

# Annual Report 2014/15



## Contents:

Foreword by Gill Rigg, Independent Chair

Role of the Board

- Board structure and membership
- KSCB links to other strategic Boards

2014 to 2015 – What we did

- KSCB Self-Assessment 2014
- Peer Review December 2014

Local Authority Designated Officer Report

Private Fostering Report

The State of Safeguarding of Children and Young People in Kent

Voice of Children and Young People

Reports from each KSCB Group

- The Business Group
- The Quality and Effectiveness Group
- Case Review Group
- Learning and Development Group
- Child Death Overview Panel
- Trafficking and Child Sexual Exploitation Group including the Missing Children Working Group)
- Education Safeguarding Group
- Health Safeguarding Group
- Policy and Procedure Group

KSCB Finance Report

What next - Strategic Priorities 2015-18

Conclusion

Appendices

- |            |                                                                                        |
|------------|----------------------------------------------------------------------------------------|
| Appendix A | KSCB Self-Assessment 2014                                                              |
| Appendix B | KSCB Peer Review Feedback                                                              |
| Appendix C | Key learning topics from the 2014-15 case reviews                                      |
| Appendix D | 'The sexual exploitation of children: It couldn't happen here, could it?' Key findings |
| Appendix E | KSCB Strategic Priorities 2015-18 - Business Plan                                      |

## Foreword from the Independent Chair, Gill Rigg

Welcome to the annual report of Kent Safeguarding Children Board (KSCB). The report is produced in accordance with the statutory guidance in Working Together 2015, and describes the key areas of work which the Board and its Groups undertook during the year 2014-5, some of the successes and also some of our ongoing challenges.

I took over as the Independent Chair of the Board in March 2014 and have been the Chair throughout the year, a role which I feel very privileged to have. I have been very much welcomed in Kent by all of the agencies and I have been very impressed by the strong commitment and hard work by staff at all levels of organisations, who continue to work to make Kent a safer place for our children and young people.

During the year, we restructured the way that the Board works, to make it more focused and business like. We established a Business group, which brings together the Groups chairs, who undertake so much of the work, to ensure there was a strong connection with all of the key themes. We re-established the Board's priorities, and continue to adapt and change these as necessary.

We held a very successful conference in November with over 300 delegates, and I was very pleased to be able to co-chair it with a young person, Sophie. Hearing the voice of young people was the key theme of the conference and was one of the one of the challenges in the year, and this continues. The feedback from the conference delegates was that the input of young people into the conference was much valued, and we will ensure that this is built into the 2015 conference.

We had two external challenges during the year. Kent was one of eight authorities chosen to take part in the Ofsted thematic review of Child Sexual Exploitation (CSE) in October 2014. Whilst there was no Kent specific report, the Inspectors did feedback that they thought that there was a growing and informed understanding and commitment to the work on CSE, but that the CSE strategy and action plan was under developed. There were examples of positive work, but also inconsistencies. As a result, a further action plan was developed, and the efforts of the Board have been redoubled in this area. We have also ensured that our response to children and young people who go missing was given a much higher priority.

Our second external challenge was inviting a team of peers to undertake a Peer Review of the work of the Board, and this took place in December. They felt that the Board restructuring was positive, and gave agencies confidence that it was truly multi-agency, that processes were in place to hold partners to account and there was a sense of purpose and stability. They concluded that there was good support from the Safeguarding Business Unit. However, they felt that the Board needed to connect more at a more local operational level, and that the voice of children and young people was not evident in the work on quality assurance.

All of the areas of development have been built into the 2015/8 business plan, and we continue to drive forward improvements in all our areas of activity. The Board has particularly welcomed the focussed activity on developing the Early Help offer.

I hope you find the report interesting and informative, and we would be pleased to hear from you if you have any thoughts, comments or questions on the report.



Gill Rigg

Independent Chair, KSCB



## **Kent Safeguarding Children Board (KSCB)**

### **Role of the Board:**

### **What is Kent Safeguarding Children Board and what does it do?**

KSCB is the partnership body responsible for coordinating and ensuring the effectiveness of Kent Services in protecting and promoting the welfare of children and young people.

The Board is made up of senior representatives from all the main agencies and organisations in Kent concerned with protecting children.

KSCB provides a vital link in the chain between various organisational activities, both statutory and voluntary, to protect children and young people in Kent. Our aim is to ensure that these activities work effectively in the provision of a joined up service.

KSCB is responsible for scrutinising and challenging the work of its partners to ensure that services provided to children and young people are effective and make a difference.

We are also responsible for raising awareness of child protection issues in Kent so that everybody in the community can play a role in making Kent a safer place for children and young people.

Our message is – **Protecting Children From Harm is Everyone's Business**

### **Board members and structure of KSCB**

Board Member Agencies 2014-15

CAFCASS

CXK

District Council representative

Health providers (nominated representatives from the Health Safeguarding Group)

Kent Specialist Children's Services

Kent Education and Young People Services

Kent Police

Kent Probation

Kent, Surrey and Sussex Community Rehabilitation Company

Nominated representatives of Kent Clinical Commissioning Groups

NHS England (Kent and Medway)

Public Health

Youth Offending Service

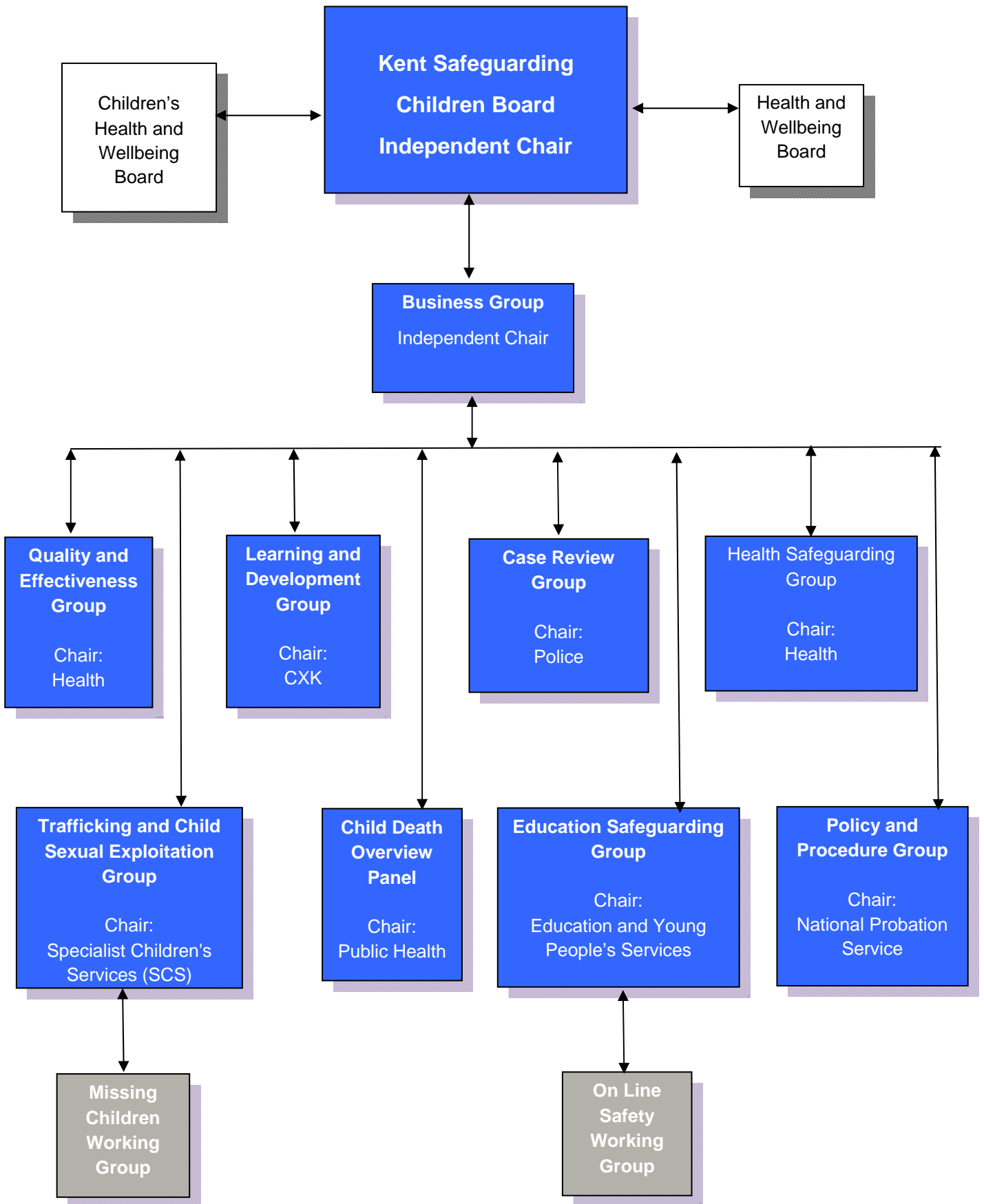
Adult Safeguarding Board

Adult Services representative

In addition, KSCB is supported by 2 Lay Members.

The Board's Constitution, including the Terms of Reference for each of the groups can be found on the KSCB website:

# Structure of Kent Safeguarding Children Board



## KSCB links to other Strategic Boards

A protocol has been formally agreed that sets out the working arrangements between the Kent Health and Wellbeing Board (HWB), Kent Children's Health and Wellbeing Board (CHWB) and Kent Safeguarding Children Board. This protocol can be found on the KSCB website.

[http://www.kscb.org.uk/data/assets/pdf\\_file/0010/46387/PROTOCOL-BETWEEN-HWB-CHWB-AND-KSCB-BOARDS-FINAL-APPROVED-VERSION-25-MARCH-2015.pdf](http://www.kscb.org.uk/data/assets/pdf_file/0010/46387/PROTOCOL-BETWEEN-HWB-CHWB-AND-KSCB-BOARDS-FINAL-APPROVED-VERSION-25-MARCH-2015.pdf)

The aim of this protocol is to support all three partnerships to operate effectively, being clear about their respective

functions; inter-relationships; and the roles and responsibilities of all those involved in promoting and maintaining the health and wellbeing of children and in keeping children safe. This is essential in order to maximise the safeguarding of children and young people, to avoid the duplication of work and to ensure there are no preventable strategic or operational gaps in safeguarding policies, services or practice.

The HWB, CHWB and KSCB have a shared commitment to ensuring that safeguarding and the promotion of the welfare of children is a priority in Kent, being mindful of the importance of the child's voice in this process.

The Boards will have an ongoing and direct relationship, communicating regularly through identified channels/ lead individuals, and will be open to constructive challenge in order to promote continuous improvement in safeguarding practice and outcomes.

The Boards commit to work together to ensure effective local partnership arrangements with the appropriate governance which are focused on contributing to protecting children from harm and on promoting their health and wellbeing.

It was recognised that more work needed to be undertaken to make stronger links with other key strategic Boards in Kent, such as the Safeguarding Adult Board and the Kent and Medway Domestic Abuse Strategy Group. This is now being addressed (2015-16) by the formal reporting of these Groups' (and the HWB and CHWB) business to KSCB meetings.

*"The Kent Children's Safeguarding Board feels to be much better supported by a number of sub-groups whose chairs meet regularly in order to co-ordinate and move the integrated work and developments forward. The big challenges for children's safeguarding are discussed and joined up plans are being worked on together."*

**Andrew Scott-Clark**  
**Director of Public Health**

## What did we do?

### Key KSCB Performance Indicators 2104-15

#### Priority 1

##### **Co-ordinate, monitor and challenge the effectiveness of local arrangements for the quality and appropriateness of early help and preventative services.**

Early Help and Preventative Services (EHPS) launched the new Kent Family Support Framework (KFSF) in September 2014, replacing the Common Assessment Framework (CAF), to ensure the highest quality service delivery and improved outcomes for children, young people and families who need Early Help.

The KFSF incorporates three interacting service delivery areas and processes: Identification – Notification and Decision Making; Assessment; Plan, Delivery and Review. A key element to providing effective Early Help and Prevention is the consistent use across the children's workforce of procedures and processes to identify and address the risks and needs of vulnerable children, young people and their families and reduce the demand for social care services.

The Early Help Triage team is the 'front-door' to targeted Early Help services, and handles KFSF notifications from a range of partners. The team was established in September 2014 by seconding in staff from other areas of EHPS. It has evolved both in terms of staffing and working practices, and is now fully staffed with permanent staff as part of the restructure of Early Help services. Triage now forms part of the Information and Intelligence Service, and the team has clear business processes in place for all types of notifications in order to work seamlessly with partners, Districts and SCS.

Performance figures for Early Help initially were inconsistently presented throughout the year, as the processes were embedded, but mechanisms have now been put in place to ensure timely and accurate reporting of performance data and progress. As you will see in the Board's future priorities, this continues to be a feature.

#### Priority 2

##### **Ensure multi agency and joined up working which protects and supports children with specific vulnerabilities, including the provision of timely and appropriate services.**

Audits, case reviews and external inspection/review (Ofsted Thematic Inspection on CSE and the Peer Review) undertaken throughout the year show that strong, positive multi-agency working at operational level is taking place. At the same time these activities also highlighted a sometimes inconsistent approach across the County.

The Board's Quality and Effectiveness (QE) Group examine quarterly performance indicators supplied by a range of partners in order to satisfy the Board that the arrangements in place to safeguard and promote the welfare of children are good. (This is expanded in the QE Report later in this Report)

A wealth of information is available to the QE and the focus this year has been on partners contributing to the analysis of these statistical measures, commenting on whether outcomes have improved. We are in an improved position but the group still has more work to do to ensure valuable contributions are available at these meetings. In order to help with these improvements there has been a review of the data presented and a new outcomes performance report is under development, this is in place from April 2015.

### **Priority 3**

#### **Develop a family focused approach in relation to substance misuse, mental health problems and domestic abuse.**

Throughout the year, a greater emphasis on the 'whole family' has been adopted. This is clear through the family assessment processes used for the identification of the need for Early Help through to those families who require specialist services to support their needs. Learning from Case Reviews and multi-agency audits has identified some inconsistent practice in this area. Examples of very good practice have been experienced, but also areas where the provider of adult services has lost sight of or has not recognised the impact of the adult's issues on the children within the family. Greater working between the County's Strategic Boards will assist to breakdown such issues in the future. Greater scrutiny and challenge in this area is required and this features in the Board's future priorities.

### **Priority 4**

#### **Provide evidenced assurance to the KSCB through robust monitoring, scrutiny and challenge, that multi-agency safeguarding practices are improving and there is ongoing learning and development for staff.**

During the year, KSCB produced its Learning and Improvement Framework. This document outlined how the Board and its Groups were to work more closely and how their work was to be coordinated in a joined up way that ensured that Groups were not working in isolation. Throughout the year, the principles of the Framework were used to support the work of the Business Group. An example of this is the development of the Learning and Development Strategy and Training Programme following child death reports, case reviews and multi-agency audits.

As you will see in the Quality and Effectiveness Group report later in this Report, the Board needs to further develop timely and accurate information through which it can be re-assured that multi-agency safeguarding practices are improving. The reporting of data with analysis from partners into the Quality and Effectiveness Group is essential for the Board is to receive meaningful evidence of improving practice.

In order to have a record of how the Board scrutinises and challenges itself, the Independent Chair has introduced a 'Challenge Log'. This is a record of challenges made by Board members around any safeguarding matter that they feel requires greater scrutiny, and where appropriate, action. This 'Challenge Log' is reviewed at Board meetings and activity against each challenge reported back to members. Here are some examples of 'challenges' and agencies' responses:

Following the presentation of low qualified Social Worker staffing numbers and high caseloads to the Board in 2014, the Board required re-assurance around Specialist Children's Services' policy on the recruiting and retention of Social Workers and case allocation and management. SCS were asked to present their policy to the Board followed by quarterly reporting of their staffing figures to demonstrate the activity that was being undertaken to address the low staffing numbers and high case loads. Within three quarters, the Board had received the required re-assurance that the vacancy levels had drastically reduced and that caseloads were being appropriately managed.

As part of the introduction of the Business Group, all agencies were challenged as to the appropriateness of their representation at all of the KSCB Groups. It was felt that some staff attending meetings did not carry the authority required to allow the Groups to carry out their roles. All agencies conducted a review as to their representation, resulting in new Group members being appointed and Group activity reported in to the Business Group becoming more meaningful.

The 'Challenge Log' continues to be reported to the Board.



## **KSCB Self-Assessment 2014**

During 2014, the Board undertook a Self-Assessment against the Ofsted Descriptors for LSCBs as taken from the Ofsted Inspection Framework. All Board members took part in the process, providing their views and evidence on the Board's standing against each standard. The collective feedback provided an honest assessment of what Board members felt were its strengths, and equally, those areas that it needed to focus on to ensure that it was undertaking its role. The details of the Self-Assessment can be found at Appendix A.

The findings from both the Peer Review and the Self-Assessment were used by the Independent Chair, Board members and Group members in a Board Priority setting workshop held in January 2015. This was the first time the Board had run such a workshop and the outcome from the session provided the skeleton of the Board's priorities and Business Plan for 2015-18, (see Future Priorities at the end of this Report). It also outlined the key challenges for each Board member, their agency and the Board's Groups.

*"The voice of the child has been amplified through the new style of Board meetings. The governance system has improved with much greater accountability of the Groups to the Business Meeting through to the Board."*

**Sally Allum**  
**Director of Nursing**  
**NHS England: South (South East)**

## **KSCB Peer Review Dec 2014**

In December 2014, KSCB welcomed a Local Government Association Peer Review. The review was conducted from senior Local Authority and LSCB staff from Windsor and Maidenhead, Southampton and West Berkshire. The review was undertaken over three days with Board members and Designated and Operational Staff being interviewed.

The process was positive and constructive with a detailed presentation provided by the Reviewers which was presented to the Board at the end of the review week. The findings focused on 'Strengths' and 'Areas for Consideration' on the Board and its Groups, Quality and Effectiveness and Learning and Development. The details of these areas can be found at Appendix B.

*"Progress has been maintained this year but partner agencies need to do more to ensure and demonstrate that the voices of children are at the forefront of their policies and processes."*

**Roger Sykes**  
**Lay Member**

## Local Authority Designated Officer (LADO)

The LADO is responsible for the oversight and scrutiny of individual cases, also the provision of advice and guidance to employers and liaison with other involved agencies to ensure that the allegation is dealt with in an effective manner through a fair and due process.

In Kent, the LADO function is managed via four full time officer posts, supported by a manager and administrative support. The Interim Manager (part-time) has overseen the team for the duration of this report, but will be replaced by a new full time manager at the end of July 2015. LADO officers are senior social work qualified staff who have a background in child protection practice and management.

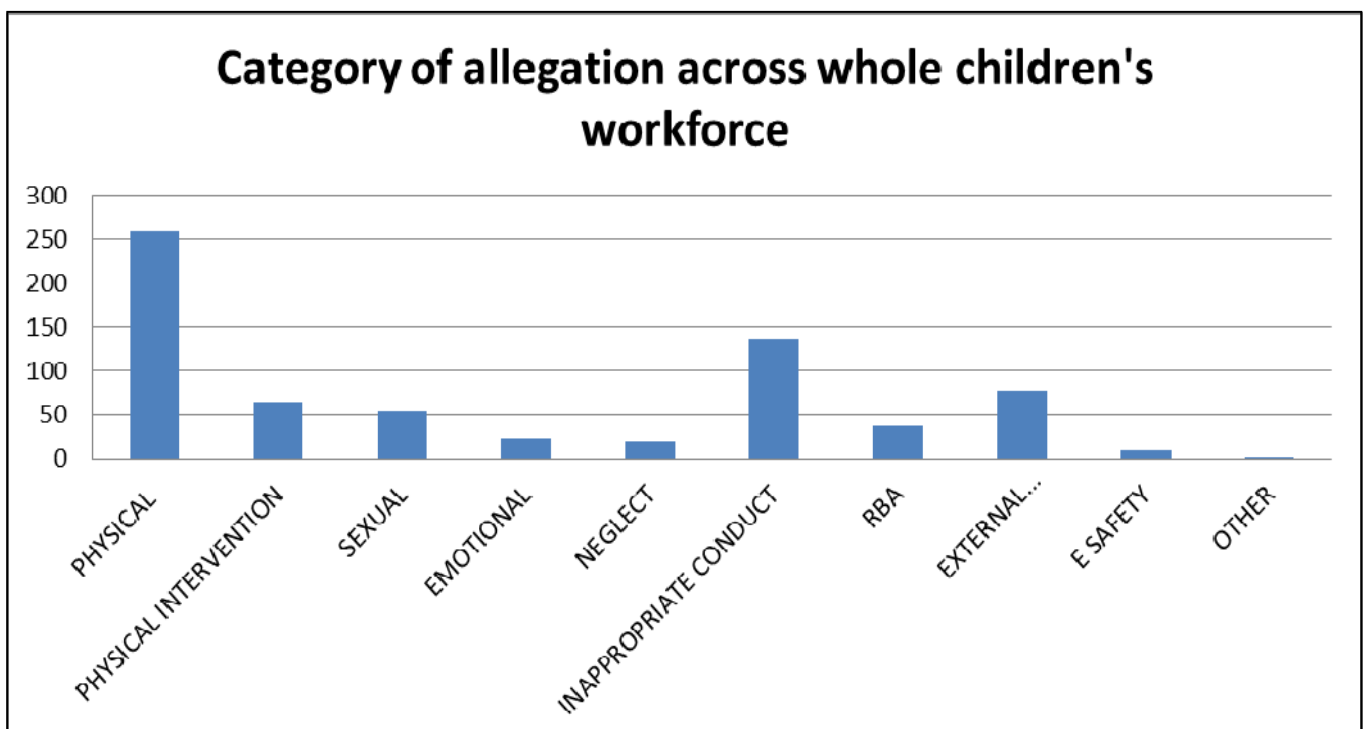
The LADO service maintains a detailed data base which provides statistics on:

- categories of allegation
- employing organisation
- reporting organisation
- individuals involved in allegation - both adults and child
- resulting action/outcome

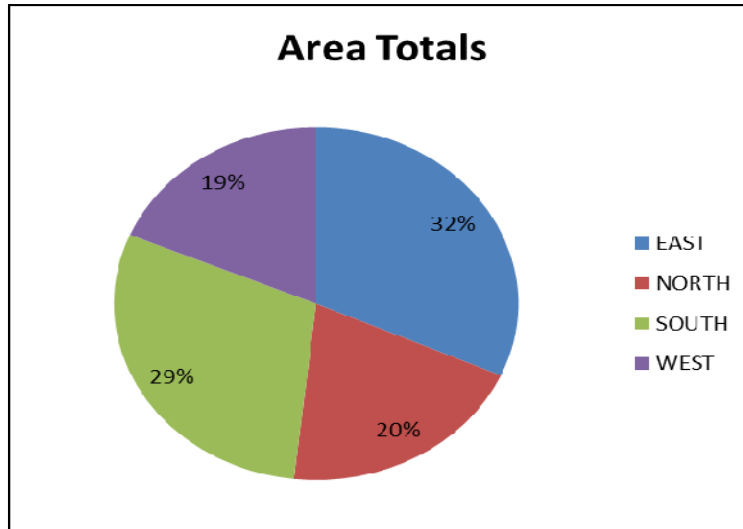
The number of calls to the LADO service for consultation and allegation management support is considerable. Between April 2014 and the end of March 2015, the team recorded 682 formal allegations against the children's workforce in Kent. This represents a 10% increase on the previous year.

The team has additionally managed a very high number of LADO-related consultations, some 859 in total. These mainly relate to staff conduct issues which, on consultation, are designated as below the allegation threshold and passed back to employers to manage as practice or competence issues rather than formal allegations. They may also constitute specific historical matters where staff are no longer working within the children's workforce, or could relate to matters of policy guidance.

### Categories of alleged abuse 2014-

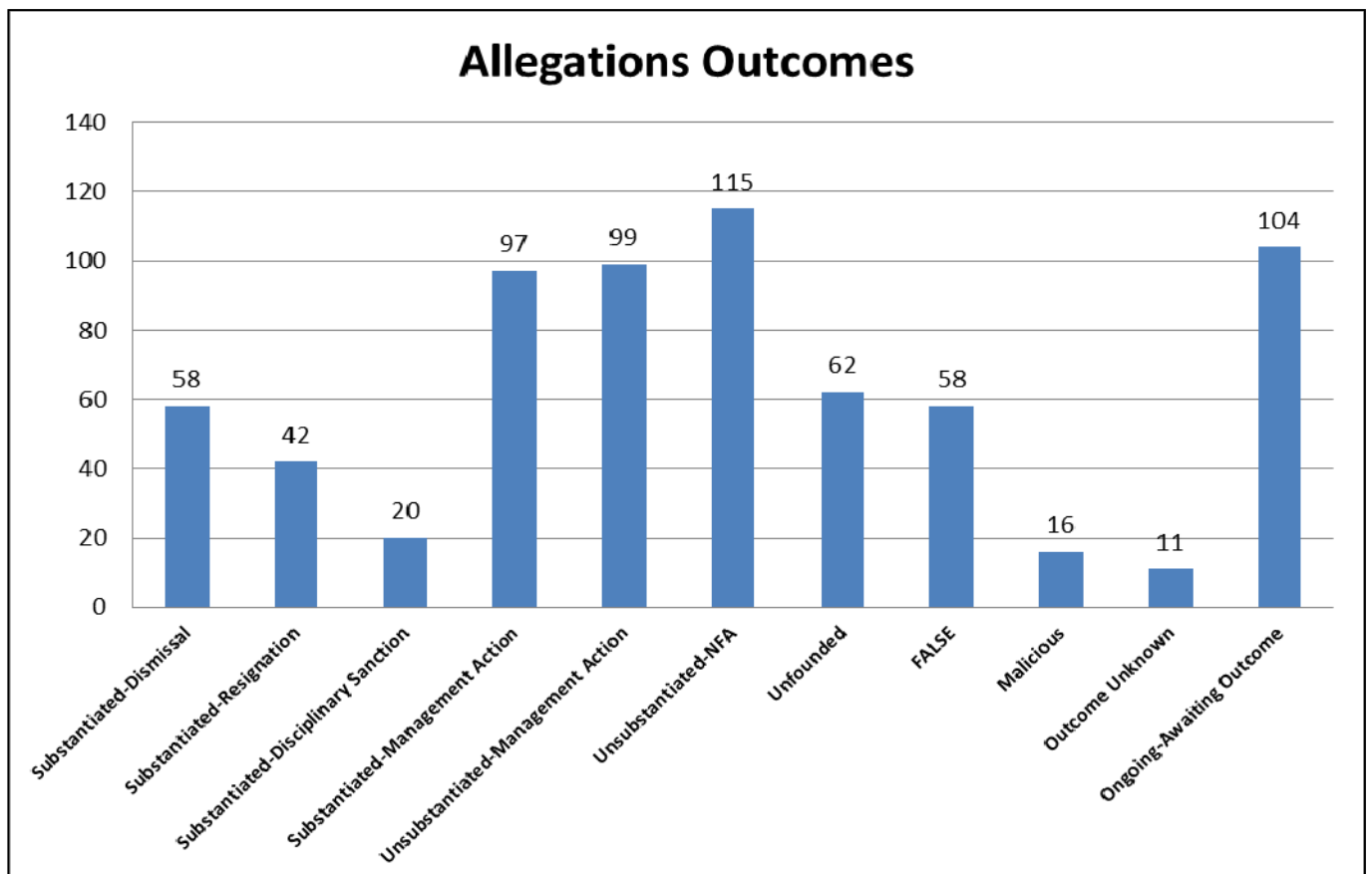


## Breakdown of allegations by Dis-



Of known outcomes, in the reporting period 2014 to 2015, 217 allegations were concluded to be substantiated (38%). This represents an 8% increase on the previous year.

Of these, 58 (27% (or 10% of the total allegations for which outcomes are known)) were so serious as to result in dismissal of the staff member, 20 of the 217 substantiated allegations (9%) resulted in another disciplinary sanction (formal written warnings), and 97 (45%) concluded with the employer providing other management action, such as advice, training, mentoring, etc. In 42 cases (19%), but with a clear decision that the allegation was substantiated at some level, the subject staff member resigned from their post. This resignation figure is also increased on 2013-14 (up from 9 to 19%). Thus 100 staff were either removed from or resigned their roles working with children as a result of substantiated/part-substantiated allegations made against them.



## Privately Fostered Children (2014-15)

At the time of writing this Annual Report, the Private Fostering Annual Report has not been formally signed off, however, the following highlights can be reported:

- On the 31st March 2015, there were a total of 25 private fostering cases open across the County. This figure is an increase of four on last year.
- Notifications have risen by 57% from last year (from 56 (13/14) to 88 (14/15) – 77 new arrangements made
- Of the 77 Private Fostering arrangements made in 2014/15, 34 involved children/young people born in the UK, which is a drop on last year's figure (32/58). This follows the national trend.
- In Kent, 87% of children were aged 10 and above at the time the Private Fostering Arrangement Assessment Record was completed. This is in line with the National figures which suggest that the majority (68%) of children in new private fostering arrangements are aged 10 to 15.
- There has been an increase in 7 day and 6 week visiting rates – this year 90.7% of children were visited within 7 days of notification (compared to only 76.5% last year) and 84.4% were visited at six weekly intervals for the first year (compared to 63% last year).
- Those private fostering arrangements that began BEFORE 1 April 2014 that were continuing on 1 April 2014 where scheduled visits in the survey year were completed in the required timescale – 50% (slight decrease)
- A programme of awareness raising has taken place which has seen an increase in notifications from schools and education provisions especially.

The plan for next year includes more awareness raising and support within SCS to continue to improve the quality of Private Fostering assessments.

*“The Safeguarding Board has continued to develop its scrutiny of Safeguarding practice across Kent. The Peer Review has assisted in highlighting additional lines of enquiry in pursuit of observed practice vs reported data to improve learning and development, not just for our front line practitioners but equally of our Senior Management, to improve Safeguarding outcomes in Kent.”*

**Sean Kearns**  
CEO, CXK

## The State of Safeguarding of Children in Kent:

There are just over 326,000 children and young people living in Kent, making up 22% of the population. Whilst much is known about the risks to Kent's children and young people, it is not possible to offer a complete picture of the children whose safety is at risk in Kent because some abuse or neglect may be hidden, despite the best efforts of local services to identify and step in to support children who are being harmed.

Whilst we can never ensure that no child is hurt; all our efforts are to try to minimise any risk to children. The following shows some of the figures for children helped and supported in Kent.

The figures included are snapshot figures taken at the end of each performance monitoring year (March 31<sup>st</sup>).

## Children on Child Protection Plans (CCP):

At year end, 2014/15, the number of children on CPPs was **1240**. This compares to **1117** at the last year end. This is **an increase of 123**. KSCB is provided with regular analysis of this information to ensure that the figures reflect statistical neighbours. We are as satisfied as we can be that currently, cases are effectively reviewed and children are being provided with a range of appropriate multi-agency interventions in support of their needs.

## Children In Care (CiC):

CiC are those looked after by the Local Authority. A decision to take a child away from his or her home, without parent's agreement is an extremely difficult one and can only be taken following a court decision or in an emergency, by the police or a magistrate. Even then, it is only taken after every possibility of protecting the child at home has been explored and where the decision really is the best option of ensuring the child's safety and wellbeing. The year on year figures show **a reduction of 122**, from 1624 to 1502. On the 31<sup>st</sup> March 2015, excluding Unaccompanied Asylum Seeking Children, there were 148 Kent Children in Care placed outside of Kent. This compares to 143 at the same time last year.

## Unaccompanied Asylum Seeking Children (UASC):

Some of the most vulnerable children in Kent arrive through the Port of Dover or through the Channel Tunnel each year seeking entry into the UK. Most young people arrive seeking asylum whilst others have been trafficked for exploitation. Where the UK Border Agency identifies unaccompanied children, they pass responsibility for these children to Kent County Council. There are also significant implications for all KSCB partners. The issue of asylum seekers continues to receive high profile media and political attention. At the 31<sup>st</sup> March 2015, there were 368 Unaccompanied Asylum Seeking Children (UASC) Children in Care in Kent. This is **an increase of 150** from 218 at 31<sup>st</sup> March 2014.

This continues to be a serious concern as these children are especially vulnerable to exploitation. The KSCB's Child Trafficking and Sexual Exploitation Group will continue to closely monitor progress across agencies in tackling this problem. This key priority will continue into the Board's three year Business Plan (2015/2018).

## Children in Care placed in Kent by Other Local Authorities:

As of the end of March 2015, there were **1303** children placed in Kent by other local authorities, an increase of 108 on the previous year. This high number of other local authority looked after children placed in Kent has been consistent for many years. This places significant pressure on public agencies responsible for supporting vulnerable children in Kent, including Specialist Children's Services, schools, police, and health services.

Following a recent high profile report of sexual exploitation network across the country, all councils must continue to make sure they can properly safeguard teenagers placed in residential children's homes, particularly those placed many miles from home, which increases their sense of vulnerability. These are young people at heightened risk of being sexually exploited by criminal networks and gangs and careful consideration needs to be given to the location of the placement these children.

KSCB and our partners are working very closely to explore the links and patterns of children placed in Kent and by Kent and reports of these children going missing from their placement. Understanding what happens when these children go missing will assist in safeguarding the children and help the placing authority in considering the appropriateness of some placements.

This will continue as an ongoing priority for the Board and our partners.

## Children In Need (CiN):

At year end, 2014/15, there were 1129 CiN cases that had been open for 12 months or more, this compares to 3162 the previous year, **a reduction of 2033 cases**. Both the system for recording Specialist Children's Services records and the methodology for calculating CiN cases changed between the dates of the snapshot figures.

For CiN cases open for 6 months or more the figures were 1791 for 2014/15 against 4110 for 2013/14, **a decrease of 2319**. The methodology for calculating these CiN cases changed between the dates of the snapshot figures. The figures include cases open for 6 months or more – not those open between 6 and 12 months.

With regard to the CiN figure, the methodology has changed to make it more accurate for operational teams within the 0-17 age category. The Care Leaver figures would however be included in nationally reported figures. Figures also taken out are other non-CiN e.g. adoption support, Finance only etc. This provides a more accurate picture of "active" CiN cases and is clearer in any measures where outcomes are expected (e.g. average durations).

It must be emphasised that the change in recording and methodologies for calculating CiN cases has not resulted in children being 'missed' or not receiving appropriate support. In future years we will be able to compare like with like figures.

## Number of re-referrals to Specialist Children's Services:

Re-referrals to Specialist Children's Services within 12 months, **has increased from 26.6% at year-end 2013/14 to 28.5% at year-end 2014/15**. This increase is reported as a result of the change to the recording of referrals by the Central Duty Team during the year.

## Children being supported by Early Help services:

At the 31<sup>st</sup> March 2015:

- There were **5380 open cases** of children and families being supported by Early Help.
- The percentage of cases stepped up, from Early Help to Specialist Children's Services, was **9.4%** (these are cases that originally did not meet the Threshold Criteria for Child in Need or Child Protection, but following support from and further assessment by Early Help staff, the needs of the child has been deemed to have met the criteria and has been 'stepped up' to Specialist Children's Services).
- The number of CIN and CP cases closed by Specialist Children's Services and stepped down to Early Help was **22%**
- Re-referrals to Specialist Children's Services sat at **28.5%**.

Between January 2015 and 31<sup>st</sup> March 2015 the percentage of cases closed with a positive outcome had **increased from 49% to 69%**.

*It is acknowledged that all of the above figures are a snap shot taken at the year-end 2014-15. They do not reflect performance after 31<sup>st</sup> March 2015.*

## So, how safe are the children and young people of Kent?

The performance figures provided an overview of what is reported on their activity. However, to answer the question of 'how safe are the children of Kent?' the Board considers the evidence from a range of quality assurance activity. This is done through case reviews, multi and single agency audits, reports from routine management oversight and supervision by all agencies' managers. During 2014-15, significant front line work has continued.

In response to the challenges identified last year, KSCB partner agencies have worked hard to implement policies and practices around the recognition and response to children vulnerable to Child Sexual Exploitation and Children who go missing. Staff across all agencies are now better sighted on CSE and missing children although it will take more time before evidence of the impact of this awareness is realised. This has been demonstrated in the multi-agency CSE investigation carried out during 2014-15. Learning from this investigation has been and will continue to be shared across Kent.

The impact on the placing of Other Local Authority Children in Care remains a concern for all agencies. There are evidenced links here with gangs and criminal and sexual exploitation. These continue to be a challenge, but stronger multi-agency working partnerships are being developed, for example the Thanet Task Force.

The ongoing demands being made on all agencies in Kent from the number of unaccompanied asylum seeking and trafficked children coming in to the county will continue to have an impact on agencies' resources. The KSCB Trafficking and CSE Group is working to ensure that agencies share information, and where appropriate, resources to deal with the issues around these vulnerable children.

Overall, all agencies in Kent work hard to ensure that children in Kent are as safe as possible and that all agencies are committed to supporting those who are in need of additional services. KSCB will continue to scrutinise and challenge partners to ensure that we all work together and collectively to safeguard children, working as far as possible to prevent safeguarding issues, but where they do arise, respond quickly and positively to deal with them. It is essential that every child's welfare is paramount and this message is in the forefront of each agency's organisational culture.

## Voice of Children and Young People

KSCB recognises the importance of hearing the voice of children and young people in Kent and has been seeking different ways of ensuring that their voice is heard and influences the Board priorities and work that is undertaken.

A young person from the CXK Youth Board, jointly opened our 2014-5 Annual Conference with our Independent Chair, and spoke to the conference on issues that were relevant and important to all young people in Kent.

The Board continues to actively support Kent Youth County Council (KYCC) through their identified campaigns. Members of the KYCC presented an update on their anti-bullying campaign and introduced their 'Healthy Relationships' video at our Annual Conference in November 2014.

In addition KYCC run a safeguarding interest group, which is working on a project to reduce the stigma attached to mental health issues. This project is currently underway with the results expected over the next few months.

The Board starts every Board meeting with a presentation from or about Young People. Topics included this year include: Domestic Abuse, Healthy Relationships, and Mental Health.

These sessions have been extremely informative and have given the young people the opportunity to raise their current issues with Board members.

KSCB, through our Partnership Development Officers, have been working very closely with Kent County Council in the development of a Participation and Engagement Strategy. This has included the undertaking of a LILAC assessment. The LILAC Assessment has been developed by a National VOICE as a way of involving young people with experience of the care system to carry out an assessment of how well services delivered by the local authority are enabling children in care and care leavers to participate; both at an individual level, and in the development of policies and services that support them.

The assessment in Kent took place over a three day period between 29<sup>th</sup> September and the 1<sup>st</sup> October 2014. The assessment focused on shared values, style of leadership, structures, staff, recruitment and selection, care planning and review, complaints and advocacy. Two trained Care Leaver assessors took part in this assessment alongside a LILAC Coordinator.

The assessors said:

- *"It was evident that some really good participation work was going on".*
- *"I really enjoyed meeting with the Children In Care Council (CICC), thought they were fantastic and well supported".*
- *"There is definitely good work and I believe Kent are heading in the right direction, there are improvements to be made but it is a good starting point to have an independent body come and assess to be able to assist Kent in making improvements".*

The young people said:

- *"we do get consulted a lot and I think it is a good thing because we can make a difference"*
- *"The CICC is great, I enjoy attending the groups and it's fun and also our voices are taken seriously".*

The assessment graded Kent as having achieved 4 of the 7 LILAC standards. The feedback from the young people and the assessors is currently being used to develop an action plan which will be reviewed as part of the LILAC assessment later in 2015.



## Next steps:

In 2014-15, feedback from young people from Child Protection Conferences was low. KSCB is working with Child Protection Conference Chairs to encourage greater use of the voice of the Young People in providing feedback which will then be used to support the development of the service.

KSCB will be undertaking a Countywide Young People's survey in the summer term of 2015. Topics covered in the questions will relate to relevant and topical issues for young people, including cyber-bullying, healthy relationships and drug and alcohol misuse. The results from the survey will be reported to the Board later this year.

The challenge for the Board going forward is 'So What?' The Board needs to demonstrate how listening to the young people is impacting on their agency's business. This is reflected in the Board's Strategic Priorities for 2015-18.

*"The Board continues to develop its reach and influence on safeguarding practice across the county through its invigorated membership and structures. We need to further consolidate the Board's oversight of frontline practice going forward as we collectively respond to the key strategic challenges outlined in the 2015 -18 Business Plan."*

**Philip Segurola**  
**Director, Specialist Children's**  
**Services**

## Views of Staff Working with Children

### Staff Survey 2015

The KSCB Staff Survey was introduced by the KSCB Business Unit in 2014 and repeated again in 2015. The aim is to gain an understanding of the issues that practitioners face whilst working with children and their families in Kent. The survey also gave staff the opportunity to feedback to the board regarding training gaps and their knowledge of designated safeguarding roles within their organisations.

The 2014-5 Survey was distributed across Kent to a wide range of agencies across all sectors, including the voluntary sector. A total of 1049 respondents completed the survey. The data was evaluated and grouped into district data so that the findings from the survey could be shared with Team Managers on District levels to inform practice and ensure local training needs could be met.

The four organisation categories that have produced the largest number of responses are Local Authority, early years providers/preschools, schools and health collectively making up 86% of the responses.

## Summary Report

### Awareness of the KSCB

Staff were asked to what extent they agreed with the statement that “they were aware of the role of the KSCB.”

- 89% of staff responded either ‘agree’ or ‘strongly agree’.
- Of the 11% of respondents (118 individuals) that did not agree or strongly agree with the statement.

### Awareness of which individual from their organisation is their KSCB representative

- When the respondents were asked if they knew the individual from their organisation that represented them on the KSCB, 30% disagreed or strongly disagreed.
- In particular it should be noted that 60% of staff within KCC’s Social Care, Health & Wellbeing directorate are unaware of their KSCB representative.
- The implications of these results are that KSCB and agencies’ representatives on KSCB Groups need to be more proactive in marketing the role of KSCB and their role as Group members.

### Awareness of the Kent Thresholds and Tiers of Intervention

- Staff were first asked if they were aware of the Kent Thresholds and Tiers of Interventions for Children in Need. 78% of practitioners either agreed or strongly agreed with the statement leaving 12% unaware and 10% taking middle ground.

### Awareness of who the designated child protection coordinator/safeguarding lead is for their organisation

- 97% of staff within schools, and 99% of staff within health knows who the child protection coordinator/safeguarding lead is for their organisation.
- 16% of Local Authority staff do not know their designated officer.

### Awareness of their organisations safeguarding procedures

- Staff were asked if they were aware of their organisation’s safeguarding and child protection procedures, 97% of staff responded either ‘agree’ or ‘strongly agree’.

## Knowledge of the role of the LADO

Staff were then asked if they knew what the role is of a Local Authority Designated Officer.

- 80% of staff either agreed or strongly agreed with the statement with 11% disagreeing or strongly disagreeing. This is a significant increase from the 2014 survey where 64% of staff felt they understood the role of the designated officer.
- Only 14 (5%) of 241 Early Years Provider/Pre-school staff do not know what the role is of the Local Authority Designated Officer whereas 65 (49%) of 133 Health staff responded in the same way, although it is acknowledged that within Health, it would be the Designated Safeguarding lead who be the lead contact for LADO matters.

## Child Sexual Exploitation

The survey then asked 3 questions on child sexual exploitation.

- Do you have a clear understanding of CSE?
- Are you comfortable recognising and responding to CSE?
- Are you aware of the CSE Toolkit?
  - 93% of staff have a clear understanding of child sexual exploitation although the proportion of staff that are comfortable recognising the signs and responding to them drops slightly to 80%. The proportion of staff aware of the Kent CSE toolkit drops further to 60%.
  - Certain organisation categories stand out more than others. Staff from early years providers/pre-school settings appear to be more likely than those from other organisations to have a clear understanding of CSE and also comfortable recognising/responding to it.

## Early Help Notification Process

The survey asked staff about the Early Help Notification Process. Of the 1049 survey responses, 1040 members of responded to the statement 'I am aware of the Early Help Notification Process' and 20 of these stated it was not applicable to them.

- 834 (82%) of these 1020 members of staff stated that they were aware of the Early Help Notification Process. Of these 834, 56% stated they were confident in the Early Help Notification Process. This means that of the entire survey cohort, only 45% are aware of and confident in the Early Help Notification Process.
- 56% of staff stating that they are confident in the Early Help Notification Process is comparable to last year's survey where 60% were confident in the CAF process.

## Multi-agency working

The survey then went on to ask about working relationships with other agencies in their areas.

- 1027 members of staff answered this question and 75% felt that they have good working relationships in their area. Only 3% of staff disagreed or strongly disagreed and 22% neither agreed nor disagreed. These figures are very similar to the 2014 survey where 73% of staff felt they had good working relationships with agencies in their area.

## Options selected as potential improvements to working relationships with other agencies

- 'Improved communication between agencies' comes out as the top
- Comparing these responses to those obtained in 2014 suggests that there have been improvements in information sharing between agencies as this is no longer the biggest potential improvement.

## Training

The survey then moves on to training, starting with whether training received allowed staff to effectively fulfil their role.

- 82% of staff agreed or strongly agreed with the statement and only 48 of 1049 (5%) disagreed or strongly disagreed
- 71% of staff agreed or strongly agreed that it was easy for them to access training which suggests a large number of staff are experiencing barriers to training. This is a reduction from 77% perceiving training as accessible in the 2014 survey.
- 42% of respondents from the charitable sector and 38% from the Police service could not agree that it was easy for them to access training. 50% of staff that fall into the other category also are finding it difficult to access training.
- Nearly half of staff responding to this question stated that time capacity was a barrier for them. Limited courses and places appear to be the other major issues that staff perceive as their barriers to training
- There is a big shift in the perceived barriers to training from the 2014 survey where cost and a lack of awareness of training or how to access it featured very highly.

The survey then asked staff to what extent they agree with the statement '*I am encouraged to regularly attend training*'.

- 75% of staff agree or strongly agree that they are encouraged to regularly attend training.

## **KSCB Group Reports**

As the Independent Chair outlined in her Foreword, the Board has taken on a more formal accountability and reporting structure. This will always be work in progress, although Board members and the Chairs and members of each of the Groups have all reported a greater confidence in the joining up and coordination of cross Group activity. Here are brief summaries of the activity and achievements of the Board's Groups:

## **Business Group**

**Group Chair: Gill Rigg, Independent Chair, KSCB**

On her appointment as Independent Chair of KSCB, Gill Rigg undertook a review of the governance and accountability structure of the Board and its groups. Following consultation with Board and Executive Group members, a new structure was introduced with the Business Group replacing the Executive. The Board is now made up mainly of the Chief Executives of all Partner agencies and has the decision making role for the partnership. The Business Group is made up of the Chairs of all of the Board's Groups, and chaired by the Independent Chair.

At the Business Group, each Chair presents an update from their Group, raising issues that impact on the working of the other Groups. Where there are decisions or recommendations for the full Board, these are taken to the Board with the views and comments of the Business Group members. This process has made the purpose of the Business Group more meaningful and has provided greater structure and clarity of governance to the Board's business.

The Business Group also oversees the Board's Business Plan and is responsible for providing the Board with not only what is being done across the groups, but also the evidence of the impact that the Board's activity is having on operational practice and improving safeguarding for children.

During the Peer Review in December 2014, it was recognised that although it had not been in place for very long, the members of both the Board and the Business Group had already noticed the positive difference in how the Board conducted its business.

The Business Group's challenges for the future are to ensure that it builds on the positive start and delivers on the Business Plan priorities. More evidence of impact is required and it is the role of this Group to ensure that it is provided.

## Quality and Effectiveness

**Group Chair:** Florence Kroll, Early Help and Preventative Services

The Quality and Effectiveness (QE) Group's main function is to co-ordinate quality assurance and evaluate the effectiveness of what is carried out by KSCB partner agencies, individually and collectively, to safeguard and promote the welfare of children. It has oversight of multi-agency and single-agency audits, Section 11 audits and analysis of performance data about safeguarding from the key statutory agencies in Kent.

The QE examine quarterly performance indicators supplied by a range of partners in order to satisfy the KSCB that the arrangements in place to safeguard and promote the welfare of children are good.

A wealth of information is available to the QE and the focus this year has been on partners contributing to the analysis of these statistical measures, commenting on whether outcomes have improved. We are in an improved position but the group still has more work to do to ensure valuable contributions are available at these meetings. In order to help with these improvements there has been a review of the data presented and a new outcomes performance report is under development, this will be in place from April 2015.

### **Key activity undertaken by the Group 2014-15**

#### **KSCB Audits:**

The QE carry out an annual programme of multi-agency audits; in 2014-15 these were:

#### **Quality of Child Protection Planning:**

Following up on previous audits undertaken in Child Protection, and findings from previous Ofsted inspections, the audit focussed on planning and interventions in selected Child Protection cases. This audit highlighted the importance of good quality information needing to be contained within reports at Conference; this was identified to be imperative for effective planning to take place. It was found to be critical that records are accurate and up to date to ensure reasons for decisions/actions are maintained.

#### **Section 11 Self Assessments:**

A full round of assessments were collected with a new peer review process piloted to quality assure responses; this proved beneficial for all involved and will become a standard part of the Section 11 (S11) programme in Kent. District Councils have requested the S11 template they complete be tailored to better meet their needs and this is being progressed in 2015-16.

#### **Domestic Abuse Deep Dive Review:**

This process of auditing, involving practitioners and their managers in an in-depth discussion regarding one of their own cases, continued in 2014-15 following a successful pilot last year. Two cases were reviewed where there were repeat incidents of high level Domestic Abuse recorded. The findings have been shared and will form the basis of a follow up audit in 2015-16.

#### **Repeat Missing Children and exploring links to Child Sexual Exploitation:**

Five cases were reviewed by multi-agency partners and managers where all the young people had been reported missing more than three times in a 90 day period. The review focussed on whether professionals involved had explored links to child sexual exploitation, and if evident, had addressed issues appropriately.

## 2014-15 Performance Outcomes:

The process for requesting Early Help Services changed mid 2014-15 so no direct comparisons are available at this time. The number of Kent Family Support Framework notifications received stood at 1,220 as at the end of March 2015, with the number of cases open to Early Help and Preventative Services at 5,380. The number of cases closed with a positive outcome stands at 68.8% and 9.4% of cases were stepped up to Specialist Children's Services (SCS) in March 2015.

In March 2015 there were: 581 first time entrants to the Youth Justice System in Kent; 12.3% of the Youth Justice cohort were Children in Care; 5.7% of 16-18 year olds were not in Education Employment or Training. The rate of referrals in to SCS was 512.9 per 10,000 population in March 2015, compared to 605.7 at the same point in 2014. Re-referrals within 12 months remain above target at the end of the year but are reducing month on month. Further figures from partners are included in the table below relating to Children in Need, Child Protection and Children in Care:

Performance Measure	March 2014	March 2015	Target / Benchmark March 2015
Number of Children in Need per 10,000 population under 18 (snapshot)	330.1	283.7	315.0
Number of Section 47 enquiries per 10,000 population under 18 (rolling 12 months)	161.8	141.3	100.9
Number of children with a Child Protection Plan per 10,000 population under 18 (snapshot)	36.5	38.0	35.7
Percentage of Child Protection plans lasting 2 years or more at the point of de-registration (year to date)	4.9%	2.2%	5.0%
Percentage of children becoming subject to a Child Protection Plan for a 2 <sup>nd</sup> or subsequent time within 24 months (year to date)	8.0%	7.8%	7.5%
Number of Children in Care under 18 per 10,000 population (snapshot)	50.3	46.1	48.0
Child in Care Stability of Placement: 3 or more placements in the last 12 months (snapshot)	8.9%	9.6%	9.0%
Number of cases referred to Multi-Agency Risk Assessment Conference (MARAC) where there are children in the household	210	220	n/a
Number of Domestic Violence incidents resulting in a Domestic Abuse Notification	746	807	n/a
Number of Domestic Violence incidents resulting in a referral to SCS	348	213	n/a
Number of children frequently reported Missing (3 or more incidents in 90 days)	118	237	n/a

The number of cases referred to a Multi-Agency Risk Assessment Conference (MARAC) where children are resident in the household remains high and continues to provide challenges for Kent Police and partner agencies, with nearly 1,000 cases referred over the year. Children missing from home or placement could be at risk of: sexual exploitation; missing education; engagement in criminal behaviour and be more vulnerable to other risk-taking behaviours. KSCB have been developing policies and procedures that safeguard and promote the welfare of this at risk cohort. Work is ongoing, collecting and cross referencing data from partners on these missing children, to ensure the extent of need is known and appropriate interventions can be implemented.

## Upcoming Challenges:

- QE aims to continue to improve methods of gathering safeguarding evidence from partners, scrutinising their performance, sharing any best practice and learning via other groups of the Board.
- More work remains for all partners with regard to the analysis of the data that is presented to QE in order that a more detailed multi-agency analysis can be undertaken.
- The work of QE will ensure the Board receives relevant and timely information that will enable children in Kent to get the right help at the right time.

## Case Review

**Group Chair: Superintendent Andy Pritchard, Kent Police**

The Case Review Group supports the KSCB Independent Chair in establishing the initial scope for any serious case review (SCR) (where the criteria as set out in Working Together to Safeguard Children 2015 are met), or other type of review, and to develop procedures and protocols for undertaking those reviews in Kent.

### Key activity undertaken by the Group 2014-15

The Case Review Group has developed and implemented a Case Review Notification Process that ensures that partners can refer in cases that they feel warrant the Case Review Group to consider for a formal case review. This has resulted in 16 formal notifications to the KSCB Case Review Group in 2014 - 2015.

These have resulted in:

- Two Serious Case Reviews (one to be published in autumn 2015, the second in late 2015 or early 2016)
- Two Other Local Authority Serious Case Reviews
- Seven formal Management Reviews,
- Five cases are pending management reviews in 2015-16

Those Kent reviews undertaken have taken the form of:

- Practitioner events,
- Manager and practitioner learning events, and  
Independent Manager Reviews.

The purpose of all case reviews undertaken is to identify key learning lessons with the intention of using these lessons to improve working practice. All Reviews have been chaired by members of the Case Review Group and findings and recommendations reported back to the Case Review Group.

Learning from these reviews has been identified and integrated in to the existing KSCB Multi-Agency Training programme, or where new topics have been identified, new training has been commissioned and delivered.

Agency representatives on the KSCB Case Review Group have been tasked with cascading the learning from reviews undertaken to their own agencies following their presentation to the Case Review Group.



## Key learning topics from the 2014-15 case reviews:

Sexual Abuse  
Record Keeping  
Child Protection Conferences/Review Conferences  
Strategy discussions  
Self-Harm  
Voice of the child  
Supervision  
Toxic Trio  
Working with families

A more detailed breakdown of the areas below these headlines can be found at Appendix C.

## Key challenges:

The embedding of learning from all case reviews is an area that still requires greater evidence of effectiveness. In 2015-16, the Case Review Group, Quality and Effectiveness Group and the Learning and Development Group will be working in a more joined up way to ensure that not only is learning disseminated, but there is evidence of its impact on operational practice. The Quality and Effectiveness Group will include the impact of learning on operational practice as part of its audit programme.

## Learning and Development

**Group Chair:** Sean Kearns, CXK

### Training

There were significant developments in respect of KSCB's core training offer during 2104-15. These include:

- Core multi-agency training offer:
  - \* A total of 145 individual courses relating to 36 different topics were delivered to 3281 multi-agency delegates across all 12 districts of Kent.
- Bespoke Training:
  - \* Similarly, 93 bespoke courses relating to 11 different topics were also delivered to organisations within 13 different sectors across all 12 districts of Kent.

### Trainers

Two 5-day 'Train the Trainer' courses were held in this period and 25 new trainers have joined KSCB's College of Trainers. The position of Associate Trainer has also been created to enable existing trainers from within partner organisations to be trained to deliver KSCB courses, thereby cascading learning within their teams and agencies and extending its reach throughout Kent.

The first two 'Train the Trainer' courses for Child Sexual Exploitation (CSE) were held in February and March 2015 respectively and a total of 36 multi-agency trainers trained to deliver this subject to both multi-agency groups and their own organisations.

KSCB also uses Specialist and External Trainers who are expert practitioners and subject matter experts, who deliver multi-agency training that requires an enhanced level of expertise and knowledge.

A Trainer quality assurance programme has also been introduced within which KSCB trainers are formally and independently observed and their delivery evaluated. To date, all observations have been graded either good or outstanding. The 2014 Trainer Development Day was attended by 38 delegates and a new quarterly electronic Trainer Bulletin has been introduced to ensure KSCB trainers are kept up to date with local and national developments.

## Evaluation

It is recognised that evaluating the impact of training on operational practice is difficult. However, in addition to the existing post-course delegate evaluation, a new three month post-training 'impact evaluation' process has been implemented to confirm the extent to which new learning has informed and improved delegates' practice. The results of this process are yet to be presented but this will continue through 2015-16 and outcomes will be presented to the Board.

A delegate feedback form is also regularly used by all trainers to record any issues which delegates share during training so that these can be fed back to the appropriate team.

## Child Death Overview Panel (CDOP)

**Group Chair: Andrew Scott Clark, Public Health**

This panel has the responsibility for reviewing all deaths of children in Kent. The panel is chaired by Kent's Director of Public Health and its work is supported by two Designated Doctors for Unexpected Death; a Child Death Coordinator, partner representatives (including the Police and Specialist Children's Services) and KSCB Officers. This mandatory panel works in close partnership in order to monitor trends in child death nationally and locally, analyse data relating to specific child deaths, identify modifiable factors and to promote any learning from them. Whilst there are a host of other factors that are also considered as part of this work, environmental effects and parenting issues are key and these are subject to careful deliberation in each case, as is the quality of multi-agency working.

The primary aim of the CDOP is to reduce the number of preventable child deaths through systematic multi-disciplinary review, education of professionals and the general public and to make recommendations for legislation and public policy changes. These recommendations are based on panel reviews and circumstances surrounding individual causes of child death. The data is used to identify trends that require systematic solutions. In order to improve the way in which partners collect and respond to the necessary information KSCB and Health colleagues are progressing the development of a bespoke CDOP database that will provide an enhanced level of efficiency and reporting to this important process.

Age	Number
0-28 days	23
29 days - 1 year	19
1 - 4 years	7
4 - 11 years	8
11-18 years	13

## Key activity undertaken by the Group 2014-15

The Panel reviewed a total of 93 cases in the year. Some of these cases were rolled over from last year as the Panel only formally reviews cases after all other proceedings, such as the Coroner's inquest, have been concluded.

### **Key achievements**

Full information relating to child deaths in Kent is regularly considered by the CDOP panel and is used to bring about improvements in local working processes and practice whenever appropriate and to inform KSCB's learning and development.

### **Key challenges for 2015-16**

There continues to be a number of sudden unexpected deaths in infancy (SUDI) across Kent and these continue to happen in circumstances where there is greater risk for example due to parental smoking, and/or co-sleeping. A new safe sleeping campaign is currently being developed to ensure parents and families are given the best advice to reduce the risks of infant deaths happening like this in the future.

The CDOP team have developed a joint information system which will ensure the collection, sharing and reporting of information is much more efficient, over the next six or so months this system will go live. Nationally there is much interest in the Kent system as all CDOPs are recognising the need to manage information more robustly using a secure, web-based system that is accessible to all partners.

## **Trafficking and Child Sexual Exploitation**

**Group Chair: Patricia Denney, KCC Specialist Children's Services**

### **Group Chair: Patricia Denney**

The Group is working towards an integrated strategy to identify, address and reduce the incidence of Child Trafficking and Child Sexual Exploitation in Kent and Medway. Closely allied to this work is reducing the number of children and young people who go missing or runaway, including those arriving at the County's ports and International railway stations or within the community.

It aims to provide training to professionals, families and community groups to understand the profile of trafficked children and victims of sexual exploitation and help to understand their needs. The remit also includes a joined up data set to ensure intelligence is collated, analysed, understood and shared across all agencies.

### **Key activity undertaken by the Group 2014-15**

- With the Learning and Development Group, (and supported by Barnados), designed and delivered multi-agency awareness raising of issues relating to Missing Children from home and care, CSE and Human Trafficking of children through training courses, both face to face and e-learning.
- Improved the CSE Toolkit to support frontline professionals identify and support children and young people who may be victims of CSE, based on feedback from professionals who used the toolkit as part of a major Kent CSE investigation.
- Improved multi-agency practices relating to Missing Children from home and care, CSE and Human Trafficking of children through sharing data and intelligence, and encouraging best practice from learning from active cases, both local and national.
- Learned lessons from the Ofsted Thematic Inspection and carrying out required actions from the Inspection
- Developed an Action Plan for Trafficking and CSE, drawing from the Ofsted Thematic Inspection Report (attached at Appendix D), National Reports and the evolving Kent profile.
- Developed a comprehensive CSE and Missing Children Strategy to ensure that partner agencies work cooperatively to identify and deal with children and young people who are identified as, or at risk of becoming, victims and perpetrators of CSE and going missing
- Promoted the need for every child who goes missing from home or care to have a "Return Interview" undertaken and the findings to be passed to the KSCB for analysis.

## Key achievements

- Kent has taken part in the Home Office trial of special advocates for children and young people identified as having been trafficked. This means that if a child is identified as having been internally or externally trafficked into Kent s/he will be allocated an advocate on an alternate basis in order to compare outcomes for YP with those without. This is a Government funded project in conjunction with Barnardos. The interim report will be available shortly, and the year-long project comes to an end in September 2015.
- Development of a key strategic Action Plan incorporating recommendations from 14 national reports on CSE to ensure Kent response to this issue is based on best practice and lessons learnt from other local authorities, Ofsted and key national research.
- Training of all Social Workers in CSE is now mandatory, and a major training programme was started to ensure that staff from all agencies can access awareness training. This programme is ongoing.
- Central point of access has been established to receive all reports of Missing Children and to ensure that data and intelligence from each episode of missing is recorded and responded to. Procedures are now in place to ensure that every child or young person who goes missing is offered a Return Interview.

## Key challenges for 2015-16

- Continue to focus on the issues in the CSE Action Plan.
- Implementation of the Multi-Agency Child Sexual Exploitation Team and Multi-Agency Sexual Exploitation Group.
- Develop systems to understand the patterns themes, trends of risks of children placed in Kent by Other Local Authorities.
- Address the impact of the increasing numbers of Unaccompanied Asylum Seeking Children who enter Kent to ensure they are safeguarded and supported.

## Missing Children Working Group

**Chair:** Nick Wilkinson, Head of Youth Justice and Safer Young Kent

This Working Group reports to the Trafficking and CSE Group. Its purpose is:

- Ensure there is a robust system for sharing information and ensuring multi-agency planning in respect of all children who go missing from home, care or education in Kent
- Develop mechanisms to collate intelligence around children who go missing from Early Help and Preventative Services (EHPS), Specialist Children's Service (SCS), Kent Police and other relevant partner agencies
- Reduce the number of incidents and number of children who go missing in Kent County Council Reduce the risk of harm to those who go missing and to minimise the risk of child sexual exploitation

### Key activity undertaken by the Group between 1<sup>st</sup> April 2014 and 31<sup>st</sup> March 2015

- Multi-agency awareness raising of issues relating to Missing Children from home, care and education through training course, both face to face and e-learning
- Improving multi-agency practices relating to Missing Children from home, care and education through sharing data and intelligence, and encouraging best practice from learning from active cases
- Promoting the need for every child who goes missing from home or care to have a "Return Interview" undertaken and the findings to be passed to the KSCB for analysis

## Key achievements

- Significant activity by this group has enabled Kent to be in a much improved position to understand and respond to missing children in the county
- Central point of access has been established to receive all reports of Missing Children and to ensure that data and intelligence from each episode of missing is recorded and responded to. Procedures are now in place to ensure that every child or young person who goes missing is offered a Return Interview
- From 5 May 2015 all missing children reports will be received by Central Referral Unit (CRU), who will then allocate as necessary to SCS or EHPS for offer of return interview

## Key challenges for 2015-16

- Embed new ways of working in accordance with KSCB Missing Children procedures
- Ensure return interviews are undertaken and intelligence is gathered to understand risks
- Escalate as necessary the responsibility of other Local Authorities in relation to their missing children

## Education Safeguarding Group

**Group Chair: Patrick Leeson, Education and Young People Services**

The KSCB Education Group provides a forum for schools, Early Help and Educational services, including Early Years to raise awareness of critical issues on the safeguarding agenda. Head Teacher representation is strong and both Independent school and Further Education (FE) College representatives provide a crucial link with these sectors.

The Terms of Reference for the group are reviewed annually and group membership is regularly scrutinised to ensure that the right people are involved. During the last year there have been a number of priority issues on the agenda including Prevent, Child Sexual Exploitation (CSE,) Female Genital Mutilation (FGM) and e-safety, with additional actions arising as a consequence of a range of new guidance published by the Department for Education (DfE) during the early part of 2015. These include revised editions of *Working Together to Safeguard Children* and *Keeping Children Safe in Education*. Additional good practice guidance was developed for Kent schools following the revised publication of the *Disqualification Regulations* under the Child Care Act 2006, which focuses on staff suitability and risk management when safeguarding issues in their personal life have an impact on their professional role when working with children under 8 years of age.

The Education Group provides a termly report to the Quality and Effectiveness (QE) Group that outlines the level of activity in terms of safeguarding consultations, including those involving on-line protection and the training provided for schools and settings. This academic year has seen in excess of 4,000 recorded consultations being undertaken by the Lead Professional and these can range from general policy and procedural advice to specific child welfare concerns or strategic safeguarding queries. The termly Education Safeguarding Newsletter that is circulated to Group members and to schools and settings via the e-bulletin remains the key medium that is used to cascade information and raise awareness about new developments

Safeguarding training is a requirement for schools and settings. Ofsted monitors this during inspections and School Designated Safeguarding Leads must receive updated training every two years to ensure schools are meeting their obligations. During the current academic year the Education Safeguarding Team will have delivered training to more than 2,000 designated staff in schools, in addition to inset or twilight sessions for whole staff groups. In total more than 5,000 education staff will have received safeguarding training this year and this will include numerous bespoke sessions regarding on-line protection.

Education Safeguarding Advisers also commit a number of dedicated days to supporting the KSCB multi-agency training, particularly regarding issues of e safety and child sexual exploitation, which are standing items of the group agenda. Work has also been undertaken in drafting multi-agency good practice guidance on e-safety that will reflect the work of all agencies represented in the KSCB.

The safeguarding support, guidance and training provided to schools leads to a better informed workforce who work within policy and procedures. Consequently children are better protected and this can be evidenced in Ofsted inspection judgements (as reported to QE group). No school in Kent has been found to have inadequate safeguarding arrangements. Further evidence of the voice of the child is provided in the survey carried out with young people by Project Salus whose findings were fed back to the group in 2014.

Child sexual exploitation is another area for particular attention following the Ofsted Thematic inspection of the local authority. Although awareness raising and reference to procedures' tool kit is part of Designated Safeguarding Lead (DSL) training for schools and settings, more attention in the year ahead needs to be given to this initiative.

Training has been taking place to support the four Kent area rollouts of the 0-25 transformation programme. This is designed to develop and improve working practices across the integrated model of Early Help and Specialist Children's Services. A key aim is to ensure that staff are effective in implementing new working practices and expectations, and use effectively the new Kent Family Support Framework (KFSF) forms and tools. This roll-out training is being complemented by a detailed workforce development plan designed to ensure the professional development for EHPS staff, plus focused training on key areas to ensure a skilled and confident integrated Early Help workforce capable of operating a whole family approach.

## Health Safeguarding

**Group Chair:** Sally Allum, Director of Nursing, NHS England: South (South East)

### Key activity for 2014-15

- Review of the Group's Terms of Reference and membership.
- Setting up of the County Female Genital Mutilation (FGM) Working Group, with links to the National FGM Group through NHS England.
- Reporting the outcomes of the CQC Inspections that been undertaken in 2014/15, including updates on progress against the Action Plans.
- Regularly providing the Board with updates from the various Health providers, including Children and Adolescent's Mental Health Services (CAMHS).
- Keeping the Board apprised with the re-structuring of 'Health' across Kent and the South East of England.

### Key challenges for 2015-16

Continued raising of staff awareness of FGM  
Provision of 'health' safeguarding performance data to KSCB

## **Policy and Procedures**

**Group Chair: Tina Hughes, National Probation Service**

### **Key activity for 2014-15**

The Group met more frequently in 2014-15, mainly due to the requirement to review and update all of the Board's Policies and Procedures for publication of the new On-Line Procedures Manual through TriX.

With the introduction of the Business Group, there has been more detailed reporting of this Group's activity to the other Groups and a greater understanding of the areas in which to prioritise the updating of existing policies and the development of new policies and procedures.

The Terms of Reference for the Group have been updated and new representation has been included in the membership.

### **Key achievements**

- Review of all KSB policies and procedures
- Publication of the On-Line Procedures
- Ongoing development of new policies (e.g. working with young people who exhibit harmful behaviour)

### **Key challenges for 2015-16**

In order to ensure that the views and comments of all partner agencies are considered when creating and/or updating policies, it is essential that partners continue to be appropriately represented on this Group.

Due to the increasing overlap of services provided to families, there needs to be a greater linkage between the policies on the safeguarding of children and young people with those on the safeguarding of vulnerable adults.

The Group will continue to review existing policies and procedures, including the Threshold Criteria, and develop new policies in line with changing legislation and guidance.

## KSCB Finance Report

In line with the requirements of Working Together 2015, this report outlines the KSCB financial contributions from partners and its expenditure. Working Together states:

“All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.”

The 2014/15 finances and the projected expenditure for 2015/16 is outlined below.

During 2014/15, contributions from partners reduced to £238k from £250k in 2013/14. This is projected to reduce again in 2016/17. With a total income of £1,090,000 (including the carry forward, base funding and training income) and expenditure of £531k, this ensures that the overall costs of running KSCB were met as they could not have been covered solely by contributing partners. We have recently commissioned three Serious Case Reviews and this has been factored in to expenditure projections for this financial year.

With regard to the reserve, this has been raised with Board members and a programme was agreed on how this reserve is to be reduced. It is projected that, through an anticipation of a gradual reduction in Partner contributions and reduction in grants, the Board should have a break even working budget, with a small reserve to cover the costs of any future Serious Case Review (s) within three years.

## KSCB Annual Finance Report 2014-15

Expenditure	2013-14	2014-15	Projected 2015-16
<b>Staff</b>			
Salaries	294,233.22	362,493.43	347,441.97
Staff expenses	4,479.83	4,940.14	5,765.00
Staff training and development	1,479.24	4,438.64	4,500.00
Equipment	6,491.38	8,460.09	6,050.00
<b>Total Staff expenditure</b>	<b>306,683.67</b>	<b>380,332.30</b>	<b>363,756.97</b>
<b>Business Unit support</b>			
Printing, publications and promotions	1,995.54	7,768.24	7,885.00
Room hire and refreshments – Board and Groups	10,039.66	12,637.48	13,000.00
Stationery	404.85	1,779.74	1,980.00
KSCB website and on line procedures	5,283.50	3,000.00	10,900.00
<b>Total Business Support expenditure</b>	<b>17,723.55</b>	<b>25,185.46</b>	<b>33,765.00</b>



<b>Board expenditure</b>			
Independent Chair	24,325.85	17,016.66	17,800.00
External consultants	8,701.70	5,000.00	5,000.00
Lay members	200.00	200.00	200.00
Case Reviews	6,800.00	9,799.05	60,500.00
Audits	4,518.75	0.00	0.00
<b>Total Board expenditure</b>	<b>44,546.30</b>	<b>32,015.71</b>	<b>83,500.00</b>
<b>Training</b>			
Room hire, refreshments and training resources	5,913.22	24,760.06	35,580.00
Training resources and equipment		2,176.38	2,100.00
External trainers	16,000.00	30,583.38	20,000.00
Annual conference	10,000.00	11,000.00	12,000.00
E-Learning subscriptions	10,000.00	7,294.52	13,705.00
Specialist IT Support	4,269.98	4,056.00	4,537.00
CPD subscription	9,994.00	14,044.50	7,000.00
<b>Total Training expenditure</b>	<b>56,177.20</b>	<b>93,914.84</b>	<b>94,922.00</b>
<b>Total expenditure</b>	<b>425,130.72</b>	<b>531,448.31</b>	<b>575,943.97</b>

<b>Income</b>	<b>2013-14</b>	<b>2014-15</b>	<b>Projected 2015-16</b>
Residual funds	-600,679.08	<b>-686,241.97</b>	<b>-558,502.45</b>
Partner contributions	-250,524.00	<b>-238,124.00</b>	<b>-246,458.00</b>
<b>Total Partner Contributions/Residual Funds</b>	<b>-851,203.08</b>	<b>-924,365.97</b>	<b>-804,960.45</b>
Training Income	-46,158.55	-87,135.00	-85,000.00
<b>Total training income</b>	<b>-46,158.55</b>	<b>-87,135.00</b>	<b>-85,000.00</b>
KCC base funding	-199,000.00	-78,433.62	-98,524.15
Receipts in advance	-15,000.00	0.00	0.00
<b>Total grant income</b>	<b>-214,000.00</b>	<b>-78,433.62</b>	<b>-98,524.15</b>
<b>Total Income</b>	<b>-1,111,361.63</b>	<b>-1,089,934.59</b>	<b>-988,484.60</b>

<b>Total Income</b>	<b>-1,111,361.63</b>	<b>-1,089,934.59</b>	<b>-988,484.60</b>
<b>Total expenditure</b>	<b>425,130.72</b>	<b>531,448.31</b>	<b>575,943.97</b>
<b>Residual funds to carry forward to next financial year</b>	<b>-686,230.91</b>	<b>-558,486.28</b>	<b>-412,540.63</b>

## Partner Contributions 2014-15 and 2015-16

Agency	Contribution	Contribution*
Education Safeguarding	40,167.00	40,167.00
YOS	8,000.00	8,000.00
SCS	40,157.00	40,157.00
Kent Probation Service	6,276.00	6,276.00
Kent Police Authority	47,600	45,934
CAFCASS	550.00	550.00
Connexions (CXK)	0	1,000
Kent CCG and Health partners	90,374.00	90,374.00
Kent Fire and Rescue Service	5,000.00	5,000.00
<b>Total</b>	<b>£238,124</b>	<b>£235,458</b>

\* Estimates

### What next - KSCB Strategic Priorities 2015-18

In developing our priorities for the next three years, the Board, Business Group and groups, held a number of focus sessions to discuss activity and achievements of last year's Plan, current topics and feedback and recommendations from the Peer Review, the Board's Self-Assessment and findings from previous Ofsted Inspections.

The outcomes of the focus sessions were then discussed at the Business Group and presented to the Board. The following overarching themes were agreed:

- Leadership and Governance
- Voice of the Child
- Quality Assurance and Evidence of impact
- Learning from Case Reviews and Child Deaths
- Staff Development

It was also recognised and agreed, that areas of particular interest would also be included. They were agreed as:

- Child Sexual Exploitation
  - \* Missing children
- Early Help
- Children in Need
- Toxic Trio (Domestic Abuse, Parental Mental Health and Parental Substance Abuse)
- Emotional wellbeing of young people
- Sexual abuse
- Gangs
- Prevent
- Female Genital Mutilation (FGM)

A full breakdown of the activity sitting below these headlines can be found at Appendix E.

## Conclusion

During 2014-15, KSCB and our partner agencies have built on the good work from the previous year which saw Ofsted lift the Improvement Notice on the Council (December 2013). The Board has continued with its scrutiny and challenge role through the development of the Business Group and the stricter governance and lines of accountability. The Groups have established a more consistent and stable membership which has allowed them to be more focussed on the key issues, for example, Early Help, 'children who go missing', 'On-Line safety' and FGM. All of these continue to feature in the Board's Strategic Priorities for 2015-18, alongside, Child Sexual Exploitation, Radicalisation, Domestic Abuse and working with parents with mental health and/or substance misuse issues.

The other key area of focus for the Board is not only listening to the voice of the child, but acting on it and evidencing how it is being used to inform policies and procedures and improving operational service delivery.

In 2015-16, there will be a greater emphasis of joined up working with the County's other strategic Boards. We have started to work more closely but the evidence of how this is making a difference is yet to be fully realised.

As has been referred to throughout this report, all agencies are committed to working together to safeguard children and young people of Kent. There will be challenges throughout the year, both financial and operational, but all agencies remain solidly signed up to improving the services that we collectively deliver.

## Appendices

Appendix A	KSCB Self-Assessment 2014
Appendix B	KSCB Peer Review Feedback
Appendix C	Key learning topics from the 2014-15 case reviews
Appendix D	'The sexual exploitation of children: It couldn't happen here, could it? Key findings
Appendix E	KSCB Strategic Priorities 2015-18 - Business Plan

### KSCB Self-Assessment 2014

#### Ofsted General Descriptors

##### Standard:

*The LSCB is able to provide evidence that it coordinates the work of statutory partners in helping, protecting and caring for children in its local area and there are mechanisms in place to monitor the effectiveness of those local arrangements.*

##### Strengths and Achievements

- QE Group has an agreed data set and regular reporting on single and multi-agency audits
- QE meets every other month and reports to the Business Group and full Board
- QE is the group that monitors the effectiveness of local arrangements
- Partners are represented on the QE group
- KSCB is aware of single agency training provided by Education Safeguarding Team and Training lead sits on KSCB L&D group.
- Improvements in Ofsted findings and judgement
- Deep dives into local practice
- Audits of effectiveness of current arrangements.
- SCR analysis
- KSCB undertakes a series of audits both multi-agency and single agency reporting to provide evidence that it co-ordinates the work of partners in safeguarding children and families across Kent.
- The KSCB Business Group is the 'engine room' of the Board; takes responsibility for the business plan and drives forward performance

##### Challenges and area for improvement/consideration

- Greater challenge between partner agencies required at both QE and Board level
- QE does not receive sufficient analysis of intelligence from partners; data rich but information poor; partner capacity issues to supply what is required
- Take up of KSCB training by schools is generally poor. Schools are less inclined to access KSCB multi-agency training as Ofsted only monitor centralised requirements within prescribed timescales.
- Some monitoring still focuses on quantitative, although there is a movement towards qualitative. Further qualitative measures need to be developed.
- Concerns about lower take up of sexual abuse medicals.
- Pathways for children's emotional health remain complex and, in some cases.
- Training impact measured by post course evaluation, although introduced, needs developing
- Sharing the learning from KSCB groups needs to improve
- Need to evidence of how learning is being implemented
- There is a gap between the KSCB groups and the operational localities
- Holding agencies to account for contributions is a challenge

## **Standard:**

***Multi-agency training in the protection and care of children is effective and evaluated regularly for impact on management and practice.***

### **Strengths and Achievements**

- KSCB has a significant multi-agency training programme
- An impact evaluation programme is being implemented
- NHS Providers recently provided evidence as part of KSCB assurance exercise on the implementation of SCR recommendations. Providers were required to provide evidence of how they monitor that training changes practice.
- Recent changes by KSCB to promote experiential learning have been met positively by those involved.
- Training programme is comprehensive and responsive to local needs i.e. SCR findings.
- Full calendar of various pertinent topics at different levels.
- College of trainers monitored and supported by the Learning and Development group

### **Challenges and area for improvement/consideration**

- Embedding of post course practice impact evaluation across all agencies
- Partners may not be able to access training
- The work of the training and development sup group may benefit from wider coverage at practice level.
- There remains a challenge in making training more accessible.
- Evaluation quality and review of the training content needs to be kept under constant review and reflect organisational changes

## **Standard:**

***Policies and procedures in respect of thresholds for intervention are understood and operate effectively.***

### **Strengths and Achievements**

- Threshold document is published on KSCB website.
- KSCB deliver stand-alone multi-agency threshold training
- Thresholds are also included in all KSCB multi-agency training
- KSCB audit thresholds regularly and staff understanding of them are a common thread in all KSCB audits
- Eligibility Criteria and its' relevance for referral forms core of DCPC training
- CRU -multi-agency approach to consistent application of thresholds
- Deep dives into use of CRU and CiN Referrals.
- All procedures/policies available on Tri-X and on KSCB website

### **Challenges and area for improvement/consideration**

- Needs more explicit inclusion in each training session aims and objectives
- Capacity to audit topic regularly and cover other areas requiring audit as well

## **Standard:**

***Challenge of practice between partners and casework auditing are rigorous and used to identify where improvements can be made in front-line performance and management oversight.***

### **Strengths and Achievements**

- QE holds multi-agency case audits
- Findings are published on the KSCB Website
- Agencies are required to report against the recommendations
- KSCB audit on an ongoing programme, subject areas driven by priorities/emerging concerns
- The Chair of the QE is a member of the KSCB, attends meetings and represents the directorate – challenge between partners happens here
- There are positive examples of case audit led by the local safeguarding children board.
- In addition to this, the recent KSCB / Health assurance exercise on serious case review implementation identified a significant number of internal audits within health providers which included aspects of multi-agency case working.
- SCR finding shared via multi agency training, briefings and website
- Website
- Clear and transparent processes
- Q&E subgroup receives single agency reports
- There have been “deep dive” audits in the past driven by the KSCB

### **Challenges and area for improvement/consideration**

- Greater evidence is required to demonstrate that all agencies take the findings from audits seriously
- Partner capacity to undertake audits as required
- Challenges may not be made formally / followed through fully / updated regularly
- Although increase in escalation re challenge of threshold decisions evidence of some cases not being followed through fully.
- Ensuring the findings of the audits are published and lessons learnt disseminated to all agencies.

## **Standard:**

***Serious case reviews, management reviews and reviews of child deaths provide learning and feedback opportunities to the local authority that drive local improvement.***

### **Strengths and Achievements**

- Case reviews are undertaken in line with guidance
- CDOP have monthly meetings to look at all child deaths and report on patterns/themes
- Findings are published on the KSCB website
- Learning from both Case review and CDOP are included in the KSCB training programme
- Information is disseminated via safeguarding leads
- Revised process for reviewing cases is more streamlined and effective.
- The role of the Case Review group has been developed to include more authority to ensure that learning is implemented.
- The interactive training provided by KSCB provides greater insight and understanding in relation to complexities faced by practitioners and information sharing.
- The KSCB is willing to consider other methodology for learning alongside more formal SCR processes. This continues to be developed.
- SCR findings published on website in prominent place and advertised
- Briefings and agency responsibilities clear and transparent
- Themes from SCR’s picked up for wider training offer such as Child Sexual Exploitation
- Information is disseminated via safeguarding leads

### **Challenges and area for improvement/consideration**

- Re-occurring themes are still prevalent
- Many lessons from SCRs have been consistent over the years. The KSCB must ensure that repetitive lessons are covered in regular ongoing audits programmes.
- Further development of innovative training may assist in communicating key messages.
- As many health providers become larger, all health providers must ensure that repetitive lessons are included in regular audit and board assurance.
- Response time from SCR and dissemination of associated training can take a long time.
- Need to review subgroup membership so as to ensure appropriate dissemination and learning can take place
- There is no formal process by which to assess the learning from SCR – feedback from the practitioners.
- The challenges faced by the Group are to decide upon the 'type' of review to undertake in order to maximise learning and provide optimum feedback opportunities for front line practitioners.

### **Standard:**

***The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and delivery of high-quality services.***

### **Strengths and Achievements**

- Role of the QE Group
- QE meets every other month and feeds information out from and up to the Board; QE is the group that monitors the effectiveness of local arrangements; Partners are represented on the QE group
- Safeguarding in Education Advisory group supplies a quarterly report to the Board, via the Quality and Effectiveness Group (QE), informing the Board on matters such as:
- Elective Home Education – including analysis why numbers have increased, ages of children, the vulnerabilities posed, district implications and actions taken to improve outcomes
- Academic attainment of Children in Care (CIC)
- CIC known to Youth Offending service
- Persistent Absence data for all children and CIC
- Permanent Exclusions data for all children and CIC
- Fixed Term Exclusions data
- Complaints received via Ofsted regarding staff/children and what is being done, if they are founded/unfounded, trends, measures in place
- Early Years Ofsted judgements – a safeguarding inadequate rating generally leads to an inadequate rating overall
- Key Ofsted accountabilities
- Priorities of the Safeguarding in Education Advisory Group, actions planned, underway, progress and outcomes
- The overall culture of KSCB has changed considerably over the past couple of years to one where constructive challenge is expected and indeed accepted.
- Systems to evaluate local performance are in place
- The KCSB QE group provides an agreed populated dataset for evaluation at each meeting.
- The QE group requires single agency reporting on a rolling programme.
- The QE Group has agreed for a Peer Review of single agency reporting to provide rigorous evaluation and analysis of local performance
- Section 11 audit cycle in place with direct challenge from KSCB

### **Challenges and area for improvement/consideration**

- More evidence of a robust approach required.
- Reports/meetings lack an analysis of risk, actions underway and planned, and outcomes
- KSCB needs to consider focussing on the quality of safeguarding arrangements in fewer areas of scrutiny.
- The current demand for information from such a wide perspective can be overwhelming for agencies.
- As a result, Reports can sometimes lack effective analysis of risk, clear actions plans and outcomes for children.
- The reporting frequency (quarterly) and pressure to meet deadlines does not allow for reports to be approved by Education Group before presentation at Q&E group as dates of meetings are not co-ordinated to allow for this.
- The loss of KSCB District or Area Forums for multi-agency engagement in the work of the Board has left many professionals feeling detached and isolated.
- Analysis of information can be unclear and focus heavily on SCS performance.
- Types of data whilst plentiful can be difficult to compare because of emphasis.
- Difficult to see how information obtained by KSCB impacts on delivery across a range of services
- The QE group has local reps but their communication outwards is not strong
- Not all lessons learnt are shared to relevant agencies.
- The voices and experiences of children and young do not sufficiently influence & inform etc.



## **KSCB Peer Review Feedback**

**December 2014**

### **Board and Group structure**

#### **Strengths:**

- Restructuring of KSCB at a strategic level has given confidence across partner agencies that it is a multi-agency partnership.
- Belief that the processes are now in place to hold individual agencies to account, but.....
- Positive feedback about the impact of the new Independent Chair and the changes that she has put in place: cooperative nature, facilitative and engaging – universally reported.
- A sense of purpose.
- Stability in place as some core long standing members of the board.
- Good support from Business Unit on key issues, e.g. missing children and young people processes.
- Positive feedback about the Sub-Groups and the work they are doing, but.....
- Business group viewed positively by Group members and chairs
- Challenge log in place to evidence KSCB's challenge to partner agencies.
- Sub-Groups chaired by different agencies.
- Significant financial investment in the Board by partners.

#### **Areas for consideration:**

- Disconnect between strategic level and local/operational districts – concern about the way in which the old district partnerships were disbanded and need to ensure that there is consistency in terms of new arrangements and better communication and feedback up and down.
- Limited evidence of impact of the Board on children and young people's outcomes and practitioners.
- Voice of the child is not evident through the Board's assurance work.
- Lack of understanding of the impact of one area's work on another, e.g. S11 audits and case reviews.

### **Quality and effectiveness**

#### **Strengths:**

- Performance scorecard in place – being monitored through the Quality and Effectiveness Sub-Group with exception reporting to the main Board.
- Multi-agency audit programme in place.
- Some examples of impact at an operational level, e.g. CAMHS, CSE and missing persons.

#### **Areas for consideration:**

- Disconnect between the Business Plan strategic priorities, the performance scorecard and the KSCB structure.
- Lack of buy-in to the scorecard – possibly because it is focused exclusively on specialist services.
- Lack of capacity to do multi-agency audits leading to a 'backlog' within the audit
- Voice of the child and the voice of the practitioner is not reflected in the current performance scorecard.

## **Learning and development**

### **Strengths:**

- Strong focus on learning and development.
- Understanding of the importance of learning and development in driving improvement.
- Service level agreement in place to ensure that learning and development follows in a timely way from serious case reviews.
- Training sessions for Members being organised by the Cabinet Member for Children's Services.

### **Areas for consideration:**

- Learning and development not being seen as driving systemic change – focus currently on upskilling practitioners.
- Lack of medium and long term evaluation of training – limited understanding of the longer term impact of training on practice.

### **Things to drive forward:**

- Maximising the Board's positional power to affect large scale change.
- Multi-agency partnership – engagement.
- Increase the level of challenge to partners from Chair; between the partners and from practitioners' level.
- All partners commit to grow the data set further to reflect the Child's journey through universal, targeted and specialist services.
- Increase the profile of the data at a Board level; understanding of the data, what it tell you and how it is used for evidence based practice at Board or organisational level.
- Develop a portfolio of evidence of impact.
- Strike a balance of the: core safeguarding matter and a focus on a geographic area of policy into practice.

### Key learning topics from the 2014-15 case reviews:

#### Sexual Abuse

- Understanding of the Sexual Abuse Medical Pathway
- Dispelling the myth that sexual abuse medicals are 'intrusive' processes. Sexual abuse medicals are holistic, supportive, therapeutic and can be reassuring. They are not intrusive, or harmful'
- Insufficient evidence required for Police prosecution does not discount that sexual abuse may be happening and the requirement of ongoing multi-agency safeguarding activity
- Agencies' responses to sexual abuse
- Children cannot make 'lifestyle choices' that result in sexual activity with older men
- Use of social media as a meeting place/contact forum for older men

#### Record Keeping

- Requirement for accurate and timely record keeping, including updating of case management IT systems

#### Child Protection Conferences/Review Conferences

- Staff attending Child Protection Conferences must understand their role at the Conference
- Staff must submit their report in advance of the Conference
- Invitations must be sent to all agencies relevant to the case and a record of who has been invited and responses must be retained
- Where an agency cannot attend, a report MUST be submitted
- Minutes and Actions MUST be circulated to all on the invitation list (not just to those in attendance) in a timely manner

#### Strategy discussions

- Requirement for the appropriate professionals to attend Strategy Discussions, (especially Health where sexual abuse is suspected)
- Appropriate challenges if professional are not present

#### Self-Harm

- The need for early responses to self-harming in children
- Referrals to Early Help and Specialist Children's Services of cases of self-harm

#### Voice of the child

- Where continuing disclosures are being made, this must be recorded and acted upon
- Evidence as to how the voice of the child is listened to and how this has influenced decisions must be recorded

#### Supervision

- Need for more intensive supervision in complex cases

#### Toxic Trio

- Working with adults who have DA/Substance misuse /mental health issues – full consideration must be given to the impact on the children/young people in the family
- Working with parents with learning difficulties - how does this impact on the parenting capacity and how is this considered in the overall assessment.

## **Working with families**

- Respectful uncertainty
- Familial abuse and how this may be covered up within a family setting.
- Dealing with hostile and resistant families
- Ongoing concerns where the father has left the family home and is in a new relationship where there are children
- Reassurance is required as to what is currently happening with siblings.
- That all agencies ensure that faith, belief and culture systems are an integral part of any assessment and service planning.
- It is recognised that stability and consistency of professionals provides a better opportunity to assess and understand changing family dynamics and their impact.
- Where ongoing concerns remain, these should be escalated
- Requirement for pre-birth assessments where there are ongoing issues for older children and mother is pregnant

### The sexual exploitation of children:

#### It couldn't happen here, could it?

##### Key findings

###### Strategic leadership

- Local authorities and their partners are still not meeting their full responsibilities to prevent child sexual exploitation in their area, to protect its victims and to pursue and prosecute the perpetrators.
- They have been too slow to meet their statutory duties, despite being issued with guidance to do so over five years ago. Two of the local authorities inspected do not yet have a child sexual exploitation strategy in place. Half have no action plan.
- Local arrangements, where they do exist, are poorly informed by local issues and self-assessment. They do not link up with other local strategic plans
- Specific training, where it exists, is of good quality and gives staff confidence in their ability to identify and respond to child sexual exploitation. However, it is not always reaching those that need it most.

###### Performance management

- Local authorities are not collecting or sharing with their partners the information they need in order to have an accurate picture of the full extent of child sexual exploitation in their area. As a result, they cannot know whether they are making a positive difference in the prevention, protection and prosecution of child sexual exploitation.
- Not all local authorities and LSCBs evaluate how effectively they are managing child sexual exploitation cases. This means that findings are not used to improve future practice.

###### Raising awareness

- Local authorities and partners are successfully using a range of innovative and creative campaigns to raise awareness and safeguard some young people at risk of child sexual exploitation.

###### Findings from practice

- Local authorities and police do not always follow formal child protection procedures with children and young people at risk of child sexual exploitation.
- Screening and assessment tools, where they exist, are not well or consistently used in some local authorities to identify or protect children and young people from sexual exploitation.
- Plans of how local authorities and their partners are going to support individual children and young people at risk of or who have been sexually exploited are not robust. Plans specifically for children in need are poor. Child protection and looked-after children plans vary in quality. In most of the case files reviewed, there was no contingency plan in place for if the initial plan was not successful.
- Local authorities are not keeping plans for children in need under robust review. This leaves some children in a very vulnerable position without an independent review of their changing circumstances and needs.
- Management oversight of cases is inconsistent and is not strong enough to ensure that cases are always being properly progressed or monitored in line with the plan.
- A dedicated child sexual exploitation team that is solely responsible for the case does not always ensure that children receive an improved service. Where specialist child sexual exploitation support is provided in addition to the allocated social worker, there is more evidence that children are being better supported.

###### Disrupting and prosecuting perpetrators

- Not all police and local authorities are using their full range of powers to disrupt and prosecute perpetrators. Where they are using their powers well, they are effective in disrupting criminal activity. However, low numbers of prosecutions are achieved in comparison to the number of allegations made.

## **Missing children**

- Too many children do not have a return interview following a missing episode. This means that local authorities and police are missing opportunities to effectively protect these children and young people and to gather intelligence to inform future work.
- Local authorities are not cross-referencing information and soft intelligence relating to children who are frequently absent from school with their work with children at risk of child sexual exploitation.
- Even when the correct protocols are used, too many children still go missing.

## **Recommendations**

### **All local authorities should:**

- ensure that managers oversee all individual child sexual exploitation cases;
- managers should sign off all assessments, plans and case review arrangements to assess the level of risk and ensure that plans are progressing appropriately
- ensure that every child returning from a missing episode is given a return interview.
- Local authorities should establish a set of practice standards for these interviews and ensure that these are consistently met. Information obtained from the interviews should be centrally collated and used to inform and improve future operational and strategic activity
- ensure that schools and the local authority cross-reference absence information with risk assessments for individual children and young people
- establish a targeted preventative and self-protection programme on child sexual exploitation for looked after children.

### **Local authorities and partners should:**

- develop and publish a child sexual exploitation action plan that fully reflects the 2009 supplementary guidance;
- progress against the action plan should be shared regularly with the local authority Chief Executive, the LSCB, the Community Safety Partnership and the Police and Crime Commissioner
- ensure that information and intelligence is shared proactively across the partnership to improve the protection of children in their area and increase the rate of prosecutions
- consider using the available child sexual exploitation assessment tools to improve risk assessments of children and young people in their area;
- where these are in place, they should be used consistently by all agencies
- ensure that sufficient appropriate therapeutic support is available to meet the needs of local young people at risk of or who have suffered from child sexual exploitation, including care leavers
- make sure that local strategies and plans are informed by the opinions and experiences of those who have been at risk of or have suffered from child sexual exploitation
- enable professionals to build stable, trusting and lasting relationships with children and young people at risk of or suffering from child sexual exploitation
- consider how effective local schools are in raising awareness and protecting children at risk of or who have suffered from sexual exploitation.

### **Ofsted should:**

- ensure that child sexual exploitation is considered within the safeguarding sections of all future inspection frameworks and across all remits
- continue to sharpen the focus given to child sexual exploitation in all children's services inspection frameworks, including the review of Local Safeguarding Children Boards.

**LSCBs should:**

- ensure that the local authority and its partners have a comprehensive action plan in place to tackle child sexual exploitation
- hold partners to account for the urgency and priority they give to their collective and individual contribution to the child sexual exploitation action
- critically evaluate how effective the activity and progress of each of the LSCB members is against the action plan and publish these findings in the LSCB annual
- ensure that all partners routinely follow child protection procedures for all children and young people at risk of or who have suffered from child sexual exploitation
- ensure that partners meet their statutory duties in relation to children returning from missing episodes where child sexual exploitation is a potential or known risk factor -
- ensure that all partners carry out their responsibilities as defined in the locally agreed threshold document, which sets out the different levels of provision offered to individual children and young people at risk of or who have suffered from child sexual exploitation in the area, based on their individual needs
- ensure that an appropriate level of child sexual exploitation training is available to all professionals in the local area who require it; specialist training should be targeted on those working with children and young people at risk of or suffering from child sexual exploitation; attendance for both should be monitored with follow-up action taken where professionals fail to attend
- evaluate the impact of training with a focus on how it makes a positive difference to keeping children and young people safer
- include information relating to child sexual exploitation activity in their performance framework - this should enable a clear understanding of how prevalent child sexual exploitation is in their area and how effectively agencies are responding

**The government should:**

- review and update the 2009 Safeguarding children and young people from sexual exploitation; supplementary guidance to Working Together to Safeguard Children so that it reflects recent research, good practice and findings from child sexual exploitation reviews and criminal investigations
- develop a national data set that requires local authorities, the police and their partners to report on all prevention, protection and prosecution activity relating to child sexual exploitation in their area to a standard format - this should include information on both missing children and looked-after children moving into and out of the area
- require every police force to collate information specifically on child sexual exploitation, including the number of crimes reported, the level of disruption activity undertaken and outcomes, including cautions and prosecutions.

## KSCB Strategic Priorities 2015-18 - Business Plan

Theme	Ref	Action
1. Leadership and Governance	1.1	Governance arrangements to be agreed between boards with clearly defined reporting structures (Health and Wellbeing Board and Adult Safeguarding Board, Domestic Abuse Strategy Group) in order to scrutinise local arrangements to safeguard and promote the welfare of children and to ensure strategies are effectively coordinated.
	1.2	Ensure appropriate agency membership of Board Groups and required commitment to activity undertaken in that role to demonstrate effective membership
	1.3	Recruit a Board representative from the Voluntary and Community Sector
	1.4	Board members to have a greater understanding of partner agencies' role and responsibilities through a programme of Board members' walkabouts and observations
	1.5	Develop the role of Lay Members to include a remit for bringing the voice of children and young people to the Board
	1.6	Develop the role of the KSCB Business Group to enhance joined up working across all KSCB Group
	1.7	Build and develop a culture and confidence of self-challenge through: Cross Agency Peer reviews Maintaining a 'Challenge Log'
	1.8	Independent Chair to continue the programme of annual one to one meetings with all Board members
	1.8	Develop closer links between front line staff and the Board through wider communication of the role of the Board and publicising its activities and impact
	1.9	Review and refresh the Threshold Framework document in line with the Early Help Strategy with the various levels of intervention clearly described and the types of services available outlined, and assess the outcome of early help services
2. Voice of the Child	2.1	Demonstrate what the Board is doing obtain the voice of the child, including children from Hard to Reach Groups and how it is using their voice to inform the setting of priorities and developing practice
	2.2	Each Agency provides timely reporting that: Evidences what is being done to obtain the voice of the child, including children from Hard to Reach Groups Evidences how Children and Young People's voices are being used in the development of practice and setting of priorities Evidences impact of how this is making a difference and how agencies know
3. Quality Assurance and Evidence of impact	3.1	Agree a KSCB Scorecard that reflects a focus on the 'journey of the child' – (Pre-birth to adulthood) including: Universal, Early Help and Specialist targeted service provision Data and evidence that demonstrates how safe children are becoming
	3.2	Each Agency provides timely reporting to populate the scorecard that: Reflects their key safeguarding issues Includes analysis of data, not just numbers Evidences impact of how this is making a difference and how agencies know
	3.3	Agree and deliver a themed audit programme (including Section 11) focussing on the Board key priority areas and implement audit tools that measures practice and impact, not just process
	3.4	Ensure that the lessons from all audits are published on the KSCB website and communicated to front-line managers and practitioners through effective dissemination and on-going re-enforcement
4. Learning from Case Reviews and Child Deaths	4.1	Review the framework to which reviews are notified to the Case Review Group to ensure that cases submitted contain sufficient information for a review decision to be made
	4.2	Review the review framework to ensure that cases are reviewed in a proportionate manner in line with Working Together 2013
	4.3	SMART action plans to be produced from practice reviews, case reviews and SCRs and the implementation of these plans to be monitored by the Case Review Group and Business Group
	4.4	Ensure that the lessons from all case reviews are published on the KSCB website and communicated to front-line managers and practitioners through effective dissemination and on-going re-enforcement
	4.5	Ensure that reporting and analysis of child deaths identifies themes, patterns and lessons to be learnt and that these are published on the KSCB website and communicated to front-line managers and practitioners through effective dissemination and on-going re-enforcement



<b>5. Staff Development</b>	<b>5.1</b>	Review and implement a multi-agency KSCB Training Strategy that: Embeds learning from Case Reviews, Child Deaths and audits Focuses on the Board's key priority areas
	<b>5.2</b>	Develop and implement a shared training evaluation process that assesses the impact of training on practice and quality assures KSCB training delivery
<b>AREAS OF PARTICULAR INTEREST</b>		
<b>6. Child Sexual Exploitation and Missing children</b>	<b>6.1</b>	Implement the CSE Strategy and Action Plan (that takes in to account all the National Reports and Ofsted Inspection/Review findings) with reporting of progress to the KSCB
	<b>6.2</b>	Establish a Multi-Agency Sexual Exploitation (MASE) group
	<b>6.3</b>	Develop a missing children data base and profile that provides a greater understanding of the links between children who missing and CSE/gangs and other vulnerabilities
	<b>6.4</b>	Develop and implement an E-Safety Strategy that outlines recognition and responses to cases of on-line grooming and the links to CSE
<b>7. Early Help</b>	<b>7.1</b>	Implement the Early Help Strategy with success measures reported to assure Board of its impact
	<b>7.2</b>	Improve partner confidence at lower levels of intervention
<b>8. Children in Need</b>	<b>8.1</b>	Implementation of the 'step up and step down' protocol is being effectively used
<b>9. Toxic Trio (Domestic Abuse, Parental Mental Health and Parental Substance Abuse)</b>	<b>9.1</b>	To develop a joined up strategic approach to working across adult and children service provision
	<b>9.2</b>	Implement a multi-agency training programme that raises staff awareness and understanding of the impact on children and young people in families where the following exists: Domestic Abuse, Parental Mental Health and Parental Substance abuse
<b>10. Emotional wellbeing of young people</b>	<b>10.1</b>	Work closely with the County Health and Wellbeing Board and the Children's Health and Wellbeing Board in the implementation of the Emotional Health and Wellbeing Strategy
<b>11. Sexual abuse</b>	<b>11.1</b>	Implement a multi-agency training programme that raises staff awareness and understanding of: the signs and symptoms of sexual abuse how to respond to allegations of sexual abuse, and the sexual abuse medical pathway
<b>12. Gangs</b>	<b>12.1</b>	To develop a county wide strategic multi-agency response to the increase in gang and youth violence in Kent (using feedback from the recent Ending Gang and Youth Violence Peer Review)
<b>13. Prevent</b>	<b>13.1</b>	Implement the Prevent Strategy in Kent that all agencies sign up to and adhere to their statutory obligations
	<b>13.2</b>	Coordinate and oversee agencies' responses to the strategy
	<b>13.3</b>	Implement a multi-agency training programme that raises staff awareness and understanding of radicalisation on children and young people
<b>14. FGM</b>	<b>14.1</b>	To develop and implement a county FGM strategy that includes: a multi-agency awareness campaign a multi-agency training programme for staff