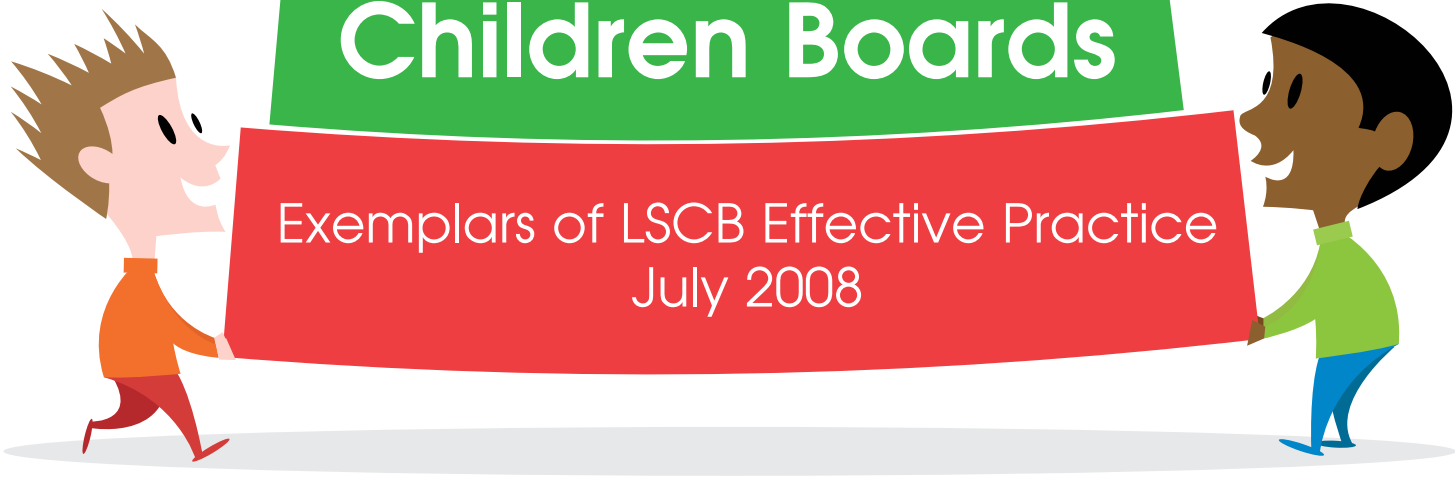
A commitment from
The Children's Plan

Local Safeguarding Children Boards



Exemplars of LSCB Effective Practice
July 2008

department for
children, schools and families

Introduction

The *Local Safeguarding Children Boards: A Review of Progress*, published in June 2007, set out the Government's forward work plan to support the further development and improvement of Local Safeguarding Children Boards. One specific commitment was to gather and share examples of LSCB practice in a way that would help LSCBs grapple with common issues.

The Department for children, families and schools has published two sets of effective local practice.

Part one

The first set of 13 case studies covers a range of areas, from governance and sharing policies and procedures to engaging with partners, that LSCBs had identified as requiring further information and support.

Part two

The second set of eight case studies focus: firstly on, how the child protection system can intervene successfully to safeguard the siblings of gang members; and secondly, on how local services identify and safeguard sexually exploited young people.

These case studies have been collated on behalf of the DCSF from individual LSCBs and provided for information to help LSCBs learn from each other. For further advice LSCBs should refer to the statutory guidance *Working Together To Safeguard Children (2006)* and *The Local Safeguarding Children Boards Regulations 2006*.

This document is designed to be complemented by 'The LSCB Challenge and Improvement Tool', to support the future development of LSCBs.

Criteria for selecting case studies

Where possible, LSCBs were selected from local authorities that had been objectively assessed as high performing with regard to safeguarding children. For example local authorities who were:

- Rated Grade 4 for 'Staying Safe' in the Annual Performance Assessment
- Rated 'Outstanding' for Safeguarding in the Joint Area Review.

However, opinions of the LSCB Business Managers who felt their LSCB had been effective in the practice areas specified were also considered. The aim was to get a good spread across the nine Government Office regions as well as a mix of unitary and county councils was sought.

The process for producing a case study involved:

- Telephone interviews with three key stakeholders within the LSCB. In most cases this involved the Chair and two additional nominated members
- Drawing on the interviews, the production of a draft case study of the LSCB was undertasken. Nominated contacts were asked for comments and amendments; and
- The case study was finalised and agreed with the nominated contact on behalf of his/her LSCB.

Part one
Index of case studies

Part two
Index of case studies

Local Safeguarding Children Boards
Part one

Case Study 1: Birmingham

GO Region: West Midlands

Area of Effective Practice: People Who Pose a Risk of Harm to Children (PPRC)

Supporting Documents: available on request from BSCB

- Review of Licensing Function
- Person Spec – Licensing Officer
- Job Description – Licensing Officer
- T of R BSCB QA&A Sub-group
- Audit and Scrutiny Plan

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In order to be more effective in the area of missing children and people who pose a risk of harm to children, Birmingham LSCB has established a Missing Children's sub-committee. This sub-committee has since developed a set of procedures for responding to children who are missing from school, care and from home. The procedures have increased response times and decreased the number of referrals to the Police and to the Children's Team.

The Process – Missing Children

Under the Area Child Protection Committee, missing children were the responsibility of the education department of a Local Authority, (children missing from school) or by Children's Social Care (missing from home or care). Under the LSCB, which formed in April 2006, a Missing Children's sub-committee formed to respond to the three strands of missing children; from school, from home or from: care. The committee is comprised of representatives from the Police; the Operations Team for Local Authority Residential Care; 'Focus Housing', a local agency engaged in outreach work with children living on the streets; Targeted Family Support Team, Social Care, Education Welfare Service; Barnardo's, and a representative from a local NCH Missing Children's project.

Previously, children in care were reported missing each time they left the care arrangements without consent and the police would not sign off the case until they had seen the child at their care home. This system could not identify between children who had left their place of care without consent to visit a family member or friend, and those who had left for another reason and could be in potential danger. This resulted

in an overwhelming number of referrals for Children's Social Care and Police.

In the new sub-committee a risk assessment tool was developed. The sub-committee opened a dialogue between representatives from West Midlands Police and Children's Social Care about the ineffectiveness of the system. Under the new procedures every child entering care would be assessed as to how likely they were to go missing and the actions to be taken if they did. To identify the risk of going missing, factors such as previous behaviour, history of going missing, age and vulnerability were considered. In an assessment, an agreed time frame was given for when a child would be determined a priority and at risk of going missing. For instance, if a child is young, has never previously been reported missing, or has learning disabilities, they would be treated as a priority by the Police. A photo of the child would be included in the assessment, to decrease the response time to a referral.

The outcome of the new risk assessment tool has been extremely positive. Carol Douch, Head of Safeguarding, states that the police now receive far fewer referrals and therefore are able to prioritise these cases because they are fully aware of the tool and know how a child's case is being prioritised. Anecdotal feedback also suggests that this tool has enabled children who really do go missing to be located and safeguarded faster. Once a child/young person has been located they receive a visit from a Children's Society's independent practitioner. They then discuss with the child/young person the reason for their absence to ensure that there is no concern with the care which is being provided.

The Process – PPRC

The LSCB and the Strategic Multi Area Public Protection Arrangements (MAPPA) board have also developed procedures for managing notifications of persons who pose a risk of harm to children (PPRC).

Previously, the Local Authority Safeguarding Unit would be notified by the Youth Offending Team and Probation each time a PPRC was either convicted of a crime, went to prison, moved or released from prison. The referral would be assessed by a social worker to determine whether this posed a risk of harm to children in the local area. This system resulted in a huge workload and didn't allow time for robust risk assessment or the effective prioritisation of cases.

In January 2006, new procedures were taken forward through the MAPPA meeting. This was attended by representatives from the Youth Offending Team, Probation, Prisons and the Police. Under the new proposals, Probation and the YOT agreed to conduct assessments of persons known to them as to whether they posed a specific risk of harm to children and inform the Safeguarding Team. Within seven to eight months of the initial discussion, the new procedures were piloted and following a successful pilot period, signed off in January 2008.

The new procedures are as follows: Probation may work with a PPRC and receive notification that he/she is moving addresses. Probation are then responsible for conducting an assessment and feeding back to the Local Authority, either stating "*This is an assessment, for information purposes, the offender is a risk but is not in contact with children*", or "*The person is a risk and is in contact with children and you need to do an assessment*". This system has proved successful in terms of determining which cases need to be assessed by the Child Protection Team as a priority. It has eased workloads and led to faster response times for priority cases.

The new procedures were agreed by both the MAPPA board and the LSCB and have been adopted by eleven out of the fourteen other local authorities in the West Midlands region. There is much support for the new way of working in the region; this is largely due to some agencies being co-terminus with all of the authorities, such as the police. Each of the local authorities involved have taken it back to their LSCBs and MAPPA boards to be approved. Those local authorities using the new procedures can customise them to suit their own arrangements including the use of letter templates and proformas.

In Birmingham LSCB, the Safeguarding Unit for the MAPPA boards is responsible for the coordination of this process. The LADO provides a link between the MAPPA board and the LSCB and reports new developments to both Boards. There is a standing item on the LSCB agenda of any changes to the MAPPA. This has been an effective arrangement for ensuring the quality of the work done through two separate reporting procedures.

Case Study 2: Bolton

GO Region: North West

Area/s of Effective Practice: Engaging with Partners: Negotiating funding and developing inter-agency safeguarding guidance – Framework for Action

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Is the LSCB happy to be contacted for further details? YES

Bolton has a positive safeguarding culture borne out of the previously strong Area Child Protection Committee (ACPC) and a clear commitment from partners to the safeguarding children agenda. The LSCB works hard to maintain the commitment of its partners by providing opportunities for networking and development through a number of ways such as annual events and away days. The willingness to attend board meetings and annual events is also supported through the LSCB's clear business planning processes and expectations of members highlighted in membership agreements, the constitution, and clear terms of reference outlining roles and responsibilities.

An annual event is held which is open to inter-agency staff across all agencies delivering services in relation to the safeguarding agenda, e.g. health visitors, hospital staff, frontline police and youth workers. The event is used as a vehicle to communicate the activities of the LSCB and to discuss and set future priorities. Agency representatives are invited to take part in workshops covering various areas relevant to the effective operation of the LSCB; such topics include, for example, revising inter-agency guidance and procedures with the aim of actively consulting agencies and covering topics such as language, embedding the Common Assessment Framework (CAF) and ways of identifying needs from early interventions.

Awaydays for Board members are also organised to discuss relevant and topical issues and focus on the development of the Board. An example of this is an awayday held in January 2007, attended by all members, to consider and map themes and trends in safeguarding within their host organisations. Attendees were asked to prioritise these and generate the top ten issues emerging across Bolton; the results of which were used to inform the business planning process. Other topics for awaydays have included: effective business planning, resources and increasing financial contributions. The Business Manager is responsible for planning these events.

The LSCB's strong partnership working arrangements have enabled it to work effectively with partners in a number of key areas. The following provides some further information on: Negotiating funding, reviewing the Child Concern Model and launching a Framework for Action.

Negotiating Funding

The idea for a resource audit arose in the early days of the LSCB when it became clear that the budget of the predecessor ACPC was not adequate to support the widened safeguarding agenda. Partners also felt that as safeguarding was a multi-agency responsibility, all agencies should contribute to the LSCB business. Hence the LSCB decided, in September 2005, that rather than manage the resources of the LSCB in a piecemeal way, it would be more effective to develop and conduct an audit process that could be used on a continuing basis to identify the Boards resource requirements. In response to this Bolton carried out a **'cash' and kind' audit** of all contributions made to the work of the Board by each of its partner agencies. This is now used to review and agree financial contributions.

The resource audit was planned and undertaken in September 2005 and was coordinated by the business manager. One of the aims of the audit was to quantify the cost to partner agencies of the time they contributed to the LSCB. Hence partner agencies were given a pro-forma and asked to audit their direct financial contribution and the cost of the time they spent on activities undertaken for the LSCB, such as training and attending meetings.

The findings of the financial audit were presented to Board members at a half day awayday in November 2005. During the awayday, the costs of essential items and necessities were examined, followed by a discussion about who should pay for these essentials. In the past, for example, the cost of conferences and workshops had traditionally been met by the local authority. It was agreed that all the statutory partners would contribute to funding the essential costs. However the focus was as much on maintaining the contributions 'in kind' as on increasing the cash budget and spreading contribution across a wider range of partner agencies.

An external facilitator was used to chair the event. He is known to the LSCB, regularly works with them, and is valued for his local knowledge of Bolton and his familiarity with the local safeguarding processes and staff members. He proved invaluable in facilitating the discussion about financial contributions and in supporting members to identify the Board's essential requirements.

After the event a report was produced outlining the agreed contributions by each agency over a three year period. Due to the expected contribution from each agency being considerably more than previously contributed under the ACPC, incremental increases to contributions over the three years were agreed. The funding model was informed by Working Together. The final report went to the Board to be discussed in June 2006. It was then discussed by each of the individual partner agencies and agreed in October 2006.

The Board agreed to repeat the resource audit at regular intervals: annual auditing was rejected as being too frequent and burdensome and instead a three year cycle of review was agreed. When the next audit is undertaken, in 2011, rather than use a self-reporting form to identify and record individual organisation 'cash and kind' contributions, the Board will establish a set of criteria. This will enable the audit to be more focused, transparent and equitable.

Developing Framework for Action: for all children, young people and families in Bolton

In 2006, Bolton initiated a review of their Child Concern Model. The review included a questionnaire about the Child Concern Model; practitioners from a range of organisations were asked what worked well, what could be changed and what language would ensure consistency across all departments and agencies.

Analysis of the responses identified three key areas for review:

1) thresholds and criteria; 2) 'child in need' meetings; and 3) the consultation process.

In undertaking this work, the LSCB wanted to move away from language of 'child protection' in order to reflect that safeguarding is everyone's responsibility. They were also keen to talk about 'levels of need', rather than 'levels of vulnerability', to place the stress on the fact that all children have needs (to various degrees) and look at how services, parents and carers respond to those.

Throughout the process, inter-agency task and finish groups were involved in leading and developing the Framework for Action. To further inform development, single and inter-agency consultation was carried out with frontline workers at each stage. In addition, participants at CAF training sessions were asked to comment on the Framework for Action, which also enabled links to be made between CAF and safeguarding. The revised document, which is stronger around prevention and early intervention, is now in place.

Safe Recruitment

In addition to the above the LSCB also does some useful work around safer recruitment. The Board led on a significant piece of work around how agencies currently recruit staff and from this made recommendations in order to ensure synergy and consistency across agencies. This process helps to build inter-agency relationships and encourages agencies to look at safeguarding together.

The Impact

- Strong partnership work and clear communication about safeguarding ensures that all partners think about keeping children safe as part of their work in their own area, and becomes 'a golden thread' that runs through everyone's strategic planning.
- The outcomes of the resource audit have been very positive. Due to agencies being involved in the process from the start they can understand the need and logic that underpins it and therefore there is more support and 'sign-up'. As a result of this the budget has more than doubled, with a positive impact on business planning and delivery, as well as the Board now being able to fund additional administrative support for the Child Death Review Panel and for the Board.
- The development of the Framework for Action means that they have procedures and processes in place that are effective; this is evidenced in the increased number of CAFs and young people accessing services. This early identification of needs means Bolton should also see a reduction in the number of children needing protection in the area.
- There is now increased ownership from partners of the safeguarding agenda, particularly from those that hadn't previously thought it was their responsibility, for example: working together around bullying, road safety; away-days have helped broaden responsibility and helped the board to get through broader issues. Partner agencies are now more aware of their roles and responsibilities, and

increased engagement and pro-activity also increases their interest and thirst for knowledge. For example, Environmental Services, which are in direct contact with children but aren't directly providing services in a traditional way (as they are more responsible for buses, health and safety, trading standards), were recently given a presentation about the Framework for Action; this has resulted in them requesting training, further information and an e-learning package on safeguarding.

- Partners are also showing an interest through their increased involvement in projects. The LSCB identified the need to improve their communication about keeping babies safe while they sleep; in response to this they have established a 'Safe Sleeping task and finish' group. The group's aim is to ensure that information about 'safe sleeping' is available in a number of settings, including probation offices, substance misuse services, etc, and that the information is accessible to harder-to-reach families. Workers in these services are also trained to ensure they are giving out consistent messages. Funding for this project was sourced from partners. Partners have also helped to fund other resources such as a 'Learning to Live with your Teenager' handbook.
- Partnership work also helps the business side to progress. A significant impact over the last couple of years is a move towards partners now being more questioning and bringing issues of their own to the Board. They are identifying topics and raising these as issues e.g. trafficking of older teenagers and how that links into existing frameworks and the increasing number of cannabis farms; so that other agencies can be aware of them and think about how they respond.

Key Success Factors

Despite the competing demands on the various partner organisations Bolton feels that there have been few barriers to working in this way. Key success factors of effectively engaging partners were identified as being:

1 Preparation and starting early. This was facilitated by a confident ACPC.

2 All partners engaged in the early and ongoing development of the Board.

3 The continuity of staff members and ability and willingness to learn from events.

4 Getting the right people, at the right level, engaged and ensuring that everyone shares a common language and common aims for safeguarding children. What are we going to do and how will we do it?

Case Study 3: Harrow

GO Region: London

Area of Effective Practice: Clarifying governance arrangements and engaging partners

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Harrow LSCB was established in October 2004 and has worked hard to ensure it links the actions of the LSCB to the Children and Young People Strategic Partnership (CYPSP), whilst maintaining its independence.

The CYPSP has seven sub-groups: one for the five Every Child Matters outcomes and two additional sub-groups, 'Early years and parenting' and 'Children with disabilities' (including learning disabilities). The LSCB has six sub groups, Audit and Performance; Policy and Procedures; Training and Development; Communications; Anti-bullying and a Child Death Overview Panel.

The CYPSP and LSCB are linked by two sub-committees, the 'Staying Safe' subgroup of the CYPSP; and the 'Communications' subgroup of the LSCB. The Communications sub group is responsible for public communication and professional awareness of the LSCB; the newsletter, website and the e-news letter for the partners.

The LSCB has a Developing Quality Assurance programme comprising four main elements: 1) monitoring agreed targets, 2) monitoring the child protection statistics 3) qualitative group analysis of cases and 4) periodic audit.

1) Monitoring agreed targets:
The 'Staying Safe' subgroup was formed in 2005 and links the CYPSP with the LSCB. The Chair is the Social Care Head of Service and members include representatives from health, social care, traffic accident reduction, the voluntary sector and representatives from the anti-bullying subgroup of the LSCB. The group focuses on issues relating to the child population as a whole and has set targets around anti-bullying, accident rates and the high level monitoring of the overall safeguarding agenda. For example, they have set targets for bullying and ensure their progress against these targets is evaluated.

2) Monitoring the child protection statistics:
The Audit and Performance subgroup of the LSCB is responsible for routine monthly multi-agency monitoring of children with a child protection

plan. This ensures action can be identified swiftly to guarantee optimum performance.

3) Qualitative Audit (known locally as 'Open Audit'): 'Open Audit' involves a practitioner making a presentation to a multi-agency audience, focussing on the positive aspects of multi-agency working and the areas for development. This is followed by a group analysis with conclusions and recommendations.

4) Periodic audit:
This sometimes arises out of any of the above, but can also arise as a result of a representative presenting an issue. For example, the quality of communication at the point of referral is critical to the safe and swift transition through the child protection system. The audit and performance subgroup conducted an audit of this through telephone interview and file review. This resulted in a largely positive outcome with some areas for development which were acted upon.

The structure of the CYPSP, the LSCB, and the shared 'Staying Safe' subgroup is crucial to maintaining the independence of the LSCB. The LSCB in Harrow regards itself very much as an independent Board and takes on the role of challenging the CYPSP. This process is facilitated by the Chair of the 'Staying Safe' subgroup being a member of both the LSCB and the CYPSP. This role ensures:

- a continuing link between the LSCB and the CYPSP;
- that the CYPSP is prioritising the safeguarding work of the LSCB in its own work; and,
- that none of its work compromises the safeguarding of children in Harrow.

The Governance Review

Over the last twelve months the LSCB has been holding a "governance review". This has consisted of a 'formal yet friendly' interview between each member of the Board, the Chair, and the Development Manager. During these meetings, they discuss the roles and responsibilities of the Board member, in light of the Constitution, and the feedback mechanisms between the Board member's agency, the Board member and the LSCB. The outcome of this meeting is summarised in a formal letter to the representative and circulated to all members of the Board. According to the Vice Chair of the Board this has been helpful in terms of moving the governance framework from being implicit to being explicit and ensures board members have clarity and guidance around their roles. There is now a feeling that people are better supported and professionally safe. It has also helped to develop a common purpose between partners, that practitioners feel valued and that they are making a worthy contribution to the safeguarding agenda.

Engaging Partners

The LSCB conducts a rolling programme of development for the full Board and for the sub-structure. As well as meeting with individual Board members as described above, Chairs of subgroups meet together twice a year to ensure consistency among the subgroups and to ensure they are working to their agreed business plan.

An away day is arranged for the LSCB every year, and each subgroup spends half a day working out their action plan for the following financial year.

In the summer of 2006, a series of seminars was developed with the aim of promoting awareness of Children's Trust arrangements for Managers. Middle Managers were targeted because they have the most difficulty in getting to events due to imperative operational responsibilities.

The seminars served as a consultation exercise. The communications subgroup of the LSCB picked

up on the misconceptions in the managers' understanding of the new arrangements. They corrected these misunderstandings through the communications strategy. Common misunderstandings included: the Children's Trust arrangements would be a 'tidal wave of change', a completely new system, and that middle managers' jobs and professional integrity would be compromised.

The next event, 'The Children's Trust Arrangements Launch', was planned for May 1st 2008 and will be a celebration of the new arrangements and the progress they have allowed. Children will help to deliver the day, and there will be a talk by the Children's Commissioner.

Culture change

In the days of the ACPC, the statutory agencies involved had difficulties working together due to a series of problems and tensions between the agencies. With the advent of the LSCB a planned culture change programme was undertaken, largely driven by the Chair of the Board and the subgroups.

The structure of the Board meetings was changed to enable a focus on key issues of safeguarding per meeting, and the time spent on the minutes and the business agenda was minimised. This was backed up by developing consensus throughout the partnership on areas requiring attention, and by excellent administrative support. Partners were provided with briefings on each agenda item prior to meetings to ensure they were prepared for the discussion and had an opportunity to discuss with their sphere of influence.

Promoting the broader agenda for the LSCB has been a real challenge for everyone. It has involved stretching capacity and resources and thinking across the agencies to encompass issues such as e-safety, anti-bullying, accident prevention and developing a personal, social and health education (PHSE) program for children in primary schools using www.missdorothy.com materials. The LSCB aims to educate a generation of young people on how to stay safe.

The Impact

The governance review has enabled the LSCB to secure commitment from Board members. Attendance is monitored closely and if a Board member does not attend and sends apologies, the LSCB e-mail the individual on the day to offer support to attend the next time. They aim to make members attendance as easy and comfortable as possible by providing first class administration, briefings in advance and ensuring they consider everyone's views during the meeting. This is helped by ensuring the agenda is about decisions only that group can make, and is not overly bureaucratic. Agenda setting is therefore an important process. The LSCB meetings are not unreasonably long, are chaired well and there is realism about what is achievable.

Part of both the change process and symbolic of the culture change has been the development of their own strap line: "*Analysis for learning not investigation for blame*". This tag is a public declaration of culture change and a tool by which members can hold each other to account. Board members have a sense of belonging to an umbrella culture, where challenge and even conflict is an inevitable part of multi-agency working and difference, but it is how they manage that together that really counts. This is a phrase used often by members in order to indicate their sense of trust.

Case Study 4: Kent

GO Region: South East

Area of Effective Practice: Governance: Linking with Children's Trust and the wider LSP

Supporting Documents:

- KSCB Constitution: available on request from KSCB
- KSCD Structure Chart: available on request from KSCB

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Kent Safeguarding Children Board's (KSCB) Constitution and Governance arrangements were developed during their transition from an Area Child Protection Committee to an LSCB in late 2006. This transition was used as an opportunity for partner agencies to identify what would be different as an LSCB and how they would deal with a multi-agency safeguarding children agenda.

This process helped to better engage its thirty seven partners, promote the safeguarding agenda, and secure senior staff level commitment.

From the outset the clarity of the governance arrangements was ensured through the use of their detailed constitution. It was felt that if the governance was right at the beginning, the commitment from, and relationships between, partner agencies would develop more effectively. It was equally important to get commitment from those carrying out LSCB votes, e.g Business Managers, to ensure Board members were not dealing with 'lower-end' issues. It was agreed from the beginning that people on the Board would be only those at a senior level.

Kent has a large team of staff carrying out LSCB votes to drive through the safeguarding agenda: a Board Manager at a senior manager's level, a training administrator, a support officer (the Personal Assistant for the Board Manager), three part time support officers in the areas who support the Local Child Protection Committees and a Learning and Development Manager. From April 2008 there will also be: an Allegations Manager; a Child Death Overview Panel Administrator and a Child Death Panel Coordinator.

The Constitution

KSCB's Constitution is a detailed document which sets out:

- the functions, accountability and independence of the Board;
- the remit of activities involved in child protection and in safeguarding children;
- the organisation and membership of the Board, the Executive and the working groups, including the criteria of membership to the Board; Executive and the working groups;
- links to the Children's Trust arrangements;
- links to other bodies and forums, such as the Multi Area Public Protection Arrangements (MAPPA) and the Crime and Disorder Reduction Partnership;
- financing of the Board, where expected contributions are from and the annual budget;
- funding of the Board and the working groups, their terms of reference and the membership.

The Constitution is reviewed every two years to ensure it remains 'fit for purpose'.

KSCB have a Partner Agreement which specifies the responsibilities of KSCB members and the agency nominated representatives on the Board, all of whom are required to sign the document. All partner agencies are required to:

- confirm the nominated partner member meets the member criteria specified in the Constitution;
- commit to attending a minimum of 3 out of 4 meetings of the KSCB in a year (April to March);
- nominate a named deputy who meets the criteria and can attend up to one meeting a year on the member's behalf;
- read all documents prior to meetings and consult with appropriate personnel within their agency as appropriate;
- be available for consultation between meetings to facilitate the business of the Board;
- ensure their agency makes an appropriate contribution to the resourcing of the KSCB; and
- ensure that the reports, policies, procedures and decisions of KSCB are disseminated and acted upon in an effective way within their own organisations.

According to KSCB, the Constitution signified a "*culture shift*" from the ACPC, and ensured that members are clear that "*the safeguarding agenda is all of our business*". The Constitution has had executive strategic sign-up meaning that decisions are 'made and owned' on the Board. All members of the Board know what their roles and responsibilities are because they are clearly laid out in the constitution, they are also clear on how they link back to their own agencies. In addition, KSCB developed a branding and corporate image presented on the Boards website: www.kscb.org.uk. This has facilitated separation from the ACPC; encouraging a culture change of roles and responsibilities and an acceptance of the wider safeguarding agenda, instead of simply a change of name from an ACPC to the LSCB.

A clear constitution and governance structure is deemed very important in a county as large as Kent. The KSCB has 37 partners which could potentially make work in the meetings overwhelming. Kent has put a lot of effort into making the Board work effectively, ensuring it is not overcome with information by making the meetings very focused on the priorities agreed in

advance through the Business Plan. The meetings work to a clear and focussed agenda, this involves a lot of pre-meeting work by the Board Manager and others but is a way of ensuring that the Board deal with the high-level work they should.

If a full agenda is likely the Board schedules a number of half-day workshops before the Board meeting to consider the additional items. This allows extra time for Board members to consider and discuss the various issues. The Vice-Chair of the Board stated, "*Our agendas are full and so we need more time to ponder things over and these are a good way of taking more time than the average meeting*". An example of when this is necessary is when considering how to engage young people. This is a new issue for the Board and therefore extra time is needed to consider how they are going to effectively carry out their responsibilities in this area.

Limited capacity is also overcome by ensuring members' LSCB roles and responsibilities are built into their job descriptions, particularly in terms of required time commitments. For example, in the designated nurse's job description, it is stated that he/she is required to work with the KSCB to help deliver its programme. This gives him/her 'ownership' of the Board and ensures that he/she has appropriate capacity with his/her role.

Capacity is also an issue in the subgroups; this is dealt with through the effective prioritisation of the workload. One way to make sure people have capacity in addition to performing their normal 'day jobs' is to set activities in a time limited fashion. If the sub-groups are clear that a task is time limited, focused, and outcome expected, then members are more likely to deliver. Another way that the capacity issue is dealt with is through "project work" and using examples of good practice from elsewhere. For example, KSCB have found it useful to approach partner agencies and investigate the work they are doing in certain areas order to share learning and save time.

As well as issues around capacity, another real challenge to working in this way has been the need to work across the whole breadth of the health agenda, from emergency treatment to preventative care and communicating to all those involved. For example there are over 600 General Practitioners in Kent, which is a huge body to reach. This has been overcome in a number of ways. For example, General Practitioners have been issued with CDs of information of Child Protection to play in their car, agencies now think more laterally about hard to reach groups and emphasise the message that everyone has a duty to cooperate and to understand safeguarding.

Ensuring effective engagement at all levels, especially on the front line, is also a challenge. This can be tackled through the subgroups, making sure people are involved in the LSCB projects, and having multi-agency training which extends far and wide across agencies.

Key Success Factors

- getting the message across that safeguarding is everybody's business. This is enabled by banners and branding;
- clear governance through the constitution and its working groups; and
- good information flow up and down and in between the groups. All the subgroups have someone from the Board sitting on them so there is consistency.

Case Study 5: Leicestershire, Leicester City and Rutland

GO Region: East Midlands

Area of Effective Practice: Shared LSCB and Auditing Performance

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Is the LSCB happy to be contacted for further details? YES

The three local authority areas of Leicester City, Leicestershire, and Rutland share one LSCB, covering a population of over three million. The development of a shared Board was initiated by a history of the three local authorities successfully working together when they were covered by two Area Child Protection Committees (ACPC) (Leicester City ACPC and Leicester County and Rutland County ACPC), which shared sub-committees and procedures (with the exception of the Serious Case Review sub-committee).

The Process

Joint working is supported and considered to be an effective way of meeting the needs of the areas. There was subsequently a lot of support for the idea of a shared Board; particularly from: Health; Probation; Police and the Mental Health Trust that cover all three local authority areas.

A steering group was responsible for the development of the shared LSCB. The steering group was made up of: the Assistant Directors for Leicester City, Leicester County and Rutland County Council; the Independent Chair of the LSCB (who was then the independent Chair of the ACPC), the Service Managers of Safeguarding for Leicester County Council and Leicester City Council, and representatives from the Police and from Health. The group met approximately six times between 2004 and 2005 and tasks were split equally between the local authorities.

Resourcing the Board

The LSCB has an Independent Chair, Glenys Johnston who is supported by three Vice-Chairs, one appointed from each local authority. Bob Parker from the LSCB states that the benefit of having an Independent Chair is that it allows the LSCB to be independent from the Local Authorities and also allows other statutory and non-statutory partners to feel they are able to get more involved. The Board also has three dedicated full-time officers: one for training support and a practice and performance review officer employed by Leicestershire County Council; and a policy officer, employed by Leicester City Council. Administration support is

provided by Leicester City Council. Independence from all three Local Authorities is ensured by having both an Independent Chair, and also through the Board's dedicated officers operating from the same offices which are separate from the three Local Authorities' premises.

Glenys Johnston, the Independent Chair of the LSCB is the same person who chaired the Leicester ACPC and the Leicestershire County and Rutland County ACPC. The ACPC advertised nationally for an Independent Chair and the two Assistant Directors for the county councils carried out the short-listing and interviews. Glenys was initially recruited on a two-year contract, and this has now been extended on a two year basis since her initial appointment. Deciding to renew the Chair's contract is undertaken in a Review meeting, attended by the Chair and the Vice Chairs of the LSCB. They examine the work and progress of the Independent Chair over the two years, and on this basis a decision is made as to whether to extend the contract.

The LSCB is overseen by the Directors of Children's Services and the Chief Officers and Executives of all the agencies involved in the LSCB. The Directors of the three Local Authorities and the Chief Executive Officers do not sit on the main LSCB, but instead form the Executive Board of the Children and Young People Strategic Partnership in their own authorities. The Independent Chair of the LSCB has a review meeting every six months with the Directors of the three Local Authorities and has a formal protocol to govern the relationship. In this meeting they review the Business plan and annual report, and discuss strategic issues, including the future resourcing of the Board, and how to deal with the increased expectations of LSCBs. In addition the Chair has separate meetings with Directors as and when necessary.

These meetings are also used as a way for the Chair to raise any concerns, such as apparent poor performance of the Board or its members.

The Chair has an annual meeting with the Chief Executives and the Chief Officers of the agencies involved where they discuss the annual report, the business plan and performance management information. According to Glenys Johnston these meetings put the safeguarding agenda at the highest level of all the agencies. They ensure the Chief Officers, Chief Executives and Directors are closely involved and know '*what is going on at the ground level*'.

The aim of the structure is to:

- ensure effective links to the Chief Executives and Chief Officers of all agencies represented on the LSCB and to the Directors of Children Services of the three local authorities;
- maintain coverage of the three local authorities, thereby retaining the advantages of a shared LSCB;
- ensure all agencies can appropriately and effectively discharge their responsibilities for safeguarding and ensure that the LSCB is efficiently and effectively administered.

One challenge of having a shared LSCB is meeting the needs of the divergent communities of Rutland, Leicester City and Leicestershire County Council. This is overcome by keeping mindful of the differing needs of the communities. The Board takes the view that whilst an issue, such as gun crime or drug abuse, may be numerically greater in one area than another, it will still be an issue in any setting. It was pointed out that an issue which affects only a small number of people in a locality can in fact be harder to deal with.

Performance Management Framework

As a way of auditing the performance of the multi-agency aspects of their work the shared Board has developed a Performance Management Framework. A key driver in developing this work was the need to be able to assure Chief Executives and Chief Officers that the LSCB is performing effectively and inter-agency practice is sound. As the Directors of Children's Services delegate the chairing of the LSCB, it is essential they have information to enable them to satisfactorily discharge their statutory responsibilities for the LSCB

The Process

Following the Laming Inquiry and the need for ACPCs to ensure that child protection arrangements were being delivered effectively, the previous ACPCs established, with additional resources authorised by the Chief Officer's group, a Quality Assurance Officer post. Under the previous two ACPCs there was a Quality Assurance sub committee which dealt with case monitoring. Under *Working Together* (2006) there has been a greater focus on 'performance evaluation and monitoring'. Developing these standards has been organised through the LSCBs Quality Assurance (QA) sub-committee.

The QA sub-committee consists of: Safeguarding Service Manager from Leicestershire County Council (Chair of the sub-committee); Head of Inclusion, Youth & Adult Learning, Rutland Children & Young People's Service; Community Paediatrician; Safeguarding Development Officer, Leicestershire County Council; DCI, Leicestershire Constabulary; Senior Evaluation Officer, NSPCC; LSCB Practice & Performance Review Officer; LSCB Policy Officer; Head of Service, Children's Safeguarding, Leicester Children & Young People Service and a Designated Nurse Child Protection / Nurse Consultant. The sub-committee meets six-weekly and works to an agreed business plan that supports the LSCB Business Plan.

The Performance Management Framework was led by the Independent Chair and the Chair of the QA sub-committee. The process involved commissioning the Independent Chair to prepare the framework, taking into account the quality strategy, audit strategy and the standards in *Working Together* (2006) and consultation with the LSCB.

The Members of the QA sub-committee took it to their agencies to be commented on and so the QA sub-committee was assured it was 'workable for all agencies'. Consultation was also undertaken through the Practice and Performance Review Officer approaching performance staff in other agencies, such as the police and health, and seeking their views. The framework was completed and agreed by the LSCB in December 2007 and has evolved over the lifespan of the LSCB. Whilst it was formally agreed in December 2007, parts of it, such as agencies reporting their activity to the LSCB and reporting the numbers of children on the child protection register, had actually been in use for a longer time. Now the framework has 'evolved' to include more comprehensive quality assurance such as how many staff members are CRB checked.

The framework includes: standards and indicators to evaluate the LSCB's own performance; core data to monitor individual agency activity; and, performance and auditing activities to evaluate inter-agency performance. It enables LSCB agencies to ask questions such as:

- how do you know that you do what you say you do?;
- do you know that staff follow procedures? and

- what are the outcomes for service users/ patients/the public?

The framework allows the QA sub-committee to deal with the LSCB's extended remit such as the requirement to audit and evaluate the arrangements made by individual agencies to carry out their activities whilst having regard to the need to safeguard and promote the welfare of children. The framework includes a set of standards for the LSCB to evaluate its work against. In addition, particular agencies will be expected to self-evaluate and audit, using their own standards and then report back to the LSCB annually. In the future the QA sub-committee plans to do more work on implementing action plans for agencies, following the submission of their self-audits.

A function of the framework is also to identify and promote good practice. This encourages staff, managers and service users to view the Performance Management Framework as a positive contribution to service delivery; and regular inter-agency file monitoring, led by the Practice and Performance Review Officer, is carried out by members of the QA sub-committee who examine inter-agency files to identify good practice and areas for development such as training. The outcome of the monitoring is fed back to the QA sub-committee. According to Bob Parker, the Chair of the QA sub-committee, using the file monitoring process to identify good practice and disseminate is a positive feature of this work alongside the identification of practice that needs to improve.

The Chair of the LSCB believes that a great benefit of the performance management process will be in raising the profile and idea of evaluating services and inter-agency working, with the effect of helping people aspire to achieve. In addition, the performance framework will allow the LSCB to "evidence their performance" to elected members, and executives of member agencies, inspectorates and member agencies themselves. Member agencies identify areas where they are not performing sufficiently well, and work to improve these.

Key Success Factors

- trust between agencies;
- the commitment of the executives of the agencies represented on the LSCB and all members of the LSCB;
- having an Independent Chair who is able to resolve conflict;
- having exceptionally high standards and completing projects and work that has been agreed; and
- having a business plan that ensures that the component parts of each action are delivered across the sub-groups.

Case Study 6: Lincolnshire

GO Region: East Midlands

Area of Effective Practice: Child Death Overview Panel

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Is the LSCB happy to be contacted for further details? YES

Lincolnshire LSCB Child Death Overview Panel (CDOP) has been in operation since January 2007, a year prior to its functions becoming statutory. The CDOP is a subcommittee of the LSCB and reports to the LSCB.

Each year in Lincolnshire, there are around 65 deaths of children under the age of 18 years, roughly 35 aged under one year, and 30 deaths of children aged between one and eighteen years. The process of setting up the CDOP was led by Dr Robert Wilson, LSCB vice Chair, and agreed by the LSCB. Robert contacted all the main agencies, and under the CDOP, they discussed how a child death review should be done and drafted procedures. There had been two suicides of children in the area at the time and the panel decided to use these as pilot cases in order to determine the effectiveness of the newly drafted procedures. These cases fed into the development of the child death review process. Under the child death review procedures, each time a child dies, the main agencies (NHS, Children's Services, Police, and Road Safety Partnership) notify the Chair of the CDOP as soon as possible. The PCT receives a copy of every death certificate and the panel have a complete list of every death in the LA area. Using this list of deaths, the secretary of the Chair of the CDOP sends a standard proforma to each agency, between one and two months after the death. At the same time, the secretary sends a standard letter to the parents of the child to inform them of the process, offering them the opportunity to contribute information to the panel, and offering to provide them with a summary of the findings. The proformas are returned to the secretary, who is a staff member of the PCT, and collated into a single document. The CDOP meets monthly and considers the proformas submitted since the previous meeting. The panel decides for each case whether any further action is required. The criteria they use to decide whether to recommend the need to hold a serious case review is set out in *Working Together* (2006). If they consider that these criteria are met, on cases where a serious case review has not been initiated, they then recommend this action to the chair of the LSCB. For each case they consider

whether there are any recommendations for any of the individual agencies. As every case is very different they don't tend to follow a set checklist, and any recommendations from individual cases are monitored and followed up in the same way as those from Serious Case Reviews.

The Lincolnshire CDOP does not have a parent representative on the panel because of the sensitivity and confidentiality of what they are discussing. The consultation with parents was an important part of the development of the procedures. This was done in the following way:

- the Chair of the panel contacted the Stillbirth and Neonatal Death Society, who then arranged a meeting of bereaved parents.
- fifteen parents attended this meeting where the Chair presented an outline of the proposed child death review process, why it is done, and the relating paperwork including a draft letter that is sent to parents following the death of their child.
- the Panel specifically wanted to find out if parents would want to be told at all about the review, and if so, at what time period following the death of their child. Parents felt that they did want to be told, and that one month after the death would be the appropriate time. Thus, the panel now start the process between 1-2 months following the death of the child.
- parents were also asked if they would want a summary of the findings. They said they would like to access them if available but did not want to be sent this automatically. Thus, the panel inform them that a summary is available on request;
- parents were also given the opportunity to comment on the draft letter and subsequently a number of changes have since been made where they felt the letter was too official.

The overall aim of this consultation process was to ensure the procedures had been designed as sensitively as possible. It was considered to be a success and the parents were pleased with the idea of being engaged and consulted.

Following the feedback received during the consultation process a letter is now sent to all parents involved in child death reviews, which states that they are welcome to contribute any information to the panel and that the CDOP is happy to share information with the parents after the Review.

The main challenge for the child death review panel has been the development of a whole new way of working; nothing comparable had previously taken place for children or adults. The process of obtaining, collating and analysing the proformas took more administration time than had been anticipated. Each agency found it time consuming to pull the relevant case notes and extract the data. Another challenge has been the lack of funding for the child death review process. Funding had to be negotiated for the first year of operation and now comes from the various agencies involved; they have also given a great deal to the process. Up to the time of this study no additional funding had been available for this process; however DCSF & DH have allocated funding from 1st April 2008 which is expected to be sufficient to cover all the costs involved.

The Impact

Although it is early days, the benefits are becoming apparent. Detailed reviews into two suicides of children have been carried out and a number of the recommendations have been implemented or are in the process of being implemented. Some useful statistical information on the causes of death has also been collected.

Case Study 7: Merton

GO Region: London

Area of Effective Practice: Involvement in the development of pan-London Child Protection Procedures

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Is the LSCB happy to be contacted for further details? YES

The London Borough of Merton has been involved in the development of the pan-London child protection procedures. The London Safeguarding Children Board, the organising body for the development of the pan-London child protection procedures, provides strategic advice and support to London's 32 Local Safeguarding Children Boards. Published on-line and in hard copy, the procedures are now in their third edition; they are kept under review and updated by an editorial board made up of both senior managers and policy officers. The editorial board is also responsible for promoting good practice in the use of shared procedures across London.

The Process

When *Working Together* (2006) was revised, the London child protection procedures needed to be updated. An editorial board was established to draft the procedures, receive feedback and consult with each of the LSCBs in London. Merton is a member of the board.

During the height of finalising the pan-London child protection procedures, the board was meeting weekly. The board now meets monthly but this can change depending on the workload. Draft procedures were sent both to the London LSCBs and to forums of professionals who were asked to comment from their own professional and organisational point of view. For example, there was a health forum, which consisted of designated and named nurses across London. There is also a health representative on the editorial board. Some examples of the issues covered by the procedures include: bullying, domestic violence, information & communication technology based forms of abuse, children not attending school, sexually active children and privately fostered children.

The pan-London child protection procedures have now been published, but the process of amending and updating them is on-going. Typically this involves the editorial board drafting revised or new procedures and then sending

them to each of the LSCBs in London for comment. The comments are then considered, amendments made and sent to each of the LSCBs. It is up to the individual LSCBs across London to endorse and formally approve them.

The length of time required to draft a new, or amend an existing procedure varies. For example, with more complex issues such as female genital mutilation, more interest is generated and many more responses received as part of the consultation process. Similarly, when working with sexually active children it took a long time to get agreement as there was a debate about how to balance the need for children to receive advice and possibly contraception at the same time as safeguarding their welfare (e.g. from sexual exploitation) and requirements to report a crime (i.e. underage sex).

When the draft procedures are circulated to the LSCBs the editorial board has to be mindful of giving each Board enough time to consult. Typically, each LSCB will have to circulate the drafts internally and schedule them as an item for their own LSCB or sub committee meeting. Due to the varying frequency of such meetings this process can extend the total time required to agree a new procedure. Most procedures will take at least 6 months to get to the final draft stage; final drafts are always circulated to LSCBs in London for final comment.

The editorial board has continuing discussions about which topics should be included in the safeguarding remit, as well as those which would benefit from a pan-London approach, and which are best handled locally. Examples of issues considered are: children in gangs; abuse against animals and begging. Some agencies will request a specific set of procedures to be produced and it is up to the editorial board to decide whether this fits into the safeguarding agenda. Deciding what should be kept local and what issues should be pan-London is not always easy. Generally, however, local procedures build on the pan-London procedures so that local arrangements and contact details are specified. For example, Merton's local arrangements specify the local police telephone number to report missing children, as well as the role of a local voluntary group that supports the follow-up work related to this issue.

In addition to this, the wider remit for LSCBs includes *protecting children from harm and ensuring preventative work to avoid harm happening in the first place* (Working Together 2006, 3.10). Defining this is not easy, but taking a pan-London approach ensures the London LSCBs can consider and recognise what single and multi-agency interventions are required to reduce the instances of children suffering harm at home and abuse (physical, emotional & sexual) and/or neglect in the community.

One of the key challenges to working in this way is often the process of reaching a decision with a large number of individuals involved. This can be overcome by building respect and recognising when compromise is the pragmatic way forward. Another challenge is ensuring that you are reaching all the key stakeholders including LSCBs as well as non-statutory partner organisations. To overcome this, each of the London LSCBs hold briefing sessions to raise awareness of the procedures in an attempt to reach everybody involved in the safeguarding children agenda.

Howard Baines, a member of the Editorial Board and Safeguarding Development Officer for Merton LSCB, notes that there can be "*disagreements and strong opinions*" about what should and should not be included in the safeguarding agenda; however, "*keeping children*

at the centre of all we do has influenced a better focus at times when we might have got stuck."

The Impact

Since the pan-London shared procedures have been in place they have enabled consistency in policies across the various boroughs of London. This is important due to the frequency of cross-borough movement of children; for example, a child may live in one borough, go to school in another and access a health professional in yet another borough. The shared procedures also ensure that there is a consistent message across all the LSCBs, which ensures that children benefit from an assured and consistent response. This also helps with the problem of training a mobile workforce. Hence, if a practitioner moves to a job in another borough they don't need to be retrained in the relevant policies and procedures.

Key Success Factors

- engaging people with relevant expertise and who are involved in making decisions about child protection and safeguarding on a daily basis;
- clarity around government guidance and legislation and how to apply them;
- respect and compromise;
- the success of the procedures has been helped by the true commitment across the 33 London boroughs and partner agencies; and
- keeping children at the centre of the project.

Case Study 8: Newcastle

GO Region: North East

Area of Effective Practice: Governance: Constitution and links with CYPSP

Name of LSCB Case Study Contact: Sue Kirkley

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Is the LSCB happy to be contacted for further details? YES

The initial constitution for the LSCB was drafted by a project group in preparation for its launch. The constitution defines: the roles and responsibilities of board members; the structure of its meetings; funding contributions from partner agencies; the role of the business plan; and how the sub committees will be formed. Critically it also spells out the relationship between the Children and Young People's Strategic Partnership (CYPSP) and the LSCB. The constitution continues to evolve in line with the changing work of the LSCB.

The Process

The project group initiated the work on the LSCB's constitution involving its members in regular set up meetings. The co-ordination of the work was undertaken by the ACPC Business Manager and took into account both the guidance and the requirements of the Children Act 2004.

The constitution requires that the position of Chair of the LSCB must be reviewed annually via a survey of LSCB board members. The first survey confirmed the Director of Children's Services, the previous Chair of the ACPC, as the chair of the LSCB. This position continues to date. This process is designed to ensure that all partners are involved in the process and have equal status on the Board.

Under the constitution, each board member has influence in their own right instead of being a delegate at board meetings. In this way its members "*are there are on the Board in their own right and can challenge without the local authority having the ultimate say*". Similar independence is built into Serious Case Reviews. The Serious Case Review sub-committee has the responsibility to advise the LSCB Chair on when to hold a Serious Case Review. The constitution, developed with the involvement of a solicitor, has helped raise the profile of the Board and get sign up from senior managers. According to the Business Manager for the Board, this enables the constitution to be used as a 'live' operational document.

Implementation of the LSCB was launched at a half day event. Attended by Board members and other partner agencies, it focused on the new and wider responsibilities of the LSCB and emphasised that this was a step change in practice and not a simple re-branding of the ACPC. In the words of the Business Manager, the ACPC was in effect "*formally shut down*".

The relationship between the CYPSP and the LSCB was also clarified. This work was planned and supported by Sue Kirkley, Business Manager of the LSCB and Carol Hambling, Coordinator of the CYPSP. The LSCB is responsible for the safeguarding agenda, has responsibility for any safeguarding issue, and takes responsibility for the Staying Safe outcome in the CYPSP. When individuals happen to be members of both the CYPSP and the LSCB and the meetings fall simultaneously, they are required to give highest priority to those of the LSCB to ensure priority is always given to safeguarding. As Carol Hambling puts it, "*We have to work in partnership, and resources are limited and so this is how we achieve it*". This is formalised in the governance agreement.

The Impact

The fact that the Director of Children's Services chairs both the LSCB and the CYPSP sends a clear message to all partners about the importance of both the work of the LSCB and ensures good working relationships are maintained between the two partnerships. For example, it has helped secure senior management representation on the LSCB Board across the partner agencies. The Director of Children's Services has an education rather than a social work background, so it is seen as even more important that she chairs the board. If she wasn't the Chair, it would be very easy for her not to be involved in safeguarding at all.

The LSCB has a traditional subgroup structure to which, as the safeguarding remit has widened, other groups have been added; for instance those that focus on issues such as childhood accidents, anti bullying and domestic violence. The constitution addresses situations where there is a conflict of interest between the role of the Board member and their role within their organisation. This was experienced in a recent serious case review where there was a conflict for the Chair of the LSCB to represent both the LSCB and Children's Services. At that time it was resolved by the Chair stepping down for a particular LSCB meeting and a police representative stepping into the role of the Chair.

Joint work between the CYPSP and the LSCB is undertaken through outcome improvement meetings, the 'Staying Safe' group and close working between the co-ordinators from both partnerships. The strong connection between the two partnerships ensures that the CYP Plan always has safeguarding as a major focus. Safeguarding is also woven through the other major CYP Plan priorities. For example, all services are required to take safeguarding into account in fulfilling their service transformation pledge. Some initiatives have been shared between the CYPSP and the LSCB. For example, when the common assessment framework was developed, the CYPSP and the LSCB consulted jointly. Joint working continues and ensures that a safeguarding perspective is embedded in all of the CYPSP's work on early prevention. Other joint initiatives include replacing the annual conferences of the CYPSP and the LSCB by a joint conference. Three of the conference's workshops are also dedicated to safeguarding issues.

Key Success Factors

- having clear roles and responsibilities both for the LSCB and for its members;
- having a common chair in the CYPSP and the LSCB who is also an Executive Director;
- ensuring the CYPSP has clearly delineated responsibilities yet works closely together with the LSCB;
- a shared commitment to safeguarding from early prevention onwards;
- high levels of cooperation and an effective proactive Business Manager who spends a lot of time on managing the relations between partners in an open and honest way.

Case Study 9: Portsmouth

GO Region: South West

Area of Effective Practice: Policy and procedures: Co-Sleeping campaign

Supporting Documents: available on request from LSCB

- Portsmouth Compact: Available from PSCB
- Selection of Safer Baby Parenting Leaflet: Available from PSCB

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Is the LSCB happy to be contacted for further details? YES

Changing public attitudes and behaviour on the wider safeguarding agenda: the Co-Sleeping campaign

Portsmouth LSCB's Co-Sleeping campaign was launched in October 2007; it aims to raise the awareness of parents about the dangers of co-sleeping with their babies, and will continue until October 2008. The campaign is a response to findings from a number of Serious Case Reviews (SCR) and work undertaken as part of the LSCB's development of its Child Death Review (CDR) process. Evidence suggested that in a period of seven months, in one geographical area there were 5 deaths of babies in which co-sleeping was as an important contributory factor. In addition, there was a SCR of a baby who died as a direct result of co-sleeping.

Following the SCR, a small group of representatives from the Police, the PCT, midwifery and the Business Manager of the LSCB formed a working group to develop the Co-Sleeping Campaign. This group developed a policy about reducing the risk of co-sleeping which was adopted by the Acute Trust and guidelines for staff to raise parents' awareness of the dangers of co-sleeping.

The campaign was launched at a conference in October 2007 with the aim of stimulating public thinking around the issue. Hosted by the Foundation for the Study of Infant Deaths (FSID) in-conjunction with Portsmouth LSCB, Portsmouth Hospitals NHS Trust and Portsmouth City Teaching PCT and the Hampshire constabulary, it was attended by both health professionals and the public and attracted coverage by both the local press and radio stations.

As well as the conference the campaign has also involved:

- launching guidelines for professionals in the form of a leaflet;

- training of staff to deliver the safer sleeping message;
- designing a leaflet for parents, informing them of the risks of co-sleeping and how to 'create a safe sleep zone';
- packs for new mothers and packs aimed at specific groups of mothers: e.g. teenage mothers and those who are vulnerable due to substance misuse problems. The packs contain bibs with the Safer Co-Sleeping campaign logo on and thermometers for parents to measure the temperature of a baby's sleeping space;
- awareness raising with BME groups and social work groups;
- displaying posters in GPs surgeries, ante-natal clinics and in other public spaces; such as supermarkets in Portsmouth, the local football club and shops which sell equipment and accessories for babies;
- promoting the campaign at an LSP conference in November 2007.

There have been a number of challenges to overcome, for instance the allocation of financial and human resources. There have also been issues around the consistency in staffing, if someone leaves or goes sick, the process can unravel. This can be overcome by ensuring the commitment of the staff and representatives involved. Communication can sometimes be an issue, particularly between people in the LSCB and practitioners on ground level. It is important that practitioners can deliver the message effectively and keep their knowledge up to date.

The Impact

Whilst no formal evaluation has been conducted, early indications suggest that the campaign is successfully raising awareness. All mothers now get a leaflet regarding the dangers of co-sleeping during pregnancy and after child birth. The anecdotal evidence from health professionals, such as midwives, is that there is more parental awareness of this issue than before the campaign started. In addition, there appears to have been a lower rate of baby deaths since the campaign. Before the campaign there were over twenty baby deaths in two years and since the campaign started there has only been one death related to co-sleeping.

Key Success Factors

- good multi-agency relationships. Getting a keen group of people together, early on, who are highly motivated and who are involved because they feel passionately about the issue, not because they have been told to be there;
- effective leadership, someone who '*keeps it going*';
- co-ordination from the LSCB: if the LSCB is involved it means there is '*senior buy in*';
- financial resources are important, but not everything. The co-sleeping campaign has been organised on a budget of only £3,000. The main success factor has been the motivation of the people involved.

The Portsmouth Compact

The Portsmouth Compact comprises a series of standards that enable agencies to check whether they are fulfilling their safeguarding requirements. Originated through the work of the previous Area Child Protection Committee (ACPC) they are viewed by the independent Chair of the Board as a "*Forerunner of the Section 11 guidance*". Whilst section 11 guidance is applicable to selected key agencies, the Portsmouth Compact encourages other agencies to come into the fold and sign up.

The Compact is currently being rolled out in the voluntary and community sectors. Siobhan Burns, Business Manager of the LSCB, is working with schools and voluntary organisations to help them adopt the Compact. This will enable them to use it to monitor activity and progress and identify gaps and ways of how to fill them. Engagement with the voluntary sector is through the local umbrella organisation. Siobhan attends their monthly briefings in order to update them on policy developments and as a vehicle to enable audit compliance.

Portsmouth LSCB intended to have 'audit compliance' for the Compact by spring 2008. Compliance will be checked against a self assessment audit tool which is currently being developed by the Business Manager.

Case Study 10: South Gloucestershire

GO Region: South West

Area of Effective Practice: Developing Shared Procedures: Child Protection

Supporting Documents: www.swcpp.org.uk

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Is the LSCB happy to be contacted for further details? YES

Twelve LSCBs in the South West of England have come together to develop Shared Child Protection Procedures. The idea came from the South West Regional Heads of Social Care Group who had shown an interest in the pan-London Child Protection Procedures (Case Study 7). The aim of developing the procedures in the South West has been to facilitate the pooling of resources, to encourage the sharing of effective practice across the LSCBs, and to better protect children and young people across Local Authority boundaries. The procedures are published on a website in order that they are always contemporaneous and are intended to be jargon free and accessible to professionals, parents and children and young people.

The Process

The development of the shared procedures was led by Ruby Parry, the then Vice Chair of South Gloucestershire LSCB, but was very much a joint initiative between the Heads of Children's Social Care from the local authorities in the South West. A steering group was set up in March 2006 to oversee the joint development work. This group is made up of 15 members including: Ruby Parry, Chair of the Shared Procedures group; Sean Tarpey, South Gloucestershire LSCB Business Manager, representatives from Children's Social Care, Community Child Health, Connexions, Education, a designated doctor and the Police. From the outset, the group were clear about who they were representing, for example, whether it was their area or their organisation. It was also agreed that each Local Authority would contribute an initial £3,000 to the project and that South Gloucestershire would host the work.

Following a tendering process, the shared procedures group commissioned Reconstruct, a children's services focused consultancy firm, in June 2006 to assist with the development of the procedures. The steering group had its first meeting with Reconstruct in September 2006; they initially concentrated on drafting the

procedures based on Chapters 5 and 6 of *Working Together* (2006). A conference was then held in October 2007, hosted by the Police, as a way of consulting with staff, members of the LSCBs and practitioners. The conference was used to find out: how far the procedures met their needs; what technical issues might arise; what should be the process for all of the safeguarding boards, agreeing the language and the procedures to be implemented. As a result of this conference, it was agreed that the steering group would act as arbiter. The consultation process ended in November 2006, it involved all 12 LSCBs and local authority areas and resulted in a huge degree of commonality in views. A 'go live' date of Jan 2007 was agreed and the website was launched: www.swcpp.org.uk. There were over 250,000 hits to the website in 2007 and in general terms the procedures cover some 3 million children and young people.

The actual launch of the procedures was phased. In the first instance, the steering group and Reconstruct worked on procedures which focused on preventing harm and neglect and the process used for managing individual cases. The group then moved on to other issues such as 'Managing Allegations' and 'Safer Recruitment'. The procedures are available on a website and are designed to be used by professionals and the public; they contain enough depth to be useful to professionals whilst at the same time presenting the relevant information using jargon free language, so as to be accessible to the public. The website also has built in hyperlinks from the procedures into each of the partner LSCB websites where further local detail can be found.

According to Ruby Parry, Chair of the Shared Procedures Group, gaining adequate representation and support for the idea of shared procedures was facilitated through the '*senior buy-in*' (Heads of Service Group) the initiative had from the beginning. Each of the heads of service in the group identified individuals in their local authority who would be keen to be involved in the steering group; each was able to nominate someone to represent an organisation (such as the police) and an area (e.g. South Gloucestershire). The heads of service were also instrumental in gaining local backing from their LSCBs.

The October 2007 conference helped to raise awareness about the new way of working. As well as showcasing the work of the steering group to date it was used to secure engagement by practitioner level staff. Staff who attended the conference took information about the shared procedures process back to their agencies and LSCBs. The information was then disseminated further and comments fed back to the steering group.

The work on shared procedures is continuing. Following the initial contribution of £3,000 per local authority area, the contribution for this year will be £500 each. This sum will pay for the development of further procedures covering, for example, Serious Case Reviews, Safer Recruitment and Child Death Review Processes as well as another practitioner conference.

The process for updating the child protection procedures and creating additional procedures will entail the following: Reconstruct will write the draft procedures and will consult with the Steering Group; the draft will be added to the website for consultation for a limited time. After the consultation period the draft procedures will go back to the Steering Group for amendment and the amended procedures will then be sent to each LSCB to be signed off. Each LSCB uses their policy sub-group to read, comment on and suggest amendments to the procedures. The

Business Manager in each LSCB is responsible for circulating the procedures to partner agencies and getting them signed off. Ruby Parry, Chair of the Shared Procedures Group, notes that generally there is a great deal of consensus for the procedures. A LSCB has never refused to sign off a set of procedures.

The next phase of this work is to develop a wider set of procedures which cover the broader areas of safeguarding and to begin to incorporate the lessons from Serious Case Reviews, both local and national. On the website, there is a work plan which lists local work in which each LSCB is involved, for example, some are working on domestic violence and others on pre-birth risks of harm. Policy documents from local work are also lodged on the website and users are invited to consult on the documents for a limited period of time. The next step in the development of the shared procedures website is to engage young people and children. As a first step, the on-line tutorial is to be read out in a child's voice. Reconstruct are in the process of engaging with children and young people to get their views about what matters to them if they are subject to, or involved with, the child protection process and what they think works best. The results of this will be posted on the site and be used as a tool to inform the work of practitioners.

There have been a number of challenges in this process. For instance the sheer magnitude of the task; there are so many different professionals and agencies to be involved and managed and this takes a lot of time. It has helped to have a person in post who can dedicate a lot of time to the 'leg-work'. In the case of the South West Shared procedures, Sean Tarpey has been this individual.

Another challenge is the constant 'changing nature of the landscape', and the likelihood of LSCBs interpreting the guidance differently in different areas. It has also been important to have ways of effectively dealing with conflicts and differences of opinion. This has been done by realising that it is impossible to please everyone, but you can find consensus and take everyone with you.

Key Success Factors

- good leadership across the board. The heads of service were important in developing the shared procedures because they were in a position of authority to make decisions;
- good multi-agency networks and the need to know who should be included. Communication is key;
- a capacity to be creative. The involvement of Reconstruct has allowed them to be much more creative and has been of huge benefit;
- a good product! The shared website is an easily accessible repository of information and good practice.

Case Study 11: Torbay

GO Region: South West

Area of Effective Practice: Using a project planning approach to Business Planning

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Is the LSCB happy to be contacted for further details? YES

Torbay LSCB has developed a project planning approach to handling its work in order to gain greater involvement and ownership by its executive members. Prior to this development many executive members engaged with the board as attendees as opposed to acting as fully committed board members.

The project planning approach is used to improve the implementation of the LSCB's business plan. This involves: determining the tasks involved in a project; the resources required; project milestones; and agreeing which member of the board will act as the project sponsor.

The Process

Supported by the Chair of the LSCB, the development of the project planning approach began in 2007 and was led by three individuals: John Edwards, the coordinator of the LSCB; Helen Tune, Chair of the training sub-group; and Anthony Goble, Safeguarding Officer (Education). They agreed to base the new approach on the widely used Prince2 methodology. It was launched at a half day board workshop in autumn 2007 facilitated by a Prince2 Trainer, Paul Bradley, who was involved in project planning work elsewhere in the Local Authority. The workshop was split into two sessions. The first covered the basic principles of project management. The second examined how the project planning approach could be used to scope the priorities within the board's business plan. This focused on the example of delivering multi agency training.

The second session turned out to be critical. It enabled board members to explore the practicalities of what would be expected of them, especially how much of their time this new approach would require. It was emphasised that they would not be doing the bulk of the work but would play a key role as "project champions" or "sponsors" supporting the appointed project managers. The ice was broken when one board member volunteered to be a sponsor. After that other board members also 'warmed' to the idea.

There have been a number of challenges to overcome, in particular resources and especially time. Some members have been unable to commit themselves to any further work; this is

a learning process. It has also been challenging dealing with representatives from partner agencies who also have their own pressures. This is overcome by ensuring members are committed and have safeguarding work built into their role. There is also the worry that people could lose interest in the project planning approach and not stick to the model; however it is hoped that this will be overcome by holding people to account at Board meetings.

The Impact

Each member of the LSCB is now appointed to be the sponsor of a project, responsible for delivering one of the business plan's priorities. Project sponsors are held accountable to the Board and the progress of projects is charted against the business plan. Having Members of the Board acting as project sponsors has resulted in a wider range of agencies dedicating time to the Board's projects and objectives. This in turn has increased multi-agency buy-in. Previously, it had been the Local Authority who was instrumental to pushing forward the agenda; now there is a much more effective multi-agency approach.

The Chair of the Board reports that project planning has shifted the responsibility for organising the work of the board from the Chair to the other members of the board. "*This approach stops it from being a meeting where people just come along and nod their heads and agree and go home again*".

Whilst it is too soon for there to have been quantifiable evidence as to how the project planning approach is impacting on the LSCB, anecdotal evidence from Helen Tune, Chair of the Training sub-group and the project manager of the multi-agency training project, suggests that this approach has made delivery easier. This is largely because it clarifies the processes of a project, structures the work and provides the staff involved with access to a project sponsor who can provide practical support and negotiate with senior staff on their behalf. The transparent and upfront nature of the project planning process also enables all LSCB members to be aware of their roles and responsibilities and what time they are expected to commit to LSCB activity.

Key Success Factors

- understanding the Project Planning model and having the discipline to stick to it;
- commitment and understanding of the Board members is essential; and
- commitment of the project managers; their drive behind a project is essential.

Case Study 12: Warwickshire

GO Region: West Midlands

Area of Effective Practice: Engaging District Councils

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Warwickshire LSCB has been successful in building relationships with the five District Councils in the area and effectively engaging them in the safeguarding agenda. A Joint Protocol on Safeguarding Vulnerable Children has been developed which describes pathways for action in situations when either a Children's Team has identified accommodation issues as a source of concern about a child, or when Housing Officers identify concerns about the welfare of children living in accommodation for which the housing authority is responsible or otherwise involved.

The protocol sets out processes whereby Housing Teams and Children's Teams should approach each other on safeguarding issues. A named Designated Housing Officer (DHO), who will take a lead on child welfare issues, is to be located in each of the District Council's Tenancy and Housing Advice teams. This officer will communicate at an early stage with team leaders in Children's Services over issues concerning the welfare of children which have been raised by housing officers. Team leaders will in turn be able to approach the designated housing officer if a social worker identifies concerns which may be linked to a child's accommodation. The designated team leaders of Children's Teams are the main point of contact for District Council's Housing Officers.

If a referral needs to be made by the Designated Housing Officer to the Children's Team, the Children's Team will assess the referral within one working day and the outcome will be communicated to the DHO who then has the opportunity to clarify the outcome with the team leader. It is intended that this process will minimise situations where there may be disagreement about outcomes and identify a joint approach to managing the situation.

The Process

Work on the more effective engagement of District Councils was initiated following a serious case review involving a very young child. This highlighted the need for improved collaborative working between the housing teams in the

district council and the county council's children's teams. Warwickshire LSCB agreed that this could be best supported by the development of an agreed protocol.

A short term task group was commissioned by the LSCB to take this forward in September 2005. The group consisted of: the Assistant Head of Safeguarding in Warwickshire County Council; representatives from the Housing Divisions of the five district councils in the area, and the Development Manager for Warwickshire LSCB, Dr Vic Tuck, who chaired the group. The group met bi-monthly between September 2005 and September 2007.

The task group consulted with the LSCB, the District Council Safeguarding Forum, a group which has since become a formal subcommittee of the LSCB, and with the Operational Managers Group made up of the managers of the children's teams.

Whilst work on this protocol has now largely been completed, the task group have held back from launching the policy due to a complementary procedure also being developed aimed at vulnerable families with 16-17 years old children. This is currently being developed as part of a Local Area Agreement and the work is being led by one of the district council's housing team. The task group is hoping that the two sets of procedures will be amalgamated to provide a more comprehensive approach.

The policies are expected to be completed by April 2008, consulted upon in May, and launched in May or June 2008. Training for the new protocol will follow in June. Six to eight months after the policy has been launched, the task group expect to re-form to review progress, assess the successes and failures of the protocol, and amend it in light of experience.

Once launched, the training provided on the procedures will be aimed at the designated team leaders from the children's teams and the designated housing officers. This is to ensure the new set of procedures have the desired affect.

Training will include: addressing current issues and problems, the roles and responsibilities of the teams, and enabling each team to understand the other's assessment criteria. According to Vic Tuck, Development Manager for the LSCB, this aspect of the training aimed at understanding assessment criteria will promote an awareness of the other team's policies and help to overcome the feeling from one side that the other is being difficult, or '*dragging their feet*'. The training will also consider the issue of escalation and what actions can be taken when agreement between the housing division and children's team cannot be achieved.

There have been a number of challenges to working in this way. For instance, it was difficult to progress this work until the district councils had identified staff of sufficient seniority to take the safeguarding agenda forward. This was overcome when district councils appointed 'Children's Champions', to take forward the agenda. After some negotiations, the LSCB successfully engaged with the Chief Executives and the Lead Elected Member for Children's issues in each District Council.

The limits of delegated powers have also been an issue, as has ensuring collective understanding of how district councils operate and when they need to get clearance from Elected Members; this has the risk of making planning processes lengthy but is essential to ensure the success of joint plans.

Funding from the district councils has also been challenging. In the LSCB's view, current legislation does not give sufficient support with funding formulae. Warwickshire LSCB has invited the district councils to contribute to the LSCB; they have now noted the request and are taking it through their budget setting processes, before they respond.

Key Success Factors

- the commitment of the district council staff has been essential. There has been commitment not only because the district councils recognise their statutory obligations, but also because they already contribute to the well-being of children and families and are eager to build on this;
- remaining positive in the face of difficulties;
- the training pool, run by an inter-agency training officer. This has allowed staff from partner agencies and district councils to be trained on courses such as "Awareness of Child Protection" and "Safeguarding Children". This system has also allowed district council staff to become trainers, to deliver the training to their colleagues and raise awareness of safeguarding responsibilities.

Case Study 13: Coventry, Solihull and Warwickshire

GO Region: West Midlands

Area of Effective Practice: Shared procedures: Child Death Review Process

Supporting Documents: available on request from WSCB

- Process Flow Charts x 2

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Coventry, Solihull and Warwickshire LSCBs are jointly developing their Child Death Review processes, required under the statutory guidance, *Working Together to Safeguard Children* (2006). They were due to be in place by April 2008. This has been a joint initiative led by the Chairs of the three LSCBs, established with a pooled budget and shared management arrangements with the aim of:

- achieving consistency, meaningful data and economies through the wider application of the processes and cross border working;
- providing opportunities for reciprocal scrutiny of panel outcomes and processes and thus enhanced independence;
- provide a single point of notification of child deaths;
- sharing the development costs; and
- obtaining mutual learning and support through collaborative development.

The Process

At an initial meeting early in 2007 the three Boards agreed in principle to sub-regional collaboration on the development of child death review processes. Planning work started in March 2007, and in April 2007 a multi agency study trip was organised to the USA. The aim of the trip was to learn from their experience of implementing child death reviews and observe how the Child Death Overview Panels were run in different States. A seconded full time project manager was appointed for six months in October 2007. Each LSCB contributes an equal amount to the funding of the post which is hosted by Warwickshire.

A steering group oversees the joint development process. The group comprises of: the three Chairs of the LSCBs and their Business/ Development Managers, representatives from the three PCTs, Directors of Public Health, consultant paediatricians from the three areas,

representation from the two police forces and the NSPCC. The steering group meets bi-monthly and is chaired by the Acting Chief Executive of Solihull Council (also Chair of the LSCB).

Outcomes from the steering group meetings are reported to each of the LSCBs to get feedback; this is then taken back to the Steering Group via the Chairs of the three LSCBs.

The arrangements, processes and infrastructure for the child death review processes have been the responsibility of the Panel Manager, supported by the working group. The working group consists of:

- Chairs of the Serious Cases Sub Committees;
- LSCB Business Managers for Solihull and Coventry;
- LSCB Development Manager for Warwickshire;
- Head of Safeguarding in Coventry;
- Assistant Head of Service, Safeguarding and Quality Assurance for Warwickshire;
- Police Detective Inspectors from Coventry, Solihull, and Warwickshire; and
- Peter Sidebotham, Senior Lecturer in Child Health University of Warwick.

The project manager reports to the working group, which meets every two months to progress the development. The project manager updates the group on progress against the work plan and presents draft documents for discussion. For example, the terms of reference for the Child Death Overview Panels were drafted by the project manager, taken to the working group meeting, discussed and amended by the group and then referred to the steering group for further consideration.

The development work has particularly benefited from access to the expertise of Peter Sidebotham, who is a Consultant Paediatrician and Senior Lecturer in Child Health at the University of Warwick. Peter has led on a national study of the child death review processes, and is a member of both the working group and the steering group. He was particularly active in developing the multi-agency Protocol and Procedures for the Investigation of Sudden Unexpected Deaths of Children drawing on experience of their piloting elsewhere in the West Midlands.

From April 2008, each LSCB will have its own local Child Death Review Panel linked to a sub regional Child Death Overview Panel. A pool funded Panel Manager is to be appointed to manage the three local panels and overview panel processes. The local panels will meet bi-monthly to consider the circumstances surrounding every child death in that area, and identify whether there were any avoidable contributors to the death as part of the requirement to look at preventable deaths. They also identify lessons to be learnt locally, any emerging themes or issues, and make recommendations for changes to practice. The reports and recommendations will then be forwarded to the sub-regional overview panel.

The sub-regional overview panel will consist of the Chairs of the 3 LSCBs; Director of Public Health or representative; a Coroner or Coroner's Officer; a Consultant Paediatrician (Sudden Unexpected Death in Children Paediatrician); Local Authority Children's Services Representative; Police Child Abuse Investigation Unit; Child Health Nurse; and Neonatology/Midwifery representative. Others will be co-opted as required. Because there are three authorities and LSCBs involved, the identification of specific individuals to fill the overview panel roles is expected to be complex. The result may be a rotational arrangement whereby each area

provides representatives for the panel for a fixed period of time.

The overview panel will meet initially on a six monthly basis with the frequency of meetings being reviewed in the light of experience. The panel will identify: lessons learnt which are relevant to all three areas; sub regional trends; and share good practice between the local LSCBs. This learning will be fed back to the local panels and thence to the relevant agencies, where actions will be agreed. The overview panel may also share its learning nationally.

Each local panel will be expected to submit an annual report to the overview panel with the latter producing an annual sub-regional report for consideration by the LSCBs.

The Panel Manager will ensure that the circumstances of each child's death are entered into a nationally agreed template, and the Chair of each local Child Death Review Panel will complete a report of the panel's findings using the nationally agreed reporting tool: www.ecm.gov.uk/childdeathreviews. The Panel Manager will attend all local and overview panel meetings to advise the panel and support the process.

There have been a number of challenges to working in this way, for example, information sharing in the child death review panels, particularly from health agencies. For health professionals, the statutory requirement for sharing information about child deaths across agency boundaries and across local authority boundaries have been perceived to conflict with those in general use in health. This concern is being addressed by consulting at every level including: Government Office and the Strategic Health Authority; Local Caldicott Guardians; and at the Steering Group. An information specialist at Solihull PCT, with extensive experience of developing multi-agency information sharing protocols, has been tasked to draw up an information sharing protocol specifically to support these child death review arrangements.

The complex nature of developing the child death review process was initially quite daunting for the LSCBs. This was largely overcome by gaining first hand experience of the practice and reality of child death review processes during the visit to America. It was also helped by the commitment to implementation from senior managers and agencies across all three areas.

Key Success Factors

- effective partnership working across the three LSCBs;
- sign up at a senior level across the organisations;
- commitment to fulfilling the safeguarding agenda;
- the '*staying power*' to ensure work is completed; and
- the benefits of learning from experts and academics.

Part two

In-depth case studies of LSCB practice focusing on the areas of: Guns and gangs and child sex exploitation

This second set of eight case studies focuses firstly, on how the child protection system can intervene successfully to safeguard the siblings of gang members; and secondly, on how local services identify and safeguard sexually exploited young people.

Introduction

In order to inform future practice and guidance for Local Safeguarding Children Boards and their partners, DCSF sought to identify evidence of effective local practice on key current safeguarding children issues; firstly, how the child protection system intervenes successfully to safeguard the siblings of gang members; and secondly, how local services identify and safeguard sexually exploited young people.

DCSF commissioned OPM® (Office for Public Management) to develop eight in-depth case studies outlining the different approaches being taken by LSCBs to develop responses to these two important issues.

With regard to work to safeguard children at risk of being involved in gun and gang activity, evidence suggested that the use of the child protection system was variable. Areas were therefore identified which could provide evidence of different approaches being taken using the child protection system to address the needs of vulnerable children and young people. The fully researched examples of effective local practice outlined in this report may be used to share practice among local areas, and will also help inform the development at national level practice guidance on guns and gangs for LSCBs.

Another current priority in child protection policy is to improve local practice and understanding of issues relating to the sexual exploitation of children and young people (including prostitution, but also exploitation more broadly). Prevention, early identification, and action to tackle sexual exploitation of children and young people are key issues in the Government's work on prostitution, tackling sexual violence and abuse and safeguarding children. This is an area in which some LSCBs and their partners are undertaking strong, innovative work. As with the work on guns and gangs, the information provided in the following case studies inform the development of guidance for LSCBs on sexual exploitation.

OPM used discussions with relevant DCSF representatives and LSCB Business Managers to select the following case study areas. In-depth interviews were then conducted with up to five representatives from each of the localities.

Key Messages

As expected the interviews showed that some LSCBs have made more progress in tackling the issue of guns and gangs and sex exploitation than others. In some cases LSCBs had gone so far as developing agreed protocols and procedures. In others however the LSCB had got to the stage of recognising the issue as a priority and was in the process of developing agreed protocols to tackle the emerging problems. Where possible the impact of the differing approaches being taken, has been highlighted though some are more conclusive than others.

Even though various approaches were being taken, some key messages became apparent across the case study sites, these include:

- the importance of **establishing a sound local evidence base** (including anecdotal evidence) to use as a starting point for developing protocols. Whilst LSCBs should learn from each other, being able to ascertain a local perspective was equally important;
- protocols should be used as a means of developing a **consistent and informed multi-agency approach** and should include a strong element for effective information sharing. A consensus and common understanding of the risk factors needed to be agreed early on in the process, as well as the identification of common behaviours that agencies needed to recognise in the children and young people who may be at risk;
- success depended on the agreement across agencies that the issue was one for **prevention and early intervention rather than enforcement**, and that the children and young people were, more often than not, **victims rather than perpetrators of crime**.

Section 1: Guns and Gangs

Case Study 1: Liverpool

Name of LSCB: Liverpool Safeguarding Children Board

Supporting Documents:

- Threshold of Need and Intervention
- Safeguarding Children Procedures Manual

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Context

Following the death of Rhys Jones in the Croxteth area of Liverpool in August 2007, there has been an increased focus on collaborative multi-agency working to address the issue of young people involved in, or at risk of involvement with, gun and gang crime. Whilst practice in the area of prevention has not yet been documented in the form of agreed policies and procedures, the Liverpool Safeguarding Children Board (Liverpool SCB) is fully engaged in local activities to address the problem and the development of a formal policy is high on their agenda.

Gang activity in Liverpool is considered to be distinct to patterns of involvement in other cities such as Manchester. From the experience of partner organisations working with young people across the city, activity appears to be often centred in specific geographical areas where a core group of individuals are likely to be involved. This differs from gang involvement in Manchester, for example, which often involves more people in fringe gang activity with smaller numbers involved in the majority of gang activity. The key activity in the city is centred around the areas of Croxteth and Norris Green.

The Local Response

Liverpool has in place a Joint Commissioning Strategy for gun and gang crime as well as a local action plan in the Norris Green area. There are several streams of work, carried out by Liverpool SCB member agencies, which address children and young people's involvement in gangs and guns across the city. The following provides an outline of such activity and how Liverpool SCB links in with their work.

Joint Agency Groups: Liverpool SCB works closely with a number of Joint Agency Groups as a means of identifying young people at risk of involvement in guns and gang activity.

The Gun Crime Joint Agency Group (JAG) identifies individuals known to be involved or associated with guns in the city through a range

of different processes. Following identification, the families of the young person are contacted and informed of the approach being taken to reduce the risk of further involvement. Children's Services have an important role to play in working both with the children and their families, whilst ensuring data protection safeguards are in place and that children at risk of harm are monitored. In order to build a local presence and create a deterrent to potential gun activity, the JAG is targeting people known to be involved through introducing disruption strategies, such as making firearms less available. This also has the effect of raising awareness that local agencies are aware of those presenting a risk to the community.

Liverpool SCB also works closely with the Crime and Drugs Partnership (CDP) and the Young People Joint Agency Group, both of which focus on children and young people and drug-related crime. This close relationship allows Liverpool SCB to identify young people who are at risk of gun and gang activity through specific behaviours, such as association with known and prolific offenders. Liverpool SCB's involvement with the JAG subsequently enables risk assessment with Children's Services.

The Vulnerable Families JAG is another forum through which children at risk can be identified through several service streams. This multi-agency approach identifies vulnerable young people in households, through school attendance and reports from social workers. Information is then given to appropriate agencies for support to be offered to families

In addition to liaising with JAGs, Liverpool SCB's involvement in the process of licensing also ties in closely with its work to protect children and young people in the city from gun violence. For example, it withholds private hire car licences from people who have a history of serious offences and works with local pubs and clubs on their responsibility to protect children.

Youth participation: Liverpool SCB's communication strategy includes the need for active dialogue with the local community, including talking about gun and gang activity. The Board has therefore recently appointed a youth participation officer to work directly with young people to engage them in the local safeguarding agenda. The aim of the participation officer role is to gather and report on young people's concerns and ideas and talk to them about how to stay safe in the city. This is done through an on-the-ground approach working directly with schools and other youth fora. By employing a participation officer with an understanding of social services, it is hoped that this post will prove a proactive and interactive way of understanding and providing an accurate reflection of young people's thoughts on the risks of harm from gun and gang activity.

Another aspect of the communication strategy will involve the incorporation of young people's ideas into plans for a regular newsletter to highlight what Liverpool SCB is doing to address issues of concern, which will be distributed to both the local community and partner agencies. There will also be a dedicated information telephone number to which young people can text ideas. Ultimately, it is hoped that Liverpool SCB will be able to capitalise on young people's involvement to develop a safeguarding parliament.

Outreach: as a joint venture between the police and children's service, *Operation Street Safe*, is run to approach vulnerable young people on Liverpool's streets identified by officers on patrol. The street patrol meets young people at risk in targeted communities who are then taken to a place of safety and returned to their

families. This fulfils a safeguarding function as well as challenging parental and community responsibilities for the well-being of their young people. Members of Liverpool SCB such as the Youth Offending Team and Barnardo's are then able to take on referrals as a result of the young people identified on the patrol.

Liverpool SCB response

Liverpool SCB has been encouraged to make progress in the area of children and young people's involvement in guns and gangs in response to the Tackling Gang Action Programme (T-Gap) lead by Community Safety and including the Police, Children's Services and other youth agencies. Liverpool SCB acknowledges that effective progress can only be made through *buy-in* from all relevant member agencies; their work is therefore closely related to the T-Gap initiative with Liverpool SCB aiming to ensure that its critical partners are also members of T-Gap. Related to this venture, Liverpool SCB's success has been recognised by the recent Joint Area Review inspection for its positive relationship with partner agencies.

Liverpool SCB intends to discuss preventive measures by drawing lessons from past incidents. In particular, the Child Death Overview Panel will assess support that can be offered to victim's siblings. Liverpool SCB acknowledges that there is a gap in joining up knowledge held by partner agencies about individuals at risk (and their families), for example, there is still a need to bring together information held on extended family members to build a picture of overall risk. Liverpool SCB's approach aims to be preventive rather than solely reactive to fatalities. Liverpool SCB is aware that the young people at risk also include those outside families with pre-existing relationships with the local authority.

Those involved in gun and gang crime are often not known to the police, at which point information sharing and involvement with non-statutory agencies connected to the community becomes more critical, so that a holistic strategy can be developed. Other agencies dealing with the issue of gang and gun violence are also aware that groups and individuals from across the community can be key to tackling the problem. The police carry out focussed work with children and young people after incidents involving gangs and guns, but the faith groups also have a part to play in connecting with the communities affected, in particular due to their presence following young peoples' deaths as a result of gang or gun activity. It is also recognised that faith groups often have knowledge about where violence lies within a community, even if police are unable to charge suspects. A faith group member sits on the LSCB. Community engagement in this context involves working through schools, the church, the police and other groups with a specific influence in the area in order to reach people.

Involving partners across the city is part of Liverpool SCB's strategy to make the board more visible, however they are aware of the need to increase presence among certain community groups. The experience of the Youth Offending Team in developing practice and guidelines for staff at potential risk has precipitated action from Liverpool SCB to build similar guidance.

The Impact

Whilst the LSCB has no formal way of monitoring the effectiveness of the outcomes of its actions on guns and gangs much has been achieved in terms of mobilising organisational and community action. The Liverpool SCB has highlighted the prevention of serious crime

as one of their key priorities over the next 12 months, with the full intention of formalising their approach to further support an effective multi-agency response.

For example, Liverpool SCB recognises that engaging with the community is critical to the success of its work, particularly in local areas where a few very powerful families can intimidate the wider community. For instance, through the youth participation initiative, young people are actively involved in contributing to the local safeguarding agenda. This work has lead to Liverpool SCB creating user-friendly materials which have resulted in an increased percentage of young people attending relevant meetings.

The current effectiveness of Liverpool SCB is also evident in the numbers of engaged individuals from partner agencies and related organisations who want to be involved with the LSCB. This has created a "proactive and vocal" LSCB. The resulting increase in capacity to deal with safeguarding issues is a positive result of the T-Gap initiative and schools outreach work, enabling those dealing with safeguarding on an operational level (such as governors, staff and mentors) to feel confident about talking about the issues, equipping them to deal with it and helping them understand who to contact.

Progress has also been made in raising awareness about the responsibility of service providers with regard to safeguarding. In order to do this, mature relationships must be developed, providing individuals with adequate resources to maximise their contribution to the work of the LSCB and ensure their commitment.

Barriers and Challenges

Liverpool SCB feels that it has been successful in establishing and working towards a **common agenda** with partners. One of the initial challenges has been creating a widespread understanding of the role of each Board member; this has been overcome through the establishment of distinct roles. The LSCB is committed to working together to safeguard children in Liverpool and is planning *Keep Safe* campaigns which will involve young people and their families in all schools in Liverpool to keep children safe.

The issue of problematic young people's behaviour being seen as the **sole responsibility of one or two agencies** has been managed by recognising that successful work with children and young people involves addressing both risk of harm and safeguarding in relation to the same child:

"*We now see that we own a common problem and it's not a police issue or children services issue, but ours jointly – that is our biggest strength*"

Building confidence amongst children and young people is also important so that they feel the issues they face are worthy of attention. Liverpool SCB realises that there are many separate issues which may affect young people being at a higher risk; therefore they must have knowledge of how to get out of difficult situations. The newly appointed LSCB participation officer will collate information relating to all the support available to children and young people who may be a victim of gun crime or be at risk of involvement in gun crime: she will also look at Liverpool's comparator authorities. It is planned that children and young people will have their own safeguarding newsletter and the new LSCB website (children and young people page will have more information to sign post child for support). The Safeguarding and Reviewing Unit also have a vibrant participation group of children and young

people and one of the key questions is what do we need to do to keep them safe.

Differences in partners' governance structures also represent a challenge for LSCB:

"*for example the way the police operate, is slightly different with regard to reporting*".

Key Success Factors

Liverpool's success is shown to be related to the following principles and proven ways of working:

- partners with a **shared vision** and **clear objectives** which are transmitted to the community;
- promotion of a supportive, learning message instead of a punitive focus;
- all agencies take responsibility for guns and gangs by recognising their **interdependency**: "*One factor we still have to crack is how we manage health and safety – staff care has to be critical and joined up. For example, if you involve the police, it's much easier to get involved.*"
- recognise that risk will not be eliminated but it can be managed through **information sharing** to protect children;
- outline **responsibilities** and mechanisms to drive processes of communication and **maturation of relationships**;
- going out into the community; being proactive and visible;
- **capacity building within the community** rather than just talking to them, especially youth;
- move from a purist LSCB safeguarding children agenda to address other issues that affect children's safety (eg. Children of parents involved in gun and gang crime being seen as abuse);
- looking beyond the LSCB as a stand-alone body, such as T-Gap which demonstrates how two powerful groups working together can make a big difference.
- acknowledging work done on the **practitioner level** and not creating special task forces if capacity can be built within existing teams; and
- **an action plan** with a sliding scale, from hard to soft approaches, for CYP at risk.

Case Study 2: Manchester

Name of LSCB: Manchester Safeguarding Children Board (MSCB)

Supporting Documents:

- *Safeguarding Children and Young People at risk of Gang Firearms Activity: MSCB Protocol* Available at: www.manchesterscb.org.uk

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Is the LSCB happy to be contacted for further details? YES

Context

The rise in gun crime in South Manchester is believed to be closely connected with Manchester gangs. In today's Manchester, 'gangs' are groups of youths, who are initially associated with each other because they went to the same school, grew up on the same estates and began committing minor crimes together at a relatively young age. Typically, members of these gangs then progress to becoming involved in street level drug trafficking – often purchasing drugs from established gang members. As a result, they become affiliated to various gangs, gain status and street credibility with their peers and move through the ranks until they become 'active' gang members. The explosion in firearms violence in South Manchester is believed to reflect the rise in the supply and use of heroin in the late seventies and early eighties. The drug trade in the city quickly became an extremely lucrative one and in the early 1980s a 'gang' war started between two groups vying for control of the market in Manchester city centre. In the last ten years, the number of gangs operating in the city has increased threefold. Numerous shootings, fatal and non-fatal, have taken place over the years as the various gangs have clashed over drug territories and other disputes. Many of these were exchanges of gun fire on public streets – some planned and some spontaneous. In Manchester the gangs are by and large home grown and all the gangs operating in South Manchester are multi-ethnic. Although women are not normally used in an 'active' violent role, some are used to hide or carry drugs and are drawn into the gang culture by the lure of money and power.

It is estimated the total cost of gun violence to agencies and the wider economy in Manchester was over £7m in 2002. The youngest victim of gang-related gun violence to date has been a 14-year-old boy, the eldest a 70-year-old woman caught in the cross-fire of a gang shoot-out.

Local agencies recognise that gangs in Manchester are changing in terms of structure and age composition (increase in younger members) and have emphasised the need to change from a strategy that was focused on adult

gangs and enforcement to one that included children and young people and also focused on prevention.

The Local Response

The tragic murder of 14 year old Jesse James in Manchester in November 2006, the increasingly chaotic structure of gangs and the impact they were having on the community at large, led to the Director of Children's Services to ask what could be done in terms of early intervention. An analysis of action by other local authorities showed that few were working on early interventions in gang related activity other than from a narrow reactive child protection perspective. So began a concerted effort on the part of the MSCB to move from a traditional child protection model of safeguarding to a wider approach that takes into account all the factors underpinning gangs and guns.

A decision was made to look at the guns and gangs problem as an explicitly safeguarding issue that directly impacts on the Every Child Matters five outcomes. A multi–agency Short Life Working Group was convened made up of members from the MSCB, Probation, Connexions, Youth Service, and Social work that includes the Head of Safeguarding, Head of Probation, and a Youth Offending Team (YOT) Manager.

There was recognition that there is an increasingly complex overlap where young people involved in gangs and guns were potential perpetrators of crime but also potential victims. Gangs and guns didn't fit into the traditional child protection model: the previous thresholds and definitions of children at risk were established from the point of view of different services, focused on individuals and didn't include the third party/peer threats of gangs.

The MSCB Gangs and Guns Protocol

The Manchester Multi-Agency Gang Strategy (MMAGS), introduced in 2001, led to the Crime and Disorder Reduction Partnership (CDRP) team working solely to tackle the problems of street gangs involved in firearms use. The principal message behind MMAGS is that these problems cannot be dealt with by agencies on their own, and that multi-agency co-operation is needed to reduce the incidence of death and injury through gang and gun crime in the Manchester City area.

In August 2006, MMAGGS delivered a presentation to the MSCB. MSCB in conjunction with MMAGGS then produced the Safeguarding Children and Young People at risk of Gang Firearms Activity Protocol.

The stated aims of the protocol are to:

- ensure accountability, detailing the specific role played by each agency in delivering a co-ordinated response to the cohort;
- identify young people at risk of involvement in anti-social behaviour, emergent criminality and associating with firearms gang activity as an early intervention approach; and
- increase safe choices for young people.

The development of the protocol aimed to plug an early intervention gap with Level Two children defined as needing additional targeted support but who don't meet other agencies' thresholds. They are not committing crime so are not under the remit of the YOT, but these are children of whom a lot of agencies are aware they are at risk and without intervention will probably go on to take part in, probably gang related, criminal activities.

Locating the protocol in the MMAGGS group rather than in a social work oriented and traditional child protection environment has been

the key to the success of the initiative. MMAGGS provided an environment in which a great wealth of knowledge and expertise had already been accumulated in one place. This included: sensitivity to the complexity of the issues relating to gang and gun violence; an appreciation that gang members have the potential to make a positive contribution to society; and an understanding that many of the drivers around involvement in gangs and gun violence are broader social challenges. These include: absent fathers, inadequate parenting skills and lack of choices for young people in a given area. Hence the unit had a head start over other places where staff who are unfamiliar with this type of work often feel ambivalent and lack the confidence required to tackle it.

The protocol comprises three distinct stages: recognition, referral and screening; multi-agency decision making and signposting; and ongoing case management. Children and young people will be referred and become subject to the protocol when a practitioner considers them to be at risk of involvement in anti social behaviour involving group criminality or gun violence. Where the screening process confirms this is the case a multi agency meeting will be convened. Its functions include:

- identifying key contacts and who should act as the Lead Professional;
- initial planning to identify which services are best placed to intervene and the support they should provide to the young person and their family; and
- modifying plans in the light of information shared.

Importantly, the referral that triggers the protocol coming into play doesn't involve families in the first meeting. The reason for this is that issues around gangs and gang violence raise anxiety, even in professionals, and the first meeting is an opportunity to get pre-conceptions and questions out of the way before the parents are engaged. Whilst this goes against the grain of involving families in safeguarding from the start, such are the cultural barriers for practitioners of gaining an understanding into the realities of gang and gun violence that dealing with these before engaging with families is seen as being essential.

Ensuring that children are appropriately referred to the MMAGGS team is central to the new protocol. An example of where this had not previously been happening was in the use of Osman Warnings to children and young people. An Osman Warning is a tactical option for the police and is a result of the Osman Vs United Kingdom case (1998) where an individual was not warned when there was a threat to his life. Had the police done so his death could have been avoided. In the past young people in Manchester have been receiving Osman Warnings from the police without any further interventions being triggered. At a very recent meeting of the MSCB the protocol was amended so that an Osman Warning will result in a referral. It was argued by one interviewee that at the very least an Osman Warning should trigger a CAF and the identification of a lead professional.

Every Child Matters Outcomes

The protocol is at the heart of achieving the five Every Child Matters outcomes. Several interviewees discussed the all encompassing nature of the gang problem in general but particularly in Manchester. For example, in the case of 'staying safe', children being able to play in safe environments is an outcome on which gang activity in a locality will inevitably have a

negative impact. Children won't want to go and play in playgrounds or open spaces when they feel intimidated or at risk. Similarly there is the negative impact on the 'being healthy' outcome from the sheer physical danger of being caught up in gang violence.

The protocol aims to embed an understanding of how a broader safeguarding agenda in relation to gangs and guns across agencies can help to deliver on the five outcomes by practically intervening in cases of young people at risk of getting involved in gang or gun crime.

"*I think during this there has been an ethical, cultural shift in how they are seen – not as gangsters but as children.*"

The protocol was approved by the MSCB and launched in October 2007. All activity related to the protocol is reported to the MSCB and they are kept up to date with its developments. There have been prevention strategies put in place alongside the protocol. For example, the Prevention Work streams of the Violent Gangs Board which is a sub group of the YOT, is particularly engaged with cross border work with Trafford as many of the issues related to gangs do not stay in one locality.

The Impact

The protocol has not been in place for long enough to enable a full evaluation of its impact on outcomes. However, from a service delivery viewpoint the protocol now means that children involved, or at risk of being involved, with guns and gangs who previously did not get a service, are now being supported.

Information sharing between organisations is now taking place at a much earlier stage. However, unless this is handled properly it can work against the interests of a child. For example, when practitioners with little or no understanding of gangs are called into a meeting at MMAGGS about a child at risk there is a danger that they will view that child solely being a gang member rather than also being a child at risk. Schools, for example, need to appreciate that at the stage when the protocol comes into play they are dealing with low risk children and the challenge is managing that risk to keep it low.

One of the next steps in tracking the impact of the guns and gangs strategy will be to incorporate it into the overall performance management framework being developed by the MSCB. This aims to inform the MSCB of what outcomes are being achieved in relation to safeguarding children and young people in Manchester, enabling them to set priorities, identify key themes and drivers across the Board. This is being done in order to try to move beyond operational coordination to workforce training and development needs, changing working practices, horizon scanning and trying to establish the views of children and young people. This aims to help the board to move past just thinking about targets and centrally driven performance indicators to a more cohesive safeguarding strategy that brings all agencies into an effective development programme.

Increasingly the MSCB is bringing their concerns to the attention of key professionals who are able to provide services that are based on an assessment, recognising the risks of children sliding into gang activity but also providing services for younger siblings.

Barriers and Challenges

- **training and workforce development is a key issue and barrier to effective implementation of the protocol**. Between the launch in October of 2007 and January

2008 there were only 7 referrals to MMAGGS. A training session was therefore held at the end of January aimed at providing practitioners with the confidence to make referrals around guns and gangs and also be confident in working with CAFs and the associated risk assessments. Between the training session and the middle of March, 8 new referrals had been received;

- **equipping professionals so they can recognise and respond to gangs and guns**. Trying to get teachers and social workers to understand the complexity of guns and gangs and how it impacts on virtually all areas of life is a significant challenge;
- **intelligence sharing needs to occur more efficiently and actively**. One interviewee gave the example of stop and search. If a police officer stops a young person at 2am in a park – should that not trigger something so that the school are made aware of the potential risk to the child, or even just why they are tired and badly behaved in class;
- **effective implementation of the protocol can also be a barrier** and has come up on a number of occasions. In all multi-agency settings there is good will, and policy and procedures are put into place, but if there is no coherent implementation strategy then the impact will not be felt by practitioners on the ground or by the young people at the heart of the problem.

Key Success Factors

- the practitioner who wrote the guns and gangs protocol was fortuitously positioned in MMAGGS after completing the development of the protocol. This has meant she has been able to work with MMAGGS and **experience the technical and organisational difficulties** at first hand, as well as provide direct help with the operational development of the protocol;
- the **MMAGGS team** in general is perceived as being critical to the success of the protocol and the overall safeguarding strategy. MMAGGS is made up of seconded practitioners from other agencies that bring their expertise and particular perspective with them. There is a seconded prison worker in MMAGGS. This is seen as key, as a lot of young people and adults who are gang members are in and out of prison. The knowledge that someone with experience of prisons and the cultural awareness that brings is another positive aspect of MMAGGS. The existence of MMAGGS shows that joint working and recognising the different contributions that different agencies are making is vital to the success of any partnership working that is aiming to tackle guns and gangs;

  "*There is an absolute acceptance of the need to share intelligence and it is quite groundbreaking.*"
- the fact that there has been so much violence in Manchester has led to a group of **passionate, committed people** staying in key strategic posts long term. This has enabled them to earn respect from practitioners on the ground, young people, families and the MSCB;
- there has been significant and unwavering **support from senior management**. The original work on early intervention was commissioned by the Director of Children's Services and legitimised the need to pull in other services;
- **the need to have the community with you.** Most people in the community know who does a lot of the criminal activity in relation to guns and gangs but will not come forward. The fear runs right through to practitioners

and workers themselves. There needs to be explicit and open opportunities for community leaders to be involved in the process of prevention.

Advice for LSCBs

- there needs to be a culture of **open and honest debate** about what is working and if there are problems they need to be welcomed and tackled;
- **listening to frontline workers and young people** themselves as they know what really works and what really has an impact on the ground;
- you have to **know your own situation** and what you are dealing with. Importing from elsewhere may not always work without placing any strategies in context;
- the **whole family approach is key** – you have to work with them as a full member of a family;
- there is a need to try and **take away the media hype and drama** and to understand what it is that attracts so many young people to this way of life;
- there needs to be an **emphasis around the ECM Outcomes framework** and not just gang related criminal activity.

Case Study 3: Nottingham

Name of LSCB: Nottingham City Safeguarding Children Board (NCSCB)

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Is the LSCB happy to be contacted for further details? YES

Context

Nottingham is a vibrant and diverse city which has experienced significant growth over the last decade. It is a regional capital with a conurbation-wide population of 600,000 and has become a popular place to visit for shopping, business and leisure pursuits. Nottingham, however, is also home to significantly deprived communities often characterised by poor educational attainment, low and unmarketable skills and poor health and high unemployment. As with other major urban areas, crime also impacts on the quality of life of local communities.

Nottingham has recently been a focus of national attention due to a small number of fatalities resulting from gun and knife crime. However gun crime has been reducing. There were 11 recorded shootings in 2005 compared to 42 in 2004. Even though serious violent crime is only a small proportion of all crime, it inevitably attracts a disproportionate amount of media coverage. This has impacted on the reputation of Nottingham. Over the last few years, gun crime has disproportionately affected people from African/Caribbean backgrounds – particularly young men as both victims and perpetrators, in the areas of St Anns, Radford and The Meadows. A significant proportion of the gun crime is believed to be connected to drug-related activities and culture. The gun is used as an enforcement tool for business purposes and can be used to protect territory. As such, it is connected to tensions that exist between key areas of Nottingham. Territorialism has also been in existence and developing for a number of years in Nottingham. It rears its ugly head from time to time through conflicts of varying intensities between people from 'rival' areas – often believed to also reflect a developing "gang" culture. There is a real fear amongst young people of going into 'rival' areas and there is a real suspicion of 'foreigners' in their own areas.[1]

Nottingham recognises that the local gang culture is changing; gang activity in Nottingham shows a changing pattern of children and young people's involvement. Increasingly younger children are actively recruited into gangs,

1 www.supportingcommunities.org

increasing both the prevalence of gang culture and involving children who may have been unlikely to have been involved ten years ago. Nowadays the issue also involves much more diverse communities. With the increased size of the EU and asylum seeking communities in the area comes different issues which Nottingham is getting to grips; for example, not only does the issue now include younger children as mentioned above, but it also includes different gang 'cultures'. Children born in this country have very different perceptions of gang membership; in other countries it's often related to religion, territory issues, honour etc, but for children born in this country, it's more related to disadvantage and what they perceive as being reachable by being associated with or being a member of a gang. Awareness of these challenging issues by key agencies is on the increase in Nottingham and they are learning to deal with them.

The Local Response

Many local organisations and individuals have responded to the perceived and actual problems of gun crime by developing a range of programmes, projects and initiatives. For example, Supporting Communities is one such community sector initiative. They focus on the prevention agenda; aiming to prevent 'at risk' young people from becoming actively involved in violent crime, drug-related crime and territorialism.

NCSCB works to ensure that child protection policies, procedures and practice are coordinated effectively across all partner agencies in relation to children and young people at risk of involvement with gangs and guns. Information from cases presenting potential risk of harm to children and other family members is gathered by NCSCB. However, as the Board recognises that this needs to be supported by a set of common procedures, their creation is now included in the Board's three-year business plan. In addition, NCSCB's work – whilst related to the Crime and Drugs Partnership (CDP) – is not formally linked in the CDP action plan. Whilst a protocol to address cases of violent crime involving gun and gang activity has not yet been developed, it aims to develop a strategy which will be considered as part of its business plan for the next three years. This strategy will consider not only the assessment of risk but also the identification of support for those at risk. A main feature of this will include a minimum dataset in order to inform how systems are planned and delivered in Nottingham in the future.

Nottingham has received national recognition for the progress it has made in encouraging agencies to view teenagers as victims rather than criminals. This has had an impact on the way in which NCSCB approaches children at risk of gun and gang activity. NCSCB is continuing this approach through its member agencies regarding young people as victims rather than perpetrators. The Police have been effective in addressing the harm surrounding influential families involved in significant levels of crime.

Current NCSCB practice uses child protection procedures to respond to individual concerns about children in serious crime cases, such as those involving shooting or stabbing. It is envisaged that current arrangements for the Child Protection Plan will in future come under the safeguarding children information management team, which (with a larger remit) will include the notification and management of particular cases involving children. It is important to note that how the strategy is developed will be affected by both the Children's Plan and the Stay Safe group, producing a holistic and collaborative approach.

The Impact

As the NCSCB developments on guns and gangs are at an early stage of development and implementation it is not current possible to evaluate their impact. However, NCSCB has identified some outcomes that they are looking to achieve:

- reducing the desirability of gang culture for young people. Achieved by providing training to a range of stakeholders, including practitioners within schools as well as those working in the communities such as youth workers and community officers. Engaging families will also play a key role, as will aiming publicity at children and young people. The overall aim is to reduce the pressure from the disadvantage experienced by the children, their families and the community which currently leads children to think they can resolve issues through gang involvement or violent crime. It's about working this into something practical and deliverable;
- ideally there will be a shift and complete eradication of territory-borne perceptions of young people, so that young people see each other as young people rather than postcodes, which should help towards breaking down the community barriers;
- the development of a clear strategy and protocol for NCSCB and its partners should also help to create a seamless and collective response – one in which agencies are responding appropriately and consistently, no matter with which agency the children, young person or family member gets in touch. The aim is to stop incidences where parents have been worried about gun and gang crime and because they have not received appropriate support their child has ended up seriously injured;

Barriers and Challenges

- identifying young people at risk as early as possible through problematic behaviours is a significant challenge, and partner agencies recognise that children and young people at risk are often likely to have been a victim themselves or a member of their family may have been involved. This problem is being tackled through consulting with children and young people in order to make them feel a part of the process. By encouraging children and young people to talk to NCSCB partners about the main issues of concern and how to deal with them, NCSCB hopes to increase the numbers of young people involved in the decision-making process for future safeguarding policy and procedure;
- one of the main problems identified facing NCSCB is the size of NCSCB's remit on a variety of safeguarding issues, which can present problems relating to capacity issues to undertake the work directly relating to gang and gun issues. There have also been communication issues arising from the joint working between two partnerships with distinct roles (NCSCB and the Crime and Drug Partnership), which NCSCB has tried to address by encouraging a holistic approach. Although the two partnerships interlink, they have different drivers on gang and gun crime which affect the way issues are prioritised. For example, where the CDP agenda is characterised around government targets to reduce crime, the safeguarding board's role is wider as it is concerned with the same issues of safeguarding communities from crime but it includes a specific focus on children. In order to overcome this, the forthcoming NCSCB protocol aims to promote mutual understanding between the partnerships'

approaches to dealing with the related problems of gang and gun culture:

"It isn't sufficient to have people sit on partnerships and not understand the context or the remits of each person's position."

- this issue will also be addressed by improving the interface relationships between CDRP, NCSCB and the YOT through setting shared practice and assessment guidelines and training requirements, in recognition of the fact that the majority of the work will be delivered by people doing street work with children and young people at risk;
- an area where the multi-partnership approach has been successful in bringing together different agendas is the link between NCSCB and Multi-Agency Public Protection Arrangements (MAPPA) where the head of Safeguarding for Nottingham City is a member of the MAPPA panel. The police, as a member of NCSCB, have seconded a police inspector to the MAPPA coordinator and have developed multi-agency training.

Key Success Factors

The following factors are felt to be crucial to NCSCB's success both now and in the future in this area.

- **effective Information sharing.** The board has a key role to play in policy-making regarding confidentiality in cases where an agency may perceive a safeguarding issue which needs to be shared with relevant partners;

  "People may be grooming young people to get involved in drugs and gangs therefore, there needs to be some loosening up of how we share information."

- impact assessment is important, in order to show how NCSCB uses information about those children who are at risk from gun and gang activity;
- children should be viewed primarily as **children at risk**;

  "They're exposed to gun and knife crime and they're children exposed to abuse and neglect in some cases."

- **engaging** with those people at high risk through targeted activity, such as education, delivered through training DVDS, posters, workshops and sport. In one area, agencies have encouraged mixing between young people from different areas by getting them to play football matches on the same team; this helps to bust myths around perceived differences;
- help children and young people to understand the impact that the use of weapons has on themselves, their families, their community and that the main consequence is **fear**.

Advice for LSCBs

- develop a **framework which identifies those who are at risk** from gun and gang culture and put together a system which identifies how they will be managed;
- **begin** discussions early and start meeting with other relevant local partnerships working in the area of countering gun and gang violence such as the CDP and YOT;
- use **existing expertise** from partners;

  "Through the board we have that natural linkage, which is a very good starting point; this ensures that our staff are well-informed."

- make sure that all partners involved in the process have the services that are available and **pool** resources to maximise chances for successful prevention;

- make **training** on safeguarding children from gang and gun violence integral to the board's function;
- **efficient collection and use of data** relating to children at risk of gang and gun violence to build knowledge base;
- **involve 'frontline' workers**, such as the voluntary and community sector and those from local neighbourhood management teams;

  "they understand what happens on the ground and they have 'soft' intelligence – information which then needs to be fed into the boards."

- **engage the children at risk of becoming involved in gang and gun activities** in order to understand the issues involved in why they are becoming involved in that activity.

Case Study 4: Southwark

Name of LSCB: Southwark Safeguarding Children Board (SSCB)

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Is the LSCB happy to be contacted for further details? YES

Context

Southwark is one of the most deprived areas in the country with massively complex needs in relation to guns, gangs and vulnerable young people. The level of gang and gun violence in Southwark has been the focus of significant media attention. Southwark was the borough in which Damilola Taylor was killed in 2001 and since then there has been significant emphasis placed on early intervention, youth on youth and gang related crime. The Southwark Safeguarding Children Board, SSCB, has recognised the need to increase understanding of the impact of migrant status and possible child trafficking on young people who do not have legal status and may drift into criminality and where there are no clear parent authority figures for them.

Southwark has some specific contextual issues that make it more challenging to tackle the issue of guns and gangs:

- in Southwark, analysis by the Community Safety Unit (CSU) shows that the structure of gangs is changing: becoming looser and more chaotic at the bottom (younger), but more regimented and sophisticated at the top (generals);
- a significant number of the young people that are getting caught up in gang activity have the mental age and function of under 10 year olds, and an intervention for one child may need to be radically different from another;
- increasingly gang activity is being brought into homes putting siblings and family members at significant risk; and
- southwark has groups of young people with significant older criminal relationships.

The Local Response

In response to these challenges a concerted effort has been made to couple effective multi agency enforcement with active community engagement and prevention. The focus has widened from being solely one of enforcement to also considering the safeguarding issues. The local response is driven at a strategic level by the Crime Disorder Reduction Partnership (CDRP) and in particular through the sub groups of the SSCB. Key operational level drivers are the multi agency coordinating managers and the Southwark CSU.

The SSCB plays a service wide, strategic role in relation to safeguarding and works in parallel to Young Southwark (the Local Children's Trust). One of the main roles of the SSCB Executive is to "establish links and the exchange of information and policy, as well as leadership with other key strategic bodies in relation to safeguarding children". These other bodies include the Safer Southwark Partnership of which the Community Safety Unit is a key part. On the subject of guns and gangs SSCB has set out a broad strategic agenda of safeguarding young people through prevention and multi-agency cooperation that is actioned by SSCB's Sub Groups, the CSU and across the Safer Southwark Partnership. In identified high risk cases, the Chair of the SSCB (Director of Children's Services) may jointly commission a Gold Group with the Borough Police Commander and relevant agencies to ensure inter-agency leadership and response planning.

The CSU ensures that agencies are working together to deliver a broad range of crime reduction and prevention services. It aims to make sure that the strategic partnership and operational delivery works across all agencies involved. In late 2005, the CSU jointly funded a 6 month context review on the subject of guns and gangs which enabled it to understand the issues that they were dealing with in great detail and focus its efforts more effectively. The CSU applies the Safer Southwark Partnership Triangle of Intervention (Appendix 1) to its work on gangs and guns. Those children and young people at the top of the needs triangle are subject to long term (two year) programmes of support and intervention including intense enforcement. Risk identification and prevention work is focussed on the three lower levels of need. There are several areas where the CSU is engaging with the community and pushing the prevention and safeguarding agenda, but in particular with the Gangs Community Forum that is a vital link to the community. The forum meets every month and includes voluntary groups, community leaders and youth workers. The community representatives constantly remind service heads and multi-agency coordinators that attend these meetings that they "*have to do enforcement*". Prevention work is undermined when it is not done in tandem with successful enforcement, and often it will open the door to more effective prevention work. The feedback from young people and youth workers on the Gangs Community Forums has been that, in general, people are becoming much more aware of the risks and issues involved in guns and gangs; and importantly practitioners and parents are becoming more aware of the services that are available to them.

The multi-agency approach

Senior Managers form the CSU, Children's Services and the Youth Service sit as members of the SSCB. The operations manager for the Early Intervention Team (within the Youth Offending Service/Children's Services) also oversees the Family Intervention Project and the Parenting Team. All three initiatives focus on the risk of children being involved in crime, and their work with individual children is coordinated via the Youth Inclusion and Support Panel process. The managers of these initiatives are members of the SSCB sub group and have overall responsibility for embedding safeguarding practice into the work that they do.

If they come across an individual child who is presenting risky behaviour that child will have a Risk of Serious Harm Assessment and that will set off the necessary channels for dealing with

the concerns of the practitioner on the ground. When the Early Intervention Team receives a referral, the relevant evidence is put into their risk matrix system. For example, if a child or young person is a relation of a known gang member, they would be considered a high risk and action would be taken by the Early Intervention Team, the Family Intervention Project or the Parenting Team. Recent examples have included the accommodation of two 12 year olds under the Children Act 1989 who had been asked to carry guns.

Informing early intervention and prevention

There is a consensus across local agencies involved in enforcement and prevention work that effective multi-agency working is vital to the success of any action on gangs and guns in Southwark. It became apparent that a successful anti-gangs and guns strategy and approach needed a system whereby agencies are clear about where information is located, how it is accessed and by whom, and what action is taken once it is processed.

To this end a multi-agency identification and intervention panel system aimed at identifying children and young people who are involved , or at risk of being involved, with guns and gangs has been developed and is due to be deployed in the near future. It will operate in a similar way to MAPPA and PPO. It will be a joint Youth Offending Team / CSU system with additional support being provided by the police. The information generated should prove invaluable to all agencies working to tackle the problems associated with gang activity. The new system will also pick up information that has not previously been analysed. For example, when there has been an incident with no victim (such as 50 young people fighting in an area), the police would rarely have investigated it in the past. Information on such incidents will now be logged and analysed.

The system uses Red, Amber, and Green coding with Red being the most serious offences and Green the more anti social or victimless crimes. Red offences are seen as requiring perpetrators to be targeted and taken into custody. But a broad aim of the digital mapping system will be to identify the most relevant agency for intervention.

All young people that are known to have an affiliation to a gang are now 'tagged' through the police national computer. This means they can be identified if stopped anywhere in England and Wales and monitored through intelligence gathering.

Gang related issues are given priority in the criminal justice system.

More work needs to be done on cross borough information sharing protocols and systems in this area.

Engaging families and schools

Unless there is a known danger to the practitioner, home visits have been found to be an essential part of early intervention on guns and gangs. A large number of parents are totally unaware that their children are involved in gang activity and many are shocked and deeply concerned when they are made aware of the risk to their children. The police have developed a no nonsense approach to alerting parents of children and young people on the periphery of gangs (perhaps involved in a group fight or some anti-social behaviour). One such method is the hand delivering of CCTV stills and letters relating to the activity of their children to parents to try and stimulate parental control.

There has also been an active strategy of engaging parents and families; a number of

interviewees argued strongly that providing parents with information about gang activities in their area; signs, emblems, colours and the dangers associated with being in a gang, would enable them to become more powerful actors in the prevention process. There are various roles that parents play from 'detached and uninterested' to 'concerned but helpless'; in most cases however when parents are alerted of the danger their child is in, or on the cusp of being in, they are stunned into action.

Schools are also cited as being key to the guns and gangs strategy that emanates from the Crime and Disorder Partnership with the support of the SSCB. Through the Safer Schools Partnership schools where gang activity may be a problem are targeted, disaffected pupils identified, and social education programmes are delivered. The Gangs Disruption Team (YOT/CSU) works in schools and community centres. Evidence suggests that there is a much higher likelihood of success when such staff are invited into schools to talk and raise awareness. Engaging schools is not always simple however as there can be problems with defining the problem of gangs and some schools may be unwilling to admit that they have a gang problem. In terms of prevention however, being able to detect behaviour changes in the first or second year at school will mean that young people are identified as being at risk before they are picked up through the YOT.

To deal with the current complexity of effectively engaging schools the borough will be divided into four 'Locality' quadrants with 20 schools in each. Multi-agency teams will then tackle vulnerable students and the YOT, Education Welfare and Social Care will be represented in those multi-disciplinary intervention teams for vulnerable families. By breaking down into four areas the complexity of multi agency work will be reduced with a more focussed approach to prevention made possible.

Barriers and Challenges

- **reliance on practitioners** from different agencies on the ground: when referrals are made to different agencies, the work then has to be done through their systems which may add complexity in terms of sharing and accessing information. Different agencies have different thresholds and priorities. In Southwark there has been a lot of emphasis placed on raising the issue of gangs and guns on the agendas of practitioners and their agencies / teams. Children's Social Care is commissioning training for staff from the Gangs team to increase understanding by a wider group of practitioners;
- **professional ethics** in light of a move to have safeguarding embedded across agencies: if a young person discloses something to a practitioner which is related to gang activity what are the disclosure procedures relating to criminal activity verses the confidentiality and protection of the child? Child protection procedures on disclosure are firmly established, but with a broadening of the safeguarding agenda there will need to be work done on disclosure procedures and referral channels;
- one of the really big issues that Southwark, like many local authorities, are facing at the moment is the **media sensationalising** and glorifying being part of a gang. The constant images of young people in hoods and on street corners do not show the more harrowing impact of gang and gun violence that practitioners, parents and schools are encountering.

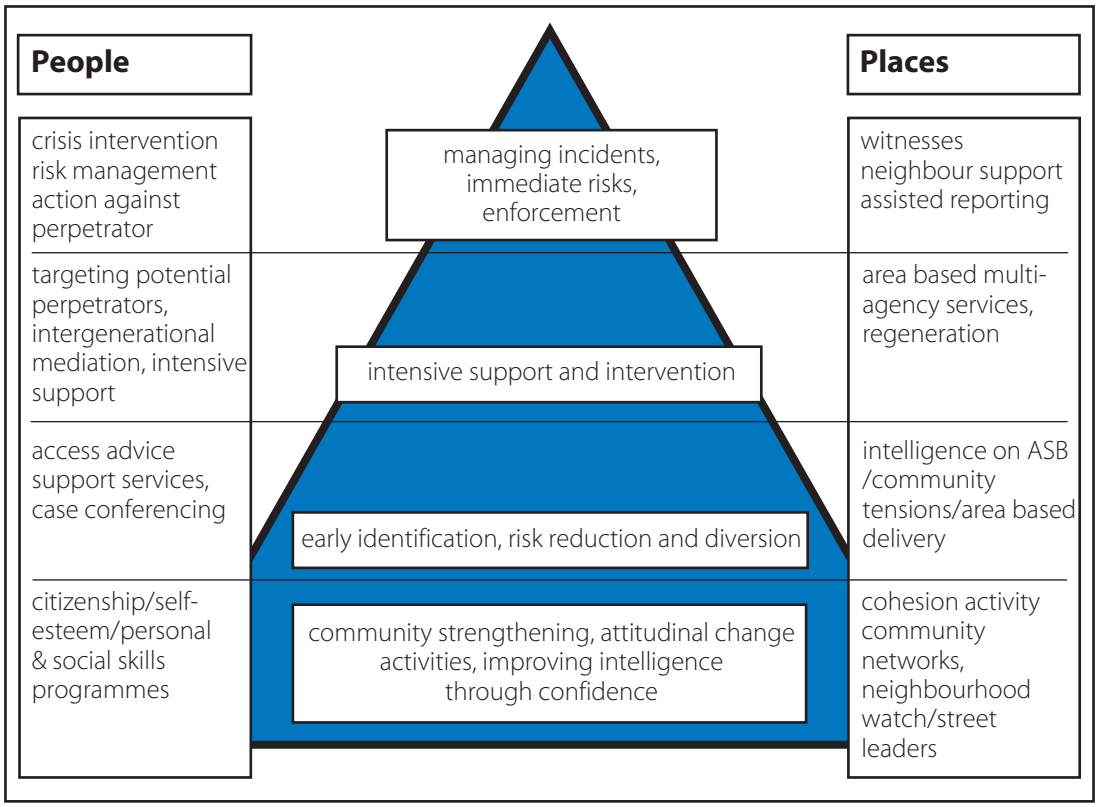
Key Success Factors

- there is a strong belief at a strategic level in the partnerships around children and young people and gangs and guns. There is a cross agency focus around not just enforcement but reducing young people offending in the first place (prevention);
- a direct honesty and reality about what is going on. People have been scared before they know the details and the facts about what they know to be true; and
- in general, securing funding and overall strategic objectives have remained with Heads of Services. This has enabled operations managers to concentrate on coordinating the multi-agency working and embedding safeguarding across different agencies.

Advice for LSCBs

- it is critical that a **context review** takes place to establish what the problems are, young people are given the opportunity to participate and that there are numerous forums for **listening to the community**;
- there needs to be **buy in from the Crime and Disorder Reduction Partnership** in accepting that to improve the lives of the community. It is not just about enforcement. Similarly it was seen as important to have the **Children's Trust** on board because even if a child or young person is involved in gang activity he/she should not be passported out into an enforcement environment;
- there needs to be an **overarching strategic approach**. There always needs to be a risk assessment but whatever intervention follows needs to be firmly linked to a risk model that relates to your gangs assessment tool (See Appendix 1).
- in terms of sharing ideas for **effective working** it is important to remember that every borough and police force has its own set of complex issues and its own unique way of dealing with the issues it will encounter;
- **skills of the practitioners** on the ground. There needs to be an attempt to build a rapport with the families and the young people themselves that precipitates any really effective intervention. Any intervention will then be based very clearly around the individual needs of the child;
- need to have **good managers to mediate thresholds and negotiate competing priorities** of the various agencies. There needs to be **multi-agency champions** that are able to see cases from a number of agencies' perspectives and thresholds and are able to gain compromises on an agency's boundaries and remit;
- **tough outreach**. With the Youth Inclusion Projects based in the crime hotspot areas with magnet activities which are linked to workshops on bullying or the impact of crime for example. If the young person wants to do the activity they need to take part in the workshop; and
- in terms of enforcement, the police and local authority working together is key. From the police's perspective the local authority is the gateway to identifying key decision makers that will be able to intervene successfully in the child that is at risk.

Appendix 1: Safer Southwark Partnership Triangle of Intervention – Extracted from SSP Community Safety Rolling Plan 2008-2012



Section 2: Child Sexual Exploitation

Case Study 1: Blackpool

Name of LSCB: Blackpool Local Safeguarding Board

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Is the LSCB happy to be contacted for further details? YES

Context

In November 2004 a young person went missing in Blackpool. This later became a murder enquiry. In responding to this enquiry, police and social work managers shared information regarding young people some of whom were felt to been involved in sexual exploitation and that this was part of a wider problem within the area.

Following the report of the missing person, Blackpool undertook a scoping exercise. One practitioner noted: '*It is important that you scope out the problem in one area. You are looking at identifying people that are most risk, identifying those young people going missing most frequently, look at the circumstances around that and take a view of sexual exploitation. You need to work out the risk indicators are for your area.*'

Given its status as a holiday town, Blackpool has a large transient population. In addition, access to leisure facilities with arcades and takeaways attract young people into the area and can act as 'honey pots'. In addition, the county of Lancashire has the highest number of registered sex offenders and Wymot prison, also in Lancashire, has the highest number of men imprisoned for sexual offences against children. Though Blackpool faces specific pressures which may contribute to level of sexual exploitation, this is not a problem unique to Blackpool. The scoping exercise also involved talking to young people to understand the scale and depth of the problem.

In view of the emerging issues of sexual exploitation in Blackpool, a decision was made to appoint a Detective Sergeant and three DC's. Following this appointment, three social workers and a social work manager joined the team as well as an education manager to form the Awaken team. A health professional was later appointed following placement on a 12 month secondment with the team.

The Local Response

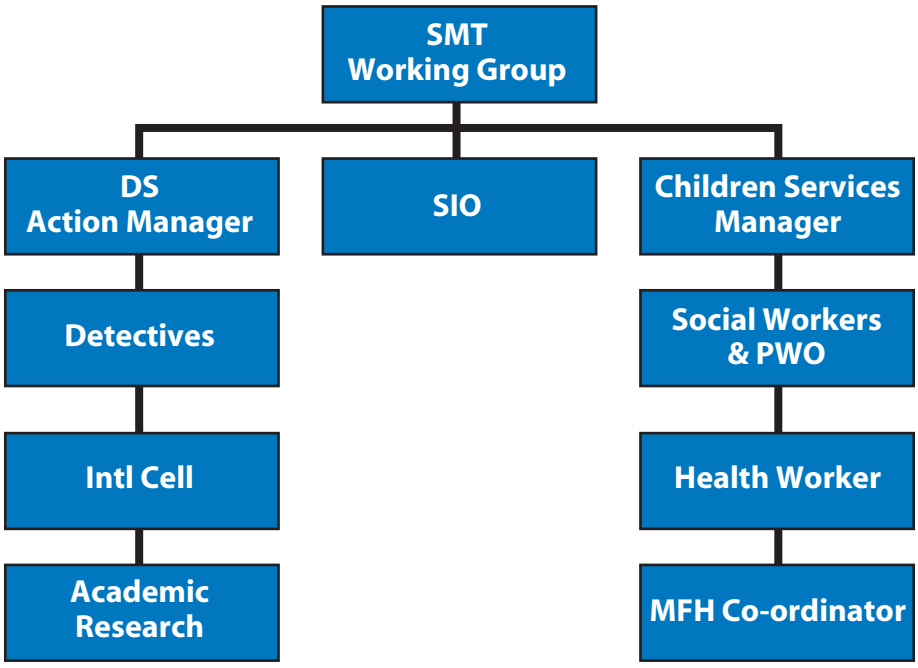
The Awaken Project was set up to provide a preventative as well as a reactive response as part of Blackpool's response to the wider community safety agenda. Its terms of reference are:

- to establish effective systems for safeguarding children vulnerable and open to sexual exploitation;

- to adopt a multi-disciplined approach to disrupting and making safe locations and establishments used to facilitate sexual exploitation;
- to engage with statutory and voluntary agencies working with vulnerable children at risk of sexual exploitation;
- develop information sharing protocols between partner agencies;
- police have primacy for investigation and prosecution of criminal acts; and
- children's services primacy in safeguarding and meeting welfare needs of children.

Overall responsibility lies with the Chief Superintendent and the Assistant Director of Targeted Services within the Children and Young People's department who form part of the Senior Management team. On a day to day basis the team is jointly managed by the Child Care Manager and a Detective Sergeant and is funded by the police, children and young people's services, and the Primary Care Trust. Later, when the LSCB was established both the managers were appointed to its Board ensuring a strategic link between the Awaken team and the Board and enabling the team to translate the strategic aims and objectives of the safeguarding board into operational goals and aspirations. One practitioner stated: '*Neither side of the team have made an exit strategy, our work is not limited to a six month limit, our work has been mainstreamed into both police and social services and has ring fenced funding.*'

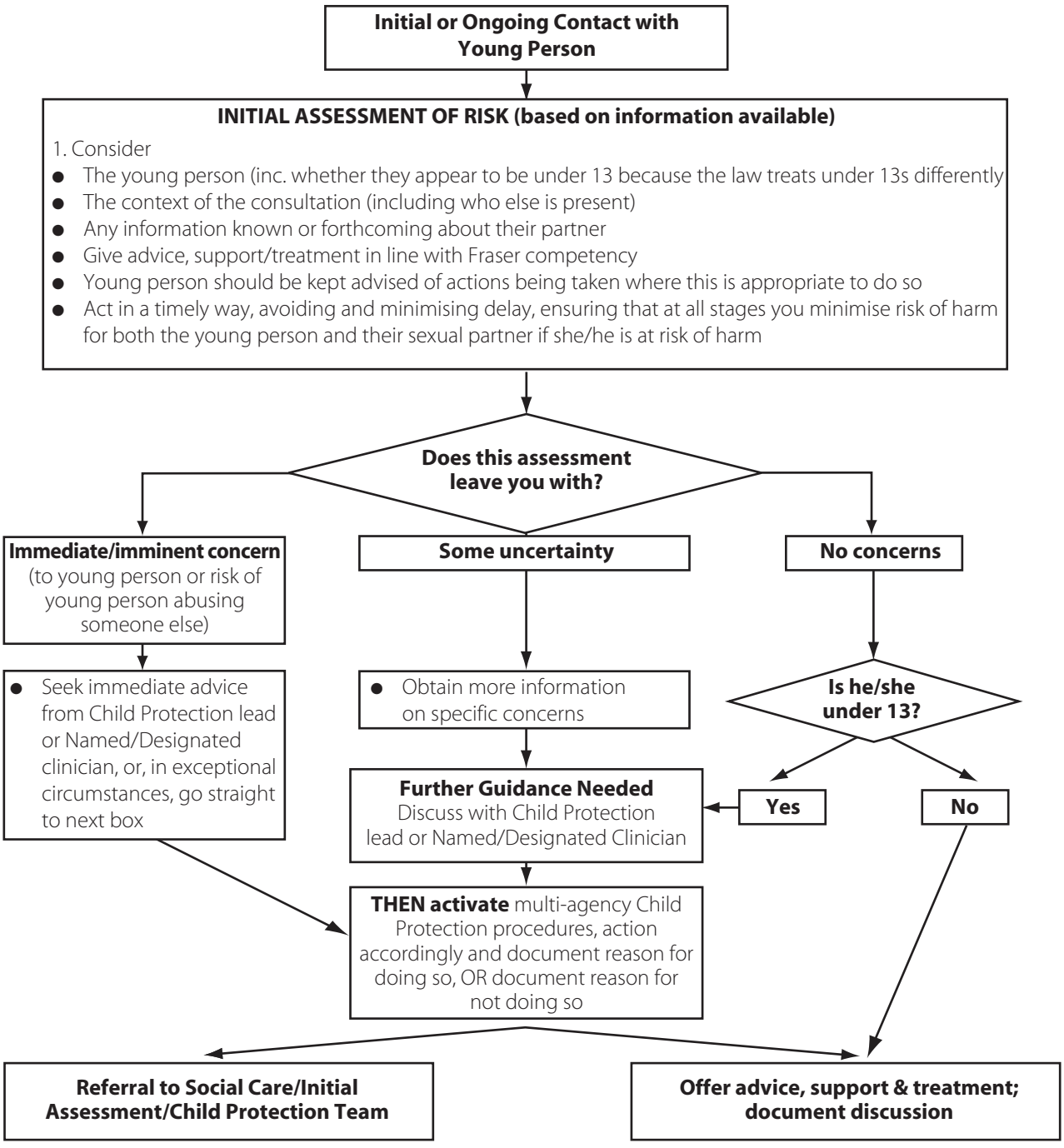
The following diagram illustrates the structure of the Awaken team.



Following a referral to the Awaken team, team members initiate a joint visit by a social worker and a detective, who then report back to senior members of the Awaken team who decide who will lead the response. Detective Constables typically take the lead when community safety issues are the prime concern. Otherwise social work staff lead.[2]

As a co-located unit, the team are able to quickly utilise police intelligence, the children and young people's department's databases and the health information networks. This helps the team build a fuller picture and make more informed decisions on referrals.

The Awaken team focus on three aspects of sexual exploitation: the victim, the offender, and the location.



2 Blackpool Local Safeguarding Children Board Protocol – Working with Sexually Active Young people under the age of 18; July 2007

- **the victim:** in working with referred young people, Blackpool adopts an assertive outreach model which involves frequent, ongoing positive contact with young people;
- **the offender:** to date, the Awaken team have undertaken 767 joint visits and 150 best evidence interviews, where young people are asked to give an account on video which can later be used to bring a prosecution. There have been over 95 arrests for various sexual exploitation offences varying from group rape to the grooming of a child or young person. To date, 37 people have been convicted and only one case has been lost, a 96.8% conviction rate. Where there is no formal complaint from a young person, the team use a section 2 Child Abduction notice to disrupt contact between an adult and a child or young person. To date, 99 section 2 notices have been served. Offenders have been arrested and convicted in relation to breach of the section 2 notice; and
- **the location:** the team focuses on 'hotspots' in the area. They use CCTV footage and business intelligence to investigate business premises or buildings that are being used inappropriately and initiate investigations sanctioned by the council's licensing board including financial inquiries.

The Blackpool Local Safeguarding Children Board has developed a protocol, published in July 2007, to assist professionals working with children and young people to support them in identifying young people vulnerable to exploitation.

A significant part of the work of the Awaken team is to raise awareness amongst other professionals. For instance, the health worker has presented information on risk factors to General Practitioners in the area. Other outreach activities include a designated link person for schools who facilitates discussions with pupils on relationship issues and risk taking behaviour. In addition, health and education team members hold discussions with teachers in the area. A credit card size 'Contact card' has also been distributed in schools and youth organisations, to provide a point of contact for young people at risk. The combined effect of these activities has been increased numbers of referrals to the Awaken team.

The Impact

- **children and young people:** Whilst no formal evaluation has been undertaken, the above rates of conviction and number of joint visits indicate the scale of the impact on disrupting and prosecuting adults involved in sexual exploitation. The awareness raising work with young people has helped them make informed choices and ultimately giving them greater control over their lives;
- **organisations and partners:** Whilst the number of referrals to and the workload of, the Awaken team has risen, working in co-located, multi agency team ensures that the workload can be managed and that a consistent approach is adopted. One professional commented that as a result of joint visits with children's services and police officers, professionals are more appreciative of the contributions of their respective professional colleagues. It has led to better working practices and a shared understanding and language on safeguarding children and young people;
- **effectiveness of the LSCB and impact on Local Safeguarding Children's Agenda:** The work of Awaken sits squarely within the role of the LSCB to deliver the Every Children Matters Agenda. Through its proactive response to

protecting children and young people at risk of sexual exploitation, the Awaken team has been able to evidence the prevention of harm.

Barriers and Challenges

- young people are often resistant to initial approaches for help. Time has to be committed to following up and maintaining ongoing support with the young people concerned. When young people choose not to disclose, the team can revisit on occasions and break down barriers with the young person concerned. Joint visits from the children and young people's manager and the police can help build trust and has led to an increased rate of disclosure;
- whilst practitioners recognise that this approach is resource intensive, using designated staff from children and young people's services as well as the police, the reallocation of time of these staff members can yield benefits across the service area as a whole;
- clarifying how the work undertaken within the Awaken team compliments that within their respective service areas of children services, health and the police has enabled different teams co-operate to mutual advantage;
- bringing together practitioners from different fields presents a challenge, particularly in ensuring that there are common goals and objectives. It is important the mission is clear to members of the team and that they have identifiable goals and objectives;
- developing protocols that govern information sharing can be useful, particularly to guide practitioners when accessing sensitive information. The Awaken team initially had difficulties accessing data on sexual health records, but having put in place protocols they are more confident in managing the process.

Key Success Factors

The following aspects were considered to be critical to the success of the approach developed by Blackpool:

- **allowing an organic process to develop –** The Awaken team developed over a period of 12 months during which protocols were developed and refined. Clear ownership of this process, by the Child Care Manager and the Detective Sergeant, has ensured its effectiveness;
- **joint Approach –** The pooling of information from a variety of sources can strengthen a claim of exploitation and lead to a higher conviction rate;
- **information sharing –** ensuring that effective protocols are in place to allow effective information sharing is crucial to developing a multi-agency approach. Having access to information ensures that there is a holistic approach to supporting a vulnerable young person;
- **responding quickly to emerging findings –** Assigning project team members to the Awaken team has allowed Blackpool to respond in a timely fashion to emerging concerns of sexual exploitation.

Case Study 2: Bradford

Name of LSCB: Bradford Safeguarding Children Board (BSCB)

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Context

In Bradford, as in other metropolitan authorities, a number of cases are identified each year where there are concerns that children and young people are being targeted by adults for sexual exploitation. These concerns may be raised by schools, health professionals, families themselves or by the police, for example, when investigating a missing child or young person. Young people who are particularly at risk are those who are marginalised and socially excluded. They may have been excluded from school, have problems at home and start using drugs.

In Bradford there have been periodic concerns that looked after children in local authority children's homes are a particularly at risk group being targeted by adults. In 2001 there was also a cluster of concerns – initially raised by two schools – that young adult males in cars were loitering outside of schools talking to young women, giving them lifts and engaging them in inappropriate relationships. This drew considerable media attention, which some presented as a race issue, drawing attention to the fact that young men – broadly identified as British Asian – were targeting younger females from another racial group for inappropriate sexual contact. Whilst this was clearly identified as a safeguarding concern involving grooming for sexual abuse, what was less clear was whether this was conducted in concert, constituting organised sexual abuse or whether it was more about a number of individuals.

In response to this issue joint enquiries were launched by the police and social services leading to a number of arrests and prosecutions, as well as a number of statutory interventions to assist some of the young people involved. A support group was also established for parents and carers in Bradford facilitated by a local voluntary organisation called CROP (Coalition for the Removal of Pimping). [3]

Bradford has a long standing project run by Barnardos called Turnaround for working with children and young people at risk or being sexually exploited. Established in 1995 and previously known as the Streets and Lanes

3 http://www.crop1.org.uk/

Project, it has worked to raise awareness of sexual exploitation as a child protection issue and challenge the misconception that it is a lifestyle choice. In their Child Sexual Exploitation (CSE) work they place a strong emphasis on promoting the three Ps of prevention, protection and prosecution of offenders.

Turnaround have a service level agreement with Bradford council, the NHS and West Yorkshire police to support the assessment and intervention process, which will identify and respond to a child or young person being coerced into sexual exploitation and then provide specialist one-to-one support. They also carry out a range of awareness raising and preventative activities with schools, professionals and parents.

Another well established third sector organisation working in the CSE field is the Blast project established by Yorkshire MesMac, an organisation which promotes lesbian, gay, bi-sexual and transgender sexual health.[4] Operating in Bradford and in Leeds now too, the Blast Project provides support for young men and boys who are involved, or at risk of being involved, in sexual exploitation and prostitution. As a key voluntary group of professionals in Bradford they take an approach which aims to be part of the wider CSE agenda, working closely with the Police, Barnardos and the LSCB and sub-groups to provide joint training and awareness raising exercises around CSE relating to boys and young men. They have secured funding from various sources including the Neighbourhood Renewal Fund, Connexions and Comic Relief.

The Local Response

Against this backdrop of issues and CSE initiatives, Bradford's Safeguarding Children Board (BSCB) was established in May 2006. In its first three year Strategic Plan[5] the Board identified, as one of three 'challenging outcomes' to be achieved by 2010, the aim of "*reducing the number of sexually exploited children in the Bradford District, and improving the 'inter-agency arrangements for identifying, assessing and supporting such children*". This includes raising awareness of the safeguarding issues, increasing the provision of training and holding the various organisations and agencies working in the area of child sexual exploitation to account.

The work on reducing sexual exploitation is being taken forward, on behalf of the BSCB by a dedicated Child Sexual Exploitation sub-group chaired by a board member with representation from a number of statutory and third sector agencies including the Blast Project and Turnaround. The sub-group is responsible for:

- reviewing and maintaining protocols and procedures relating to safe guarding children at risk of sexual exploitation;
- supporting training in this area;
- developing information for professionals, young people and their carers; and
- encouraging research within and between agencies involved in this area of work.

BSCB also created the post of a Sexual Exploitation Child Protection Coordinator, to undertake multi-agency developmental work at both operational and strategic levels. The Board has made a commitment to fund the role for the next three years and intends to make it part of the Board's core business. Key responsibilities of the role include; chairing a number of child protection meetings as part of the operational work; chairing reviews and the team around

4 http://www.mesmac.co.uk/blast/index.html
5 http://bradford-scb.org.uk/PDF/bscb_strategic_plan_07_10.pdf

the child planning meetings and facilitating multi-agency action on child sexual exploitation organised around four strategic objectives.

The Impact

In their CSE action planning, the CSE sub-group have set out key strategic and operational objectives which closely relate to the ECM outcomes. The work is undertaken by the CSE Working Group, a sub-group of the CSE sub-group. The CSE Co-ordinator plays a key role in progressing, monitoring and feeding back the outcomes of the work to the BSCB.

- **joint protocol:** aimed at improving multi-agency working, the five LSCBs in West Yorkshire, have recently finalised a West Yorkshire Protocol which incorporates a range of CSE guidance and learning. The protocol sets out a comprehensive list of risk and vulnerability indicators which in turn link to a risk assessment matrix and then a set of required actions. The protocol aims to ensure that the five areas adopt an effective and consistent approach to sharing information on at risk or exploited children, young people and the perpetrators. Reflecting on its development it was noted that the process has benefited from an inclusive approach which has helped to galvanise commitment and awareness across West Yorkshire of the CSE agenda;
- **safeguarding and support meetings:** in the Bradford District a list of children and young people potentially involved or at risk of CSE is maintained and reviewed during safeguarding meetings attended by representatives from children and social services, police as well as Blast and Turnaround. Informed by the risk indicators as set out in the protocol, if a child or young person is deemed to be a medium or high risk, a referral will be made for a section 47 assessment. Where higher risk indicators are identified, a CAF will quite often be completed and strategic meetings will then be arranged to co-ordinate an exit strategy for the child or young person. Between May 2007 to Jan 2008, 67 safeguarding meetings have been held, with 55 young people identified as Section 47 cases;
- **multi-Agency Action on CSE (MAACSE) meetings:** held on a monthly basis these multi-agency meetings provide an opportunity to track all young person CSE cases across the District and share intelligence. Up to 15 young people from across the District will be discussed at each meeting;
- **CSE Champions:** the BSCB has made a significant commitment in the training calendar for practitioners and child safeguarding managers. On completing a training session practitioners have the opportunity to take become a 'CSE Champion'. In this role they become the designated contact point in their agency for training colleagues and providing guidance on CSE issues. On taking on this role they are asked to attend a programme of 'training the trainers' events which aim to support them in their role and bring them in contact with other champions in order to share learning;

There are currently 35 CSE Champions in place across 25 different agencies and work places in the Bradford District. Creating the role has been an effective means of '*cascading learning across agencies and spreading awareness and learning across a vast number of professionals*'.

- **website resources:** The CSE sub-group has recently set up a practitioner website for practitioners working across all agencies.

The website contains CSE training packages and information on issues such as on-line grooming techniques. On completing a CSE training course professionals will be given a password to access the website. This is changed every three months and ensures that potential groomers cannot access potentially useful information;

A website called 'Safespace' is currently being developed by the CSE sub-group in conjunction with the Young Person Participation Partnership. Aimed at young people who carry out peer work around CSE, it intends to provide an accredited ICT package for their activity and provide them with access to further training opportunities and to the Youth Parliament;

- **good practice CD ROM:** Barnardos, in partnership with key agencies and young people have recently launched a good practice CD Rom. It is intended for professionals, parents and carers to use with their young people in various community settings – providing them with strategies to keep themselves safe;
- **good practice evidence gathering:** a joint training pilot programme is due to commence in the summer of 2008 conducted by the police and children's social care. The training focuses on gathering good evidence to assist the police and child protection services with prosecution and conviction of adults involved in CSE.

Barriers and Challenges

- **confronting the stigma:** There was a clear message that the significant stigma around child sexual exploitation has the potential to inhibit the proactive and probing approach that is necessary to identify where it is taking place. This also affects whether children and families access services. It can be very hard for a parent to say that their child is involved in sexual exploitation;

Schools may also be concerned that drawing attention to child sexual exploitation may put them at risk of tarnishing their reputation. A school may wait until they have 'incontrovertible evidence', leaving it very late to intervene and making prevention impossible. For the area as a whole, work on prevention and awareness raising regarding child sexual exploitation may also lead to stigmatisation. Hence many may find it easier to avoid 'up turning that stone':

"The biggest fear we always have is that that the good work we do in the CSE area will identify us as the worst place in the country".

The shock and stigma of child sexual exploitation can be overcome by having skilled and sensitive staff engaging with the young person and that family. It is the third sector who are often most able to start to develop these relationships with children and families, and can often do so sooner than statutory agencies beginning a process of brokering those relationships.

- **training and resources:** Training was commonly identified as a big issue. Multi-agency training was acknowledged as being time consuming but also as a vitally important means of bringing people from different agencies together. They can provide an ideal opportunity for practitioners to 'break down barriers' and talk through what works in practice and what problems were encountered.

A specific training issue was identified around the how to protect a child or young person in a situation where verbal persuasion to protect or discourage them from undesirable interaction is failing. Here practitioners, particularly carers

of looked after children, need to be clear about what they are legally allowed to do.

Funding issues:

"No one can criticise the concept and priorities around CSE but to continue to deal with serious cases and early interventions is the big challenge."

In Bradford many of the innovations in tackling child sexual exploitation have been achieved by integrating them into practitioners 'day jobs' and with no additional resources. Rather than establishing a more resource intensive dedicated multi-agency unit, BSCB and the CSE sub-group have placed an emphasis on developing effective multi-agency policies and procedures working across district boundaries to maximise the impact of the work.

Breaking tasks and responsibilities in to manageable sizes was found to be helpful. For example, CAMHS identified a child sexual exploitation lead to link with the CSE sub-group, which allowed a special group for vulnerable girls to be developed. This was achieved through using existing resources and adopting a very pragmatic approach. Another notable funding issue was around the necessity of securing longer term funding for voluntary organisations – a minimum of three years was felt to be the minimum amount of time for ensuring that progress and momentum is sustained.

Key Success Factors

- **awareness raising and early recognition:** By and large there is growing awareness and recognition that addressing the issue early is vital, for instance through the PSHE agenda in schools. In Bradford this has largely been in partnership with the third sector, supplemented through efforts to provide materials in a format that are accessible to families, carers and children;
- **effective intelligence recording and sharing:** Where CSE investigations have broken down, it is often because intelligence hasn't been effectively recorded. Poor or inconsistent record keeping, evidence not being secured at an early stage and young people not cooperating are some of the barriers that have to be overcome. Problems have also arisen in communicating with the Crown Prosecution Service, including their lack of awareness of the issues involved in child sexual exploitation.

  There was also a recognition that CSE is a fast moving and sophisticated field, where it is vital to keep 'ahead of the game' in terms understanding the latest grooming tactics. In Bradford close relationships with the police and effective networking and researching help to create 'a seamless flow' of information which gets highlights activity which is often 'below the surface';
- **effective and up to date protocol:** Having a protocol which is appropriate and up-to-date was seen to be crucial for driving improvements in CSE working practices. Protocols are an effective means for incorporating national guidance such as Paying the Price and the Three Ps model.

  It was also felt to be crucial to draw on the expertise and passion of the voluntary sector and who can often engage young people much more easily than statutory agencies;
- **commitment from the top-down and across:** For progress to be made, strategic ownership of the issues on the Board was felt to be vital. This in turn leads to preparedness to commit resources. Given the sensitivities

involved there also needs to be a political commitment to support the agenda.

Statutory agencies, particularly the police, often emphasised the challenge of juggling competing demands, noting that CSE was not a key performance indicator for them. Here it was noted that unless the issue was prioritised '*you will always struggle to make progress on the issue*'.

Having a dedicated co-ordinator who could devote the necessary time and attention, rather than the role being only a small part of an individuals post, was also felt to be critical to success in Bradford. Across all the agencies in Bradford there were also keen and committed individuals wanting to make progress on this issue including the CSE Champions. This empowered them to pull other people in. It was real outreach.

Case Study 3: Croydon

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Context

The scale of sexual exploitation issues in Croydon is partly a reflection of the large child population. Croydon has a very high child population of approximately 82,000 children, the highest recorded number of children resident in a London borough. In addition, a number of young people travel from neighbouring London boroughs to attend school within Croydon.

Looked After Children (LAC) often come into care because they have been abused. These children are known to be especially vulnerable to exploitation. The borough of Croydon also has an unusually large number of looked after children resident within the borough who are placed by other local authorities (at least 500 at any one time). These children are placed in private and voluntary children's homes and with foster carers supported by private fostering agencies. Placing children outside their responsible borough can be a conscious decision made in order to separate the children from their abusers. Some of the private and voluntary providers supply specialist placements and therefore care for very vulnerable children. Some of these children will already be involved in sexual exploitation and consequently may be at risk either because they are followed by their exploiter.

Croydon also has a large private rental sector in which other boroughs place vulnerable families. There are also a lot of services, such as specialist day care facilities, which are used by children, especially vulnerable children. Again this increases the numbers of children available to those who wish to exploit them.

Croydon has approximately 350 indigenous children and 750 unaccompanied asylum seekers in its care. Other authorities do not have such a high number of asylum seeking children. However, whilst unaccompanied asylum seekers comprise a majority of children in care (70%), they form only 10-15% of children and young people that are referred due to sexual exploitation.

The above factors contribute to an overall rate of referral of children at risk of sexual exploitation of 60 children per year of which 30 are in care at the time of referral. A total of 1100 children are in care in the borough of Croydon at any one time.

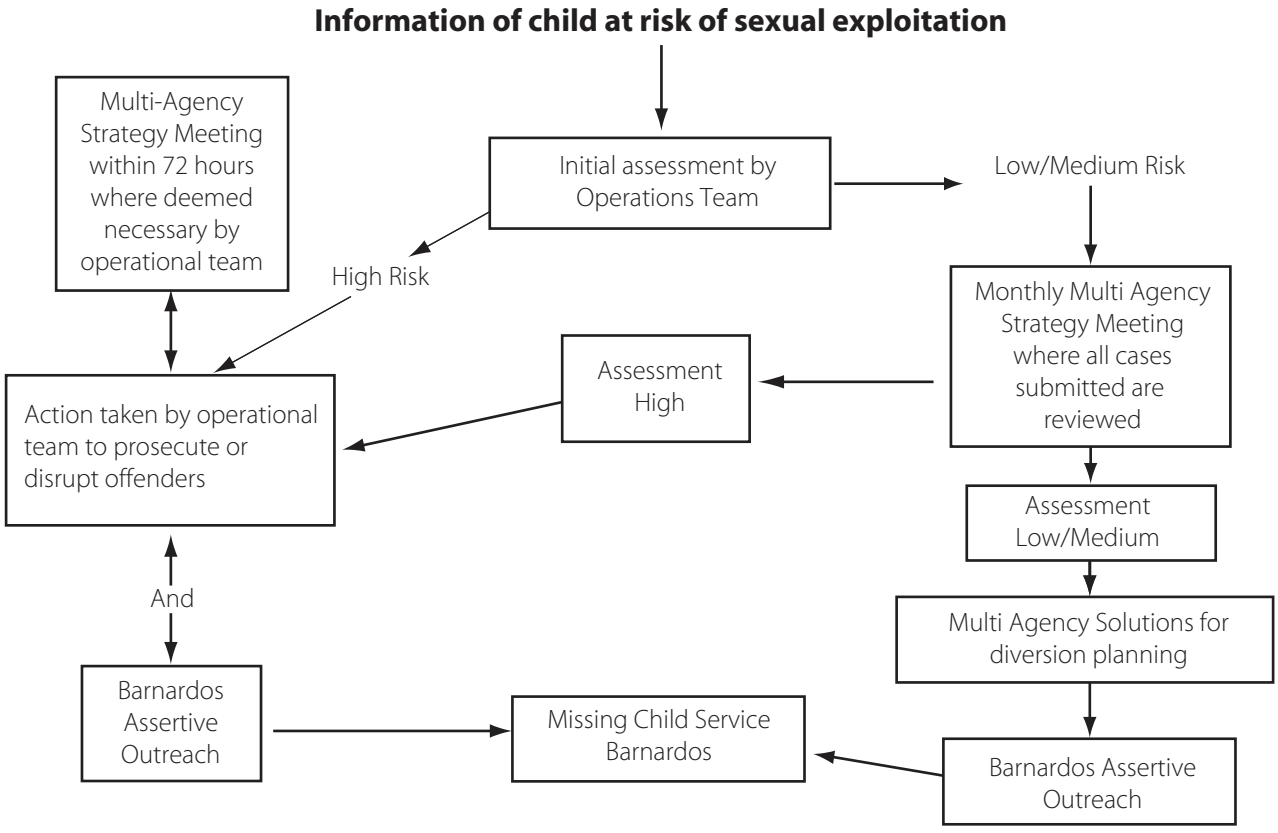
In terms of other demographic groups at risk, approximately 8-10% of referrals are boys. The proportions referred generally reflect the population demographic, but African Caribbean girls are over represented in the group that is most severely affected and involved in exploitation. This may reflect the way that preventative services are offered to BME families, given that this group is traditionally harder to reach and may access services later than other groups.

The Local Response

The Sexual Exploitation Planning group was established in 2003. A number of anecdotal concerns had surfaced which suggested sexual exploitation was taking place in the borough. In response, the Quality Assurance Unit, which sits within Children and Young People's service, began to collate information, supported by work already undertaken by Barnardo's, to quantify the nature and the degree of sexual exploitation of young people in Croydon. They were aware that the children and young people affected were often known to statutory agencies, for instance the Youth Offending Team or the Pupil Referral Unit, but had yet to be identified as vulnerable to sexual exploitation. The Assessment Manager noted that often the services would register 'the symptoms and not the causes'.

In 2004, the planning group launched a protocol to help practitioners assess the degree of risk of sexual exploitation faced by individual children and young people. The protocol sets out the key risk factors and provides guidance to practitioners.

The 2004 survey evidence and the results of the subsequent canvassing for referrals identified a significant number of children who were either



6 http://www.londonscb.gov.uk/files/conference07/1._libby_fry.ppt#256,1,CROYDON ECLIPSE Working with Sexual Exploitation In Croydon

at risk of, or actually being, sexually exploited. This evidence base was central to the securing of monies, for a three year period commencing May 2007, from Croydon's 'Invest to Save' Home Office fund. Barnardo's are lead agency and they and the Metropolitan Police provided match funding.

The Invest to Save monies currently fund four posts: a full-time project manager from Barnardo's, a full time missing person's worker, a part time project worker and a full time administration post. In addition, the core sexual exploitation project team works with the Quality Assurance Team, the designated missing person health worker and two sexual exploitation investigating police officers. The diagram below illustrates the process in place:

Following an initial assessment, the multi-agency strategy meeting offers opportunity for other agencies to help plan a support package for the young person. A significant part of the work of Barnardo's and the Quality Assurance Team is to raise awareness amongst other practitioners to help them identify children at risk of sexual exploitation and risk factors that should trigger a referral.

A child is defined as being at risk of sexual exploitation when they show a cluster of the risk factors described in the London Safeguarding Board's protocol on sexual exploitation. Going missing from a young age frequently, or for extended periods, is the factor most strongly correlated with sexual exploitation. The presence of sexual exploitation becomes obvious when young people are seen with, or picked up regularly by, older men.

The Impact

- **children and young people:** the Sexual Exploitation Safeguarding sub group was established in September 2006. In the year following the launch of the sexual exploitation protocol, by February 2006, the Quality Assurance Team received 56 referrals. In 2007/8 Croydon received 60 referrals. They suggest that they now have in place a coherent and cohesive approach to responding to children and young people that are at risk of sexual exploitation.

Following referral, vulnerable young people are offered brief therapy by Barnardo's staff or volunteers. This model of support provides a means for children and young people to rebuild their life by offering frequent, neutral but positive support. This could take the form of meetings with the young person on a fortnightly basis and sending/ making daily text messages/ phone calls. One practitioner said of this practice 'We are setting up something that is equally enticing but a lot less dangerous. This is real outreach'. Importantly, Barnardo's staff develop trusting mentoring relationships and are not viewed as statutory agents by young people. This ongoing support has yielded positive results in the lives of young people.

Outreach activities are also provided for young people within the wider community through mainstream schools and children's homes. This draws on an Education Pack, produced by SEOne, the umbrella body for a number of Barnardo's teams working in different London boroughs. The BWise2 Sexual Exploitation pack supports a six week programme for children and young people involving a variety of activities and exercises, designed to help support young people in making decisions about sexual health and life choices. This is a national resource which can be accessed via the Barnardos web site.

Parents and carers are able to contact specific leads and access the appropriate services for vulnerable young people in their care. This has

led to direct referrals to the team from concerned parents.

- **organisations and agencies:** Professionals that work with children and young people are now more readily able to identify high risk cases and have access to practitioners with whom they can share concerns. One person noted that professionals generally have greater confidence in dealing with cases involving sexual exploitation.

The Barnardo's team offers training to volunteers and professionals that work with children and young people. Specifically, the model of training mirrors the support offered to vulnerable young people as a means of giving volunteers a more meaningful insight into the trauma and disruption faced by young people who have been sexually exploited;

- **effectiveness of the CSCB:** The Croydon Safeguarding Children Board's (CSCB) was established in November 2005 and the Sexual Exploitation Group, one of nine safeguarding sub groups that report to the Board, was set up in September 2006. The Sexual Exploitation Group is a network of agencies, both statutory and third sector, tasked to formulate a response to emerging issues of sexual exploitation and to steer policy.

The original chair of the Sexual Exploitation Group, Hannah Miller, is currently also the Chair of the CSCB. This appointment is considered to have been critical in helping facilitating partnership working.

The Operations Team provides the Sexual Exploitation Group with up to date information on sexual exploitation by working closely with different agencies. For instance, Barnardo's project officers work alongside police officers to obtain information on sexual exploitation from young people. These joint visits enable police officers to meet and talk with young people whom they would ordinarily have found to be hard to reach. At the same time it helps 'demystify' the role of police officers in the eyes of the young people. In addition, patterns of behaviour which in the past may have gone unnoticed, such as older men taking young women to sexual health clinics where there is also an indication of exploitation, are now being monitored and responded by health and other staff;

- **the local safeguarding children agenda:** The sexual exploitation agenda now forms a significant part of the wider safeguarding agenda. The activities of the Sexual Exploitation group have been mainstreamed within the community safety as well as the safeguarding agenda.

Barriers and Challenges

- **accessing resources:** in the early stage of this work providing adequate resources to respond to referrals was particularly an issue for the Quality Assurance Team. Responding to referrals without a functioning infrastructure could have been problematic. Practitioners recognised the effectiveness of specialist staff from Barnardo's in enabling them to respond quickly to referrals early. However, it was also obvious that more resources were required for staffing and also accommodation for staff and a physical space within which to facilitate conversations with young people. The research into the nature and extent of sexual exploitation and encouraging referrals ensured that the Quality Assurance Team could evidence requests for necessary additional funding. However, the number of children referred is still beyond the capacity of the project workers.

- **multi-agency working:** new multi-agency relationships can be difficult to establish, particularly when complex organisations are involved. In addition, relationships and expectations do have to be carefully managed. Inviting the Chair of the CSCB to manage the sexual exploitation group provided a trusted presence, and visible evidence of support from senior management. Critically, the Chair was able to harness and facilitate dialogue between the different agencies.

In addition, there are continuing multi-agency protocol monthly meetings (see diagram above). These encourage ongoing dialogue between practitioners and ensure that there is a mechanism to support communication. Ensuring continuity of the Chair person is important, as the Chair is then more able to keep track of the development of individual cases;

- **raising awareness:** The identification of sexual exploitation is underdeveloped. Crucially, practitioners that come into contact with young people need to be able to readily identify the signs of sexual exploitation. Training and information sharing sessions have been shown to be effective in ensuring that practitioners can identify sexual exploitation and refer cases to the relevant project lead. The protocol is helpful in enabling professionals to ask the right questions.

Project leads suggest there is now a heightened awareness of the risk of sexual exploitation which has lead to the identification of children at risk. The use of young people's narratives, which are anonymised, has proven to be gripping, emotive and effective in encouraging professionals to take interest in this issue.

Key Success Factors

The following areas were considered critical success factors:

- **championing the cause:** visible senior leadership determined to focus on the issue. Having people that are clear about their role in tackling sexual exploitation as part of both the safeguarding and the mainstream crime reduction agendas;
- **evidencing the problem and getting referrals:** use the same approach for collecting statistics on children at risk of sexual exploitation as would be used for children who require a protection plan; provides the data that is required to attract the necessary resources and funding;
- **allocating dedicated time and resources:** ensuring there is a sharp focus on sexual exploitation and expertise that enables a wide range of staff across all sectors to take effective action;
- **harnessing the partnerships:** health, police and voluntary sector are key partners, working alongside children's services. Voluntary sector involvement is important. As one practitioner noted 'It keeps the rest of us honest' and children and young people feel less suspicious of their services;
- **continue raising awareness of signs and symptoms:** awareness raising empowers other practitioners to make referrals and identify children and young people that are at risk of sexual exploitation.

Case Study 4: Portsmouth

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Context

In 2006, Portsmouth's recently established LSCB received a body of anecdotal evidence from various professionals that sexual exploitation of children and young people was taking place in Portsmouth but that it was hidden and therefore gauging the scale and severity of the problem would be highly challenging.

Responding to this, the LSCB identified three key factors, which warranted further intelligence gathering and action. Firstly, there was a lack of knowledge and awareness amongst professionals working with children and young people about sexual exploitation. Secondly, unless there was sufficient evidence of such activity taking place professionals would be reluctant to acknowledge the scale and nature of Child Sexual Exploitation (CSE). And, thirdly, the children and young people potentially involved would be unlikely to disclose that they had been exploited.

The LSCB were aware that Barnardo's were well established in Southampton and that they have considerable expertise and resources for tackling CSE. The LSCB therefore secured funding and commissioned them to carry out a 12 month scoping exercise. This focused on identifying the links in Portsmouth between CSE and.

- Looked after children;
- Missing children;
- Children absent from school;
- Teenage pregnancy; and,
- Drugs and alcohol.

The LSCB also asked Barnardos to establish whether trafficking was a pertinent issue.

The Local Response

The following section outlines Portsmouth's response to date. The emerging findings and the development of structures and practice are documented below.

A project reference group, whose role was to help progress the work and resolve problems as they arose, was established and headed up by a senior manager from children's services. This clear commitment enabled active ownership of the project to be developed within the LSCB and the constituent agencies that made efforts to identify

resources where necessary in order to sustain the work.

The Barnardos lead consulted with professionals and conducted interviews with young women up to the age of 18 where, for example, a social worker had concerns that there was a CSE issue.

As part of the awareness raising agenda the lead visited the different professional groups and liaised with the network of representatives on the LSCB so that information and awareness could be 'cascaded' across agencies. This included Hampshire Police, probation, prisons, the primary care and acute trusts, the youth offending team and other statutory partners of the LSCB. In their efforts to identify potential trafficking they visited the Border and Immigration Authority (now the UK Border Agency) offices in Portsmouth as well as a wider network of agencies, including those operating in the Southampton area.

Initially the level of awareness of CSE amongst all the professionals in Portsmouth was found to be low. In response learning workshops were provided. These events highlighted key facts and figures and ensured that staff were better able to identify the indicators and risk factors. Whilst trafficking was not found to be a significant issue in Portsmouth, asylum seekers and looked after children were found to be particularly at risk as both groups were often emotionally vulnerable and susceptible to grooming activities. In the majority of identified cases, the emerging picture was one of an exchange of sexual acts to gain attention and affection. Less often, there were cases of money being exchanged, as well as drugs and other items.

The resulting scoping report set out a series of recommendations and proposals. These provided a credible business case for statutory agencies to fund futher work on CSE performance managed by the LSCB. Three options for organising the work were proposed:

1. An integrated unit (police and the children's services) – it was decided that this was not viable as the evidence for the extra effectiveness it would provide was not compelling and the costs were too high;
2. A specialist service with a dedicated worker who would concentrate on linking their work with all the strategic services – this too was deemed to be too resource intensive; and
3. Joint working and intelligence sharing with Southampton, whereby a manager would oversee CSE work; carried out in conjunction with Southampton. The manager would be a member of Barnardos staff funded by the LSCB. This was selected as the preferred option.

Under this arrangement there will be one Full-Time and one Part-Time post based in Portsmouth but managed by Barnardos in Southampton. The staff based in Portsmouth will act as a point of contact for receiving and acting on referrals and providing advice. The arrangement will seek to build on the relationships that the practitioner from Barnardo's formed during the 12 month scoping study. Staff in Portsmouth and Southampton will undertake joint training.

With an evidence base established, the LSCB describe themselves as in the second phase of the project. There is a willingness to take the work forward, particularly amongst children's services, police and health, who are finalising their own funding arrangements to sustain the work over the next two years. Health have an awareness of problems relating to CSE through sexual health indicators and the police through criminal activity. However children's services are the major funder.

Whilst the project is being established, interim activity is being undertaken to keep things sufficiently 'on pace and moving', with Barnardos continuing to give advice.

The new joint project will be overseen by a reference group that will report back to the LSCB.

The Impact

- **children and young people:** Whilst it is clearly too early to think about the long term impact for children and young people, the CSE scoping and training activity has worked with a small number of individual young people, helping them to understand the risks of their behaviour and to think more carefully about the situations they were in. At a preventative level, improved information and points of contact were established for children missing from home as they are a group who are at high risk of being exploited.
- **multi-agency working and the local safeguarding agenda:** Had the LSCB not embarked on this work the response to CSE would have continued to be fragmented and reactive with services only being provided at crisis point. By comparison, the proposed arrangements hope to establish 'a service base of professionals', who can provide a better standard of opportunities and support for children and young people and a 'tiered' approach, including to preventative work, across agencies. The CSE training and awareness raising initiated by the LSCB has made a range of professionals and agencies more confident and competent at dealing with issues with their wider group of service users;
- **LSCB:** The Board was able to use the CSE work as an example which highlighted the transformation from being an ACPC to an LSCB. It was considered to be a 'quick win' for the LSCB who have been able to demonstrate that with a relatively small amount of money a service could be established that previously did not exist. As a business model.

  "It excited the LSCB and gave it a sense of the way to do things and create an impact that previously would have been difficult to make."

Barriers and Challenges

- **establishing an evidence base:** The nature of CSE is that it is very often hidden and therefore requires a proactive response. Many of the victims are unlikely to co-operate and it can be very difficult to identify the problem. Here it is vital to look carefully at patterns of missing persons, truancy, drug and alcohol use and domestic violence.

  At the outset it was important to evidence the nature of the problem. In the case of Portsmouth '*It is not a city that has a red light district or significant brothels and it is not a city where there is significant police activity in this area*'. This could have been a potential barrier but there was a resolute desire driven by the LSCB to develop a robust evidence base and begin to identify a problem which had not previously been surfaced.
- **recognising the positive impact of CSE work:** Resources and funding issues were seen as key barriers to progressing scoping to secure funding. It could be argued that a more fragmented approach to solving cases of CSE on an individual basis is more cost-effective. However, in Portsmouth there is a recognition that victims of CSE are an incredibly vulnerable group of people and that even if where there is only a relatively small number of cases, tackling them will address a whole raft of

issues affecting young people's ability to stay safe, healthy and learn;

"It's totally irrelevant how many cases there are – its vulnerable children that are being used in that way and we should be doing something about it."

- **working across borders:** Where appropriate it is important to work co-operatively with service heads in other areas. Portsmouth will establish a joint working structure with service heads in Southampton. As one professional noted, the harsh reality is that we have to work with limited resources', and working alongside your counterpart in other local areas ensures that you gain the benefits of economies of scale.

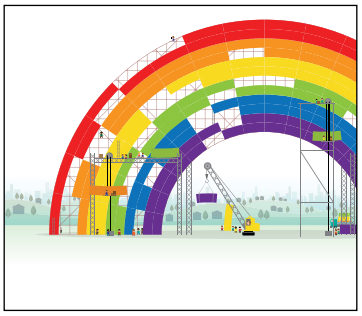
Key Success Factors

- **Commitment to a shared endeavour:** It is vital to have commitment, enthusiasm and determination to progress an effective CSE strategy. This is crucial when services are making the business case for allocating funding.

  In Portsmouth having positive interagency working and opportunities for shared learning is felt to be crucial to progressing the project and increasing shared ownership and funding across agencies such as the police, health, children's services and Barnardos. The projects' reference group had representation from the police, targeted services, drugs and alcohol and the youth offending team and this contributed to a high level of awareness about the work.

- **Securing expertise:** When looking at issues such as CSE, it is helpful to look beyond the LSCB. Here it can be: "Very easy to think within existing parameters of partners and locality agencies where actually it would be valuable to think about organisations out of the area that might be interested in partnering and bringing their capacity and expertise".

  This might include medium and large sized third sector organisations that may have considerable expertise and smaller organisations that may also have considerable skills knowledge and expertise and the ability to conduct effective outreach work and engagement activity.



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