618,211**

* Includes 2% uplift on 2009/10 variable expenditure item

** Includes one off payment of £39,998.99 for training for contractors (ring fenced monies.)

There is a development fund which currently stands at £467k. This fund will be used to help address the high level of child protection activity in the County and to improve quality assurance arrangements and drive forward the practice improvements which has been identified as being necessary. The budget for the KSCB will need to be remodelled in response to the reduction in public sector funding.

Strategic Aims and Specific Objectives

	Strategic Aims (2010/2013)	Specific Objectives (2010/2012)	Responsibility	Specific Objectives (2012 -
1	**To improve the safety and well-being of children by ensuring the effectiveness of the work of all partners in relation to safeguarding and promoting the welfare of children** • To promote and develop an outcomes-based accountability approach to safeguarding. • To have in place and deploy a robust framework for evaluating the quality and effectiveness of multi-agency and single-agency safeguarding arrangements and, in particular, the impact of these arrangements on outcomes for children and their families. • The operation of this framework impacts positively on the safety and well-being of children.	1. Partner agencies to develop and adopt an agreed quality assurance framework. 2. The particular elements within the framework will be developed year-on-year. In 2010 / 2012 Board partners will: i. Each identify two areas of activity / service where they will measure the outcomes in terms of the well-being of children and/or their families. ii. Introduce agreed and consistent arrangements to systematically collate the views of children and families, feedback from front-line staff and the views of their partner agencies. iii. Based on i. and ii. identify, celebrate and share models of positive practice. iv. Define the quantitative and qualitative information required for quality	**Independent Chair** **Individual Agencies (after OBA)** **Independent Chair** **Independent Chair** **Independent Chair**	1. To undertake a Deep-Dive Review of “Housing and Children’s Safeguarding”.

	Strategic Aims (2010/2013)	Specific Objectives (2010/2012)	Responsibility	Specific Objectives (2012 -
	• To ensure the confidence of the Kent Children's Trust and the public in the Safeguarding Board	assurance. 1. Members of the Board and key members of groups reporting to the Board to be trained in Outcomes-based accountability. 2. Strengthen arrangements for monitoring the impact of the implementation of messages from SCRs.	**Performance Monitoring Subgroup**	

	Strategic Aims (2010/2013)	Specific Objectives (2010/2012)	Responsibility	Specific Objectives (2012 -
2	**To ensure that KSCB has effective relationships with other strategic bodies, evidenced by a positive impact on outcomes for children.**	1. To develop a set of principles to govern the relationship between the KSCB and the Children's Trust Board. 2. To develop an effective relationship between the KSCB and the Kent & Medway Domestic Violence Strategy Group and the MAPPA Strategic Management Board. 3. To ensure that the KSCB contributes effectively to the development of the Children and Young People's Plan due by April 2011. 4. To build up a picture of "safeguarding need" to inform planning and quality assurance.	**KSCB Manager & KCT Partnership Manager** **Detective Superintendent PPU** **KSCB Manager (ask CTB to provide data on safeguarding need)**	

	Strategic Aims (2010/2013)	Specific Objectives (2010/2012)	Responsibility	Specific Objectives (2012 -
3	**To improve safety and well-being outcomes for children by making sure that local work is co-ordinated and avoids gaps and overlaps.** • The safeguarding practice, services and arrangements of partner agencies are well co-ordinated and operate an approach which takes into account the whole family (*Think Family*).	1. To review the effectiveness of partnership working, services and arrangements in respect of Domestic Violence and adult mental health. The methodology of the reviews will: • take account of the inter-relationship of domestic violence, adult mental ill health, learning disability and substance misuse. • include a locality perspective • include linkage with the Kent and Medway Domestic Violence Steering Group • provide the opportunity to implement the principles governing the relationship with the Children's Trust Board. 2. To ask the Children's Trust Board to report on the progress and impact (in terms of outcomes) of the implementation of the Common Assessment Framework in Kent.	**Detective Superintendent PPU** **(in connection with Head of Service, Community Safety** **Managing Director, CFE Directorate (in connection with Managing Director, Kent Adult Social Services) re investigating adult mental health.** **Managing Director, CFE Directorate & Director Specialist Children Social Services, CFE**	1. To review the effectiveness of partnership working, services and arrangements in respect of: • Substance misuse **and/or** • Parental learning disability **and/or** • Other areas of multi-agency activity which needs analysis (e.g. JSNA, needs analysis for the CYPP) identify as having a significant impact on the safety and well-being of children. 2. To strengthen co-operation with and the impact of the private and third sectors in respect of safeguarding.
4	**To improve outcomes for children by adopting – both for the Board itself and all partners - continuous learning**	1. To develop a new safeguarding learning and development strategy which will address (amongst other issues):	**Learning and Development subgroup**	1. To evaluate the effectiveness of the safeguarding learning and development strategy in terms of practice outcomes for

	Strategic Aims (2010/2013)	Specific Objectives (2010/2012)	Responsibility	Specific Objectives (2012 -
	and development. • Staff in partner agencies (including and KSC Board and Sub group members) are continuously learning and developing their skills and knowledge in respect of safeguarding work, at all levels and in all roles.	• The need to focus on *practical learning* e.g. dealing with manipulative parents • The need to strengthen *clarity of thinking* for professionals and managers • The range of potential *methodologies* e.g. learning sets. • Strengthening of *integrated working* • The potential contribution of *children and parents* to achieving learning outcomes • The potential contribution of *local higher education institutions*. • The need for learning and development initiatives to be evaluated in terms of their impact on practice and outcomes for children and their families. 2. All partners to have in place a "fit-for-purpose" supervision framework for their agency.	**Learning and Development Subgroup (to lead / co-ordinate – identify core principles)**	those trained, and the well-being outcomes for children and their families. 2. To evaluate the effectiveness of the supervision frameworks in terms of practice outcomes for those trained, and the well-being outcomes for children and their families.

	Strategic Aims (2010/2013)	Specific Objectives (2010/2012)	Responsibility	Specific Objectives (2012 -
5	**To ensure that KSCB membership, structures and business processes add measurable value to achieving positive outcomes for children.**	1. Identify any changes and developments necessary arising from Working Together 2010 and develop a prioritised implementation plan. 2. Review the membership and structure of Board in light of Working Together 2010 and the needs arising for from the aims and objectives in this business plan.	**KSCB Manager** **KSCB Manager / KSCB Independent Chair**	

Board Attendance Figures

The following attendance figures are based on the minutes and apologies received.

1) Members Attendance during April 2009 – March 2010

- 27 April 2009
- 29 June 2009
- 7 September 2009
- 23 November 2009
- 11 February 2010

Name	Title	Representing	Present	Apols	%
Bill Anderson/Helen Davies	Director of CSS	KCC	4	1	80
Sarah Andrews	Director of Nursing	ECKPCT	2	3	40
Kel Arthur	Safeguarding Manager	KCC	4	1	80
Gordon Bernard	Chief Executive	Connexions	3	2	60
Sue Bromley	Head of Safeguarding	KMPT	4	1	80
Aine Campbell	Head of Service	CAFCASS	5	0	100
Penny Davies	Manager	KSCB	5	0	100
Alan Dowie	Director	Probation	3	1	75
Trish Dabrowski	Strategic Lead of Children & Young People	SHA	0	1	0
Sarah Fletcher	Assistant Director	WKPCT	2	2	50
Janet Garnons - Williams	District Crown Prosecutor	CPS	0	5	0
Karen Goodman	Head of Operations, SUASC	KCC	4	1	80
Karen Graham	Head of Children's Services East Kent	KCC	4	1	80
Andrew Hickmott	Head of Children's Services West Kent	KCC	4	1	80
David Hughes	Chief Executive	Tonbridge & Malling BC	0	1	0
Julie Hunt	Director of Nursing and Quality	WKPCT	3	1	75
Jenny Kay	Director of Nursing	Dartford & Gravesham NHS	5	0	100
Elizabeth Kenyon	Named Doctor	CAMHS	0	5	0
Donna Marriott	Performance &	KCC	4	1	80

	Standards Officer				
Carol McKeough	Adult Protection Policy Manager	KCC	4	1	80
Jane Mitchell	Safeguarding Children & Adults Manager	SECAMB	3	2	60
Sally Moore	Deputy Director of Nursing, Quality & Midwifery	ECKPCT	4	1	80
Richard Murrells	Director, Children's Health	PCTs/KCC	1	4	20
Meradin Peachey	Kent Director of Public Health	KCC	4	1	80
Leyland Ridings	Deputy Cabinet Member	KCC	4	1	80
Lee Catling/Maria Shepherd	PPU	Police	5	0	100
Angela Slaven	Director of Youth & Community	KCC	5	0	100
Alistair Stewart	Chief Executive	Shepway DC	0	1	0
Kate Taylor	Manager, Women & Children	Medway NHS	2	3	40
Wendy Thorogood	Named nurse Consultant	WKPCT	2	0	100
Rosalind Turner	Managing Director	KCC	3	2	60
Charles Unter	Consultant Paediatrician	Maidstone & Tunbridge Wells NHS	5	0	100
Joanna Wainwright	Director of Commissioning	KCC	5	0	100
Kay Weiss	Head of Policy & Performance	KCC	5	0	100
Oena Windibank	KSCB Vice Chair / Operations Director	ECKPCT	5	0	100
Sheila Wheeler	Chief Executive	Tunbridge Wells BC	3	1	75
David Worlock	KSCB Independent Chair	KSCB	1	0	100
Cathy Yates/ Michelle Woodward (job share)	Head of Children's Services Mid Kent	KCC	3	2	60

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Written by Penny Davies, Kent Safeguarding Children Board Manager