West Sussex Safeguarding Children Partnership

Annual Report

April 2022 to March 2023

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Independent Scrutineer – Foreword

Thank you for taking the time to read the West Sussex Safeguarding Children Partnership (WSSCP) Annual Report. This document should give you an open, honest view of how the Partnership works to safeguard our children and young people. As the Independent Chair and Scrutineer of the Partnership I have the responsibility for scrutinising this report and making sure it is accurate and provides the information you, the reader, requires. I hope that it meets your expectations, provides you with the information you need and above all gives you confidence in the way the Partnership strives to safeguard children in West Sussex.

I wanted to start my introduction by offering some reassurance regarding the developing strength of the Partnership. A recent inspection of Childrens Social Care by OFSTED has shown a significant improvement in the delivery of services to our children and families. Whilst the inspection was 'single agency' it would wrong not to recognise the impact positive developments within the Partnership have had. I have personally observed the development of a safeguarding culture in West Sussex that affords everyone the opportunity to be confident that they will be supported as they strive to improve outcomes for our children and families. That culture permeates from the very top of the organisations through to the practitioners whom we rely so heavily on. There is still much to be done; the fact that this is recognised by all involved is, in itself, positive.

Representation at Partnership meetings has improved and there is a culture of support and challenge as we strive to reach our joint objectives. Perhaps of greatest importance is the fact that West Sussex is blessed with a professional, caring and incredibly hard-working community of individuals who work and volunteer in the safeguarding arena. Without these people we would not be able to provide the level of support to children and families. On behalf of the Partnership, I would like to offer each of them our sincere thanks for all they do.

This report sets out our achievements, concentrating in part, on the areas we have prioritised. Whilst it is right that we celebrate success it is also important that we recognise that we should always seek to improve. I have seen a real will to seek continuous improvement in West Sussex. The response to learning reviews has improved significantly and I am now confident that all partners are alive to disseminating lessons learned at the earliest opportunity. There remains some work to be done to assure ourselves that learning from previous reviews has been captured but a plan is in place to deal with this. Please spend some time reading the sections of this report that details learning from some of these reviews. They touch on some of the most distressing cases our practitioners, communities and families are involved in. They also offer some of the best opportunities for us to learn and improve outcomes for children. It is important that this report is fair, informative, and balanced, having read it I am completely satisfied this is the case. I want to thank everyone involved in the WSSCP for their tireless work over the last twelve months. Thank you for your continued support.

Finally, when you read this report, I would ask that you consider the impact you can have. Safeguarding children is the responsibility of all of us, professionals, volunteers, families, friends, and communities. Please don't be afraid to raise concerns, seek advice or offer to help.

Chris Robson, WSSCP Independent Chair

Independent Scrutiny – Lay Member role

The role of the Lay Member

Working Together to Safeguard Children 2018 describes the role of independent scrutiny as a means of providing "assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases.

The Lay Member's role is varied – bringing the local community voice to the Partnership; and ensuring that the WSSCP exercises its functions effectively, efficiently, and economically, with good governance and in accordance with the terms of its published constitution and Partnership arrangements.

The WSSCP is most fortunate to have a very experienced, long standing and much valued lay member who provides robust scrutiny of our improvement and assurance activity and attends the WSSCP's Steering Group. More broadly, he acts as a critical friend to the WSSCP support team providing feedback on communications and policy documents produced by the team.

As part of the 2023-26 Business Plan the WSSCP hopes to recruit new Lay Members during 2024-25 to further strengthen independent scrutiny of the WSSCP activities via a range of independent community voices.

"From the Lay Member's perspective, this has been a year of progress. Some great work in the sub-groups, not least the IAG on which I sit, has helped provide improved learning to support our teams in the field. From my contacts in the wider community, I have the highest regard for the dedication and courage of everyone who deals with the immense challenges facing young people.

I sometimes wonder if as a Partnership we undertake too many reviews; we need to be sure that that there is significant new learning that benefits all. We would do better to focus on reinforcing existing learning.

Finally, I hope very much that West Sussex will support the retention of an Independent Chair and Scrutineer. I believe that this role is essential to ensure that partners focus on the core priorities and have the benefit of support provided in an essential area of their work."

John Thompson, WSSCP lay member

Lead Partners - introduction

As statutory lead partners of the WSSCP we formulated our arrangements to work together, and with other partners locally, to safeguard and promote the welfare of our West Sussex children. The WSSCP annual report assesses the progress we have made over the past year and highlights areas where we believe the Partnership is improving, and the work we still need to do as a Partnership, which is committed to continuous development and growth.

This year continued to see unique circumstances for safeguarding, such as resourcing constraints across agencies and organisations and delivering the core WSSCP delivery functions, requiring careful balancing of partners' resources to meet their needs. Financial pressures on households, as we continued to adjust to both post pandemic realities and the continued unknowns, have thrown up new challenges e.g. around the impacts of poverty on the health and wellbeing of children and their families. Since the Covid-19 pandemic, the impact on children and young people's mental health has been significant and this very much remains an area for concern in West Sussex. The WSSCP have made a conscious effort to focus on safeguarding children's emotional health and wellbeing, with a co-ordinated multi-agency response now in place. We intend to evaluate its impact and reflect on how we can continue to support our vulnerable children across the County.

Additional Partnership concerns included the departure of several key strategic leads in conjunction with ongoing instability within the WSSCP's business support team. Despite concerted efforts to mitigate, these circumstances did collectively adversely impact on the timely progression of existing WSSCP delivery commitments. We are encouraged by the steps already taken to strengthen multi-agency working as for example our sub-group chairs worked more closely to align key deliverables. Our plan for improvement and development via our Business Plan over the next three financial years illustrates our ambition and determination to help, safeguard, protect and promote the welfare of children in the most effective way, and also to be able to evidence the impact this is having to ultimately enable all of our children to have the best outcomes.

None of the work we do and what we seek to achieve would be possible without the dedication of our front-line professionals working daily with children and families. Their indefatigable efforts to keep children safe are commendable and we thank you for this commitment in what have been and continue to be challenging times.

Naomi Ellis
Director of Safeguarding & Clinical Standards, NHS Sussex

Lucy Butler
Director of Children, Young People and Learning, West Sussex County Council

James Collis
Chief Superintendent, Head of Public Protection, Sussex Police

Executive summary - overview and key achievements

The West Sussex Safeguarding Children Partnership (WSSCP) arrangements have now been in place for three complete business year cycles. There is a clear and strong commitment across the Partnership to effect change which consistently delivers positive outcomes for children across the county. This reporting year ended positively for West Sussex County Council's (WSCC) Children's Services: an Ofsted inspection (March 2023) highlighted good outcomes for children in care and good leadership. Whilst acknowledging there are still significant areas upon which to improve, this helps set the tone for a positive shared Partnership improvement journey for 2023-24, as an assured and increasingly confident multi-agency Partnership.

The WSSCP made some significant progress over the last 12 months; of particular note is the effort made to conclude the large number of Child Safeguarding Practice Reviews and additional review related activity. The challenge for the Partnership over the next 12 months is to continue to deliver on its statutory responsibility around safeguarding reviews, whilst ensuring a proportionate response that allows sufficient focus and resource to be put into embedding key learning from reviews as well as wider Partnership activity and innovation. Furthermore, it needs to ensure that it's scale of ambition to effect change is matched with the resources needed to achieve this.

Key achievements

- **Suicide prevention:** an award-winning suicide prevention strategy was established to help tackle rising concerns around children's mental health in West Sussex. This innovative multi-agency approach included a daily triage meeting for children who are deemed to be at high risk of self-harm or suicide. It provides management support and oversight of emerging risks involving specific children - allowing for early review and safety plans to be put into place. Schools can refer children of concern directly into this team for a rapid, multi-agency response. In July 2022, it was agreed that this system would become a permanent part of our multi-agency approach to keeping children safe in West Sussex. The team were successful nominees at the HSJ patient safety awards in September 2022, winning the 'Mental Health Initiative of the Year' award. The judges stated that the new process was 'innovative, partnership working at its best, and ultimately saving lives'. This approach has been shared with partner agencies in the region and beyond.

- **ICON and DadPad:** roll out of ICON and Dad Pad promoted by a mid-year conference, continues to be successful with at least 50% of new fathers accessing the DadPad app in West Sussex. West Sussex will also benefit in 2023-24 from the introduction of the new 'Co-ParentPad' resource. There is a continued focus on key safe sleeping and abusive head trauma messages to ensure they are embedded across the entire Partnership, (i.e. not just midwifery and health visiting).

- **Improvement and Assurance subgroup** development activity included robust monitoring of audit action plans via a new reporting approach and development of audit tools and performance data. Improved connectivity between sub-group activity via a sub-group chairs forum is supporting clearer inter sub-group tasking.

- Focus on **Learning and Development** activity included a revised training offer centred on learning from audit and reviews, e.g. suicide prevention, child exploitation, trauma informed practice and adultification. Another L&D highlight saw the WSSCP host a face-to-face Conference about Online Safety.

Executive summary - key challenges

Key Challenges

Despite good progress made by the Partnership there are a number of challenges and areas of concern which need to be addressed in 2023-24:

- **Continuity of Leadership** - following a period of relative stability departures of senior leads across partner agencies including two lead partner agencies impacted strategic planning and ongoing consistency e.g. around chairing of key meetings and sub-group activity.

- **Evidencing impact** of the Partnership's learning and improvement work on outcomes for children continues to be a key challenge. Agencies and organisations are asked to comment on how they evidence impact of their work later in this report. Whilst they are confident e.g. that training, development activity and collaborative working supports outcomes for children, the evidence provided is centred primarily on e.g. initial impacts of training and collaborative meetings. This report uses two case studies which demonstrate good outcomes for children. The Partnership has commissioned an independent reviewer to facilitate an impact of learning event for practitioners and managers in 2023-24 to help the WSSCP to understand whether it has successfully embedded learning from reviews into practice. The WSSCP invested almost £100,000 to extract learning from reviews during 2022-23 and needs to know whether this expenditure represents good value for money. The Partnership must now identify and utilise the most effective ways to extract, disseminate and embed learning to make a measurable difference to children and families.

- **Capacity to deliver –** a high case review workload has placed pressures on (finite) Partner agency/organisation resources, meaning that there is reduced activity across other delivery areas. This includes the timely delivery of action plans arising from case review work. **Capacity and staff turnover** (including three different partnership managers and new administrative staff) within the WSSCP business support team during this reporting year has impeded business delivery at the pace required particularly when legacy case review activity is factored in. Whilst lead partners agreed to restore the team's headcount to pre-pandemic levels, any future funding constraints will likely diminish the Partnership's capacity to commission new training and a sufficiently robust programme of scrutiny.

- **Strengthening Partnership Group** engagement, to optimise support and interventions for children, through collaboration, helps to enable early identification and mitigation of key risks and issues. This approach will help us to listen to and understand the voice of the child, ensuring a holistic child centred multi-agency response, including understanding of a child's identity and intersecting needs. It will also support identification of emerging issues, for example the adverse impacts of the Covid-19 pandemic are expected to continue in future years. Our need to be collectively alert to what this means for safeguarding children, particularly when linked to the high cost of living and inherent pressures on families is vital. Key areas for Partnership engagement development involve working with schools and the voluntary and community sector.

- Ensuring a safe response to **mental health** challenges facing children in West Sussex is a significant challenge. There was an increased referral rate and demand for services with rising numbers of children on waiting lists with unmet mental health needs. There is a national shortage of Tier 4 provision and also appropriate social care placements. Weekly multi-agency/CAMHS meetings help ensure children who are at greatest risk are reviewed regularly, appropriate placements are sourced, and extra mental health support is provided to acute hospital teams to help them safely meet children's needs.

About West Sussex Children

In 2019 West Sussex was ranked as the **129th least deprived** upper tier local authority (out of 151) in England; this puts it in the least deprived 20% of the country overall. However, there are **17** neighbourhoods in West Sussex which are amongst the **20% most deprived** in England.

The 2021 census provides the most recent data on local population growth and ethnicity:

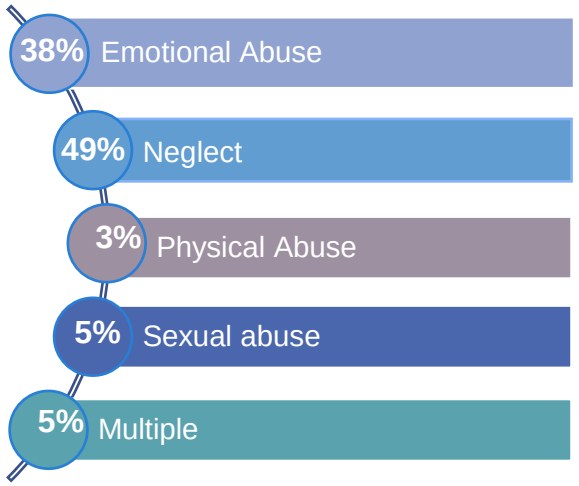
- The **population** of West Sussex has grown by 9.4% since 2011 to a total of 882,700 (1.56% of the total population of England), with growth of 7.8% in the number of children aged 0-15 years.
- Census respondents identified as: Asian, Asian British or Asian Welsh 4.3% (9.6% across England and Wales); Black, Black British, Black Welsh, Caribbean or African 1.3% (4.2%); Mixed or Multiple ethnic groups; 2.4% (3.0%); White 91.0% (81.0%); Other ethnic group 1.0% (2.2%)

The total number of children of statutory school age living in West Sussex was 114,177 (April 2022). There were 351 schools operating in West Sussex in 2021-22. 50,775 pupils attended state funded secondary schools during 2022/23 (up from 49,715. in 2021/22). Children missing education (CME) has increased to 160 in March 2023 from the previous year (114 CME)). 1.25% of West Sussex children are known to be electively home educated (2022 data).

The number of children in care in the county remained stable at 883 in March 2023 (compared to 867 in March 2022). The number of privately fostered children increased from 10 (March 2022) to 31 as of March 2023.

Snapshot: Safeguarding children during 2023, including the percentage of children on child protection plans by category of abuse (March 2023)

Total contacts: Integrated Front Door (IFD)	Total contacts resulting in a statutory intervention	Strategy discussions held	Child and Family Assessment	Child in need (per 10,000 of population)	Number of Child Protection Plans
March 2023: 4569 (March 2022: 4280)	March 2023: 1006 (March 2022: 1068)	March 2023: 690 (March 2022: 492)	March 2023: 960 (March 2022: 1079)	March 2023: 303 (March 2022: 314)	March 2023: 784 (March 2022: 702)



Voice of West Sussex children

Listening to Children: The voice of the child is captured through our review and audit work, how practitioners who worked closely with children, parents and carers is explored, involving practitioners in events wherever possible. This provides insight into children's lived experience to inform reviews and aid practitioner learning.

Areas for Development in 2023-24 - due to limited Partnership capacity during 2022-23 the WSSCP has yet to re-shape its engagement programme so that the child's voice is included in its commissioned work and e.g. staff recruitment.

Partner agencies - some examples are provided here of where Partner agencies described some of the ways they are listening to children and using their feedback to inform/improve service provision:

- **Sussex Partnership Foundation Trust** - care experienced children as well as 'experts by experience' are engaged with our Named Nurse for Looked After Children and Care Leavers. The impact of their experiences is weaved into our training with a greater focus on specific vulnerabilities of care experienced within core training. Staff who had experience of the care system have shared their lived experiences; their own expertise has resulted in their inclusion in, and oversight of training development.

- **NHS Sussex** - the government's Kickstart Scheme allowed NHS Sussex to recruit two care leavers into Participation Assistant roles; they worked with specialist teams and shadowed other professionals such as Health Visitors. The involvement of the two Participation Assistants had a direct effect on both strategic direction and frontline practice. They worked directly with staff in provider organisations to help develop and influence pathways that impact on children and ensure their voice was captured. The new maternity safeguarding pathway had direct input from the participation assistants and this ensured the voice of children and families were captured in its development.

- **Horsham District Council** established a young person forum in 2022, with ambition to develop a district wide group. There has been good recruitment to and attendance at the forum, enabling HDC to have a better understanding of children's concerns and needs.

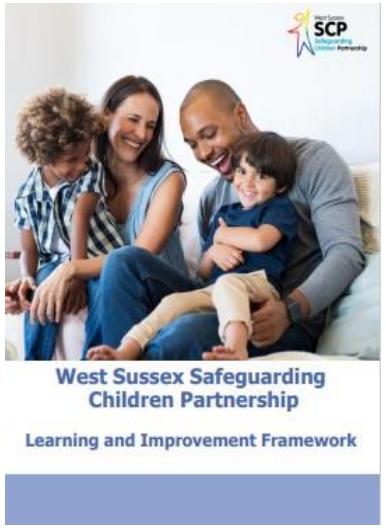
- **WSCC Public health** are undertaking a LGBT+ Children and Young Peoples Mental Health Needs Assessment This will inform system wide activity to support LGBT+ children.

Improvement and Assurance activity

The Improvement and Assurance Group (IAG) development day

A solution focused 'problem-solving' day held by the IAG in May 2022 took a candid look at barriers to effective working, and potential solutions. It identified key areas for improvement:

- Simplifying the Quality Assurance Framework to ensure its scrutiny methodology approach was accessible to practitioners.
- Improving collaboration and consistently effective multi-agency buy-in. This includes moving away from an overreliance on the WSSCP's core team to deliver Quality Assurance work.
- Overcoming challenges to the timely delivery of audit outcomes to support practical learning.
- Improving the quality of analysis of performance information.
- Following the IAG Development Day, an Independent Safeguarding Consultant delivered training to IAG members, in November 2022. This focused on audit and optimising the use of performance data. The training was well-received by the group; Partner agency/organisation attendance was disappointing.



Action taken to effect changes…. and challenges encountered

- A new Learning and Improvement Framework was developed by Partner Agencies. More work is needed to raise awareness of the framework across all levels of the Partnership.
- Improvements have been made to the audit tool to ensure the impact of learning activity from case reviews such as ensuring the child's voice is captured and to ensure that fathers/male care givers have been included in assessments and safety planning is routinely monitored.
- Delivering audit work in a timely way continues to be a challenge due to capacity across the Partnership to participate in audit activity, including producing audit reports (due to lack of dedicated resource to complete the audit report). Whilst there was very positive front-line practitioner involvement and insights gained from a multi-agency neglect audit undertaken during this reporting year, analysis of multi-agency returns was delayed. There is a perception that 'the Partnership' will produce this work and a lack of agencies/organisations being willing/able to own the work. Lead Partner agency representatives pick up much of this work, but are already stretched to their limits with e.g. sub-group chairing functions.
- Significant improvements to tracking the impact of audit action plans has been introduced in the IAG – this is already seeing evidence of impact of improvements undertaken and a greater understanding across the partnership of how we need to evidence where positive change is affected.

WSSCP data - 'Call to Assurance'

As a result of the improvement work identified, a mechanism has been introduced to request that partner agencies provide further information in relation to data indicators that IAG members identified as requiring further exploration. This has really strengthened our understanding of these issues and the extent to which we as a Partnership are assured. The following call to assurance examples demonstrate how the IAG is using data in this way to identify where additional assurance and/or potential improvements may be needed.

Call to Assurance - WSSCP practice in relation to Neglect

Tackling neglect is a priority for the Partnership. The IAG noted a decline in the number of children who are subject of a Child Protection Plan under the category of Neglect, considered within the context of the potential impacts from the rising cost of living. The IAG was cautious about interpreting the apparent decrease as a sign of improvement. Key findings included: unresolved issues concerning the consistent application of a neglect definition, consistent use of the multi-agency Neglect Toolkit, the recording of neglect in casework, and applying thresholds correctly. Learning from recent Rapid Reviews and a multi-agency Neglect audit suggest the Partnership still has considerable work to do to improve practice in relation to neglect. This exercise created a focus for further activity in what is recognised to be a challenging area of practice.

Call to Assurance WSSCP practice in relation to children who are missing receiving a Return Home Interview (RHI)

A deterioration was identified around children who were recorded as experiencing a missing episode having a return home interview (RHI). On closer examination 100% of children were offered a RHI; in some cases however, this offer was declined. Improving recording and covering staffing absences also contributed to data/recording gaps. It was found that Children's Social Care (CSC), Police, and the Missing Team work together effectively to ensure children who regularly go missing have safety and 'trigger' plans in place to ensure there is oversight of children placed outside of the local authority area. Key changes were introduced in response to the findings: improvements made to the clarity and visibility of Missing and RHI on CSC's data base system. This allows a better view of children missing, enabling a more effective capture of and response to repeat missing episodes. The Missing Team are meeting with care leavers to seek their views about best practice around capturing children who are missing and/or exploited data. The RHI process is being reviewed with them, to provide valuable service user insights.

Call to Assurance 'Step Down' to Early Help

Early Help services ensure that children and families are connected to the right kind of support quickly through a co-ordinated response with partners; they work closely with children's social care to ensure that services are stepped 'up' or 'down' to ensure that children receive the right level and type of support at the right time. Data presented to the IAG showed an increase in children 'stepped down' to Early Help (EH) following a Child and Family Assessment (CFA). Further exploration of data found that this increase was attributable to work undertaken by EH to raise awareness of the 'Step-Down' process. The 'Step Across Panel' doubled its capacity to accommodate this change, resulting in a reduction in the number of unallocated cases and waiting times for allocation. This robust and effective approach ensures the right thresholds are in place and provides confidence that the right children are being 'stepped down', resulting in better outcomes for them. The further strengthening of CSC and EH join up is also a key improvement arising from this work.

Improvement and Assurance - audit activity

Safeguarding Children who are Electively Home Educated (EHE) - Pan Sussex audit

The number of children who are electively home educated (EHE) rose during and after the Covid-19 pandemic. Whilst many children are very successfully home educated, practitioners must be attuned to the potential for safeguarding concerns in this arena. Practitioners need to differentiate between educational neglect and a successful EHE arrangement and to identify safeguarding concerns. It is also important to understand whether the child has been removed from mainstream education for positive or negative reasons.

This in-depth audit of six EHE children (aged 8-16 years), sought to understand why children moved from mainstream schools to EHE. Perceptions of bullying; anxiety; religious days not being respected; unfair treatment; lack of support; and being unhappy at school were cited by families. The audit raised awareness across the Partnership of situations where EHE and Safeguarding issues may intersect and the need to understand EHE contexts. The EHE audit demonstrated a range of strengths including effective engagement with most families, and the child's voice and lived experience informing work undertaken by the multi-agency network. Inter-agency processes were generally effective; for example, communicating safeguarding concerns between partners and the appropriate transfer of cases to the Children Missing Education (CME team).

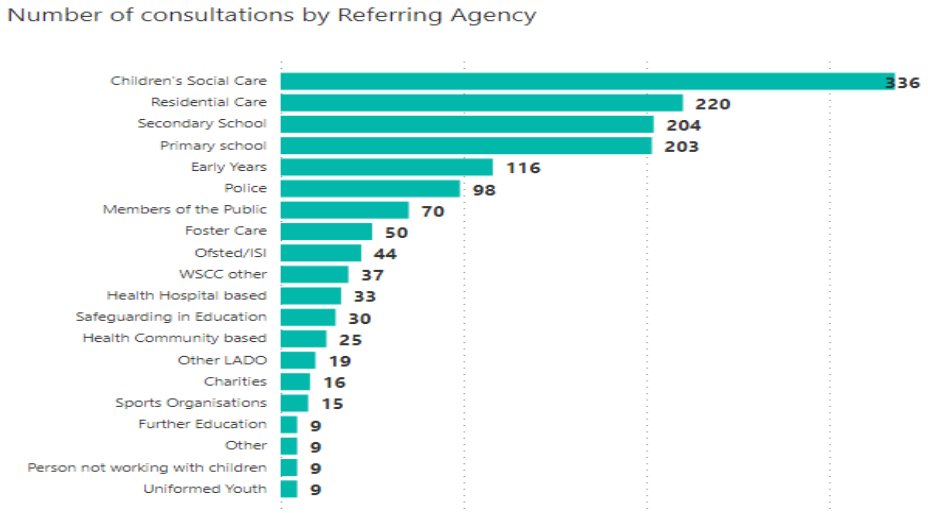
Key recommendations for systems and practice from EHE Audit included:

- Ensuring educational neglect resources are available to practitioners, supporting effective practice.
- Multi-agency professionals must understand when a safeguarding referral should be made to the Integrated Front Door (IFD) for educational neglect, in line with the WSSCP Continuum of Need.
- Professionals need to become more attuned to cultural considerations.
- Engaging with resistant parents disguised parental/care giver non-compliance with service providers more effectively.
- Pan Sussex Dispute Resolution and Escalation Protocol should be utilised, where appropriate.
- Contextual safeguarding issues should be recognised.
- Professionals should avoid 'blaming' attitudes and language.

Local Authority Designated Officer (LADO) - assurance

The Local Authority Designated Officer (LADO) service sits within the CSC's Safeguarding, Quality and Practice service and deals with allegations against staff who work or volunteer with children and there are concerns they may have: behaved in a way that has harmed a child, or may have harmed a child; possibly committed a criminal offence against or related to a child; behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children; or behaved or may have behaved in a way that indicates they may not be suitable to work with children.
Analysis of referral data for 2022-23 resulted in development of a LADO key priority area for 2023-24: to strengthen Partner's understanding of safeguarding and the allegations management process.

During 2022-23 the West Sussex LADO team were proactive in seeking to provide greater safeguarding assurance across the community by starting the 'safe clubs for children' and 'safe to play' campaigns, partnering with the National Working Group (NWG) Safe to Play partner, following a multi-agency launch event in February 2023. Hosted by Brighton and Hove Albion, the event was attended by Children's Services, Sussex Police, various sporting national governing bodies, voluntary sector and Sussex Clubs for Children.



This graph (left) details which organisations are most likely to refer concerns which led to consultations taking place: CSC; schools; residential settings; and police. This data enabled the LADO service to identify organisations who contact the LADO service less frequently with allegations or for consultations regarding lower-level concerns. The LADO service will focus on awareness-raising workshops for these settings next year.

LADO Case study - investigation to ensure appropriate use of restraint

Child A had bruising on their left arm and wrist which they alleged was sustained following a physical intervention by a staff member.

The allegation was unsubstantiated, however learning was identified around ensuring agency staff were sufficiently trained in the physical intervention methods used by the setting, should they be required to undertake such interventions. It was also identified that all staff need to know which members of staff are trained to use physical interventions, should the need for support arise.

Learning from Serious Safeguarding Incidents - activity

2022-23 was a very busy year, capacity to swiftly progress statutory functions including learning from Serious Safeguarding Incidents (SSI), Rapid Reviews (RR) and Local Child Safeguarding Practice Reviews (LCSPRs) was severely impacted by the large volume of commissioned work combined with continued instability in the WSSCP's business support team.

The individual circumstances and demographics of the children reviewed varied e.g. their ages ranged from under one years old to seventeen years. There is insufficient ethnicity and gender data to provide broader insights and trends for learning, but exploring whether a child's identity and intersecting facets and needs were understood by professionals working with the family is as an integral part of learning from RRs and LSCPRs. It is evident that partner agencies and organisations need to improve in this area. Key learning from serious incidents activity, themes and key learning identified is summarised below.

Summary of 22-23 activity

Rapid Reviews - four completed centred on: suicide and effective multi-agency working.

One **LCSPR** completed (about suicide) and two **LSCPRs** commissioned (covering suicide and effective multi-agency working).

Additional learning commissioned from serious safeguarding incidents of which one was about youth violence and a further three (two about suicide and one focussed on transitions to adulthood) will all conclude during 2023-24.

Working with other Safeguarding Children partnerships: one rapid review completed (youth violence), with two LCSPRs and one non-statutory review ongoing (serious youth violence and exploitation; and child sexual abuse).

Key Emerging themes

- Effective multi-agency working
- Serious Youth Violence and Exploitation
- Impact of childhood trauma
- Suicide prevention
- Domestic Abuse (DA)
- Working across Local Authority (LA) areas

Key learning identified

Professional curiosity; quality of assessments/assessment of risk; information sharing, including parental consent; neglect, including neglect of medical needs and resolution of professional differences.

Seeing children who offend as children and looking at reachable moments and relationship-based working. Impact of transitions (primary to secondary school and transitions to adulthood).

Understanding identity and complex intersecting needs and potential 'adultification' of children using a trauma informed practice lens.

Need to develop a preventative early help approach to support children's emotional health and wellbeing before it reaches a crisis point.

Understanding children as victims of DA under the Domestic Abuse Act 2021.

Challenges of timely communications and information sharing across different systems and local contexts and practice approaches.

Learning from Serious Safeguarding Incidents - impact and challenges

Embedding learning and demonstrating impact on practice

Multi-agency training has been developed and a conference led and hosted by another Safeguarding Children Partnership is planned to upskill and support frontline practitioners to understand the importance of exploring a child and family's identity and greater awareness of adultification bias and intersectionality to inform assessments and appropriate interventions and/or support which meet their needs.

Detail about our learning around identification of and supporting children and families where neglect was identified through reviews appears later in this report under the Pan-Sussex neglect tool kit work and learning from practice sections.

Due to concerns as to whether learning is consistently embedded into frontline practice, the Case Review Group (CRG) commissioned a practitioner event in 2023-24 to evaluate the impact of learning from a local review (completed in 2021) and a Rapid Review undertaken in 2021 which identified learning around non-accidental injuries in babies and children under two years.

Key challenges

Due to the high number of reviews in progress and recommendations to take forward, the CRG developed a combined (composite) action plan. A multi-agency working group was set up for CRG members to meet quarterly to monitor progress and implementation of actions into practice. The large volume of actions that need to be progressed by the CRG is a key challenge to be robustly addressed in 2023-24.

In response to recurring themes that arose during 2022-23, the CRG tasked the Learning and Development group to look at barriers to learning and provide assurance that learning is implemented consistently into frontline practice during 2023-24.

During 2022-23 there were inconsistencies to the membership of the CRG, including changes of Chair, Partnership Manager and interim business support in place. This settled in the autumn/winter of 2022 with a Partnership Manager, permanent Business Support led by a new Chair and Vice-Chair.

A Task and Finish group is to be convened in 2023-24 to identify barriers to information sharing by practitioners looking at parental understanding of why agencies share information/consent.

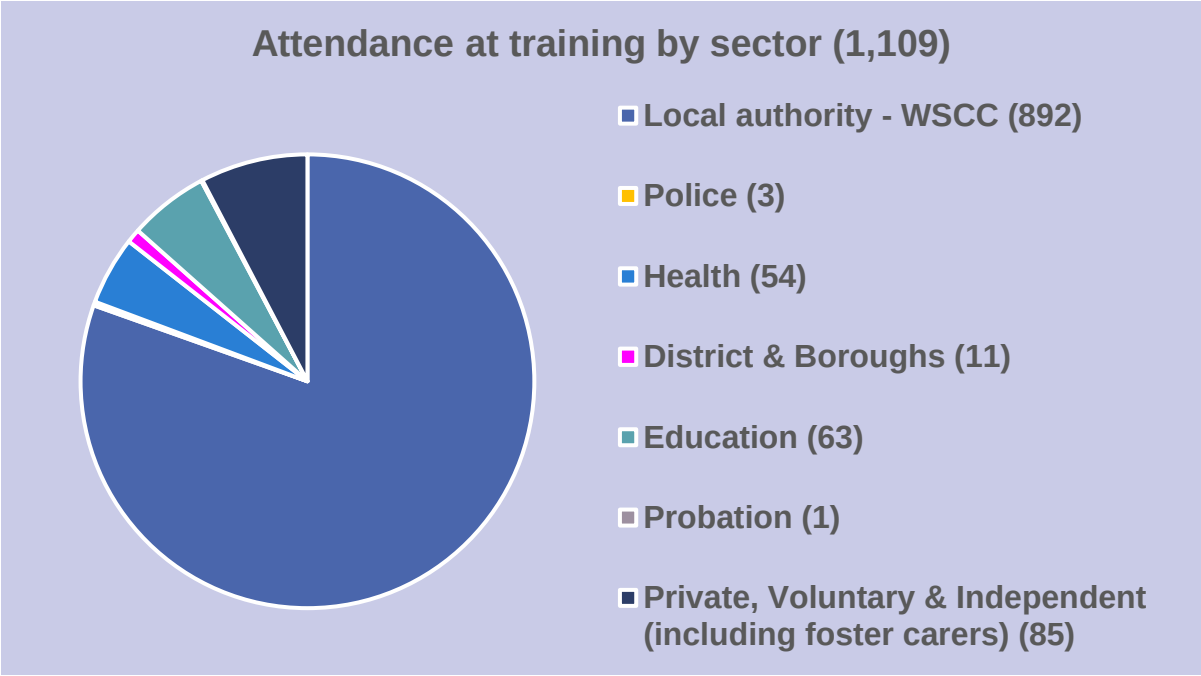
Learning and Development activity

The **Learning and Development subgroup** is proud to have developed various mediums to deliver training, from online Microsoft teams, audio podcasts, video briefings which can be better utilised by out of hours services and those who provide 24/7 service such as police and ambulance staff as well as a return to face to face sessions which better facilitate professional relationships, case discussion and ultimately multi-agency learning. Courses delivered virtually have continued to be popular and well attended. This has been taken into consideration when planning next year's training programme.

The WSSCP provides a wide-ranging training offer which is available to all agencies working with children and young people within West Sussex. Between April 2022 and March 2023, training was still being delivered virtually with the exception of two courses. The range of courses offered, listed at in full at Annex A has expanded and twenty courses were being delivered during this time, including suicide prevention, adultification and exploitation training. 1,109 practitioners across the partnership attended a WSSCP training course, increased from 904 in 2021–22.

During this period, with the exception of the Role of the LADO training and the West Sussex Annual Safeguarding Conference, all courses have been delivered online.

The number of practitioners in the training pool continues to fluctuate. This is due to trainers moving roles and taking on additional work in their daily role. The WSSCP recruits and trains trainers to support professional development.



Learning and key messages continue to be shared across the partnership in a variety of ways, to ensure that as many practitioners as possible are reached. Information is shared in the following ways:

- ❑ Via WSSCP subgroups
- ❑ WSSCP website – which has a range of resources and e.g. links to Pan Sussex Child Safeguarding and Protection Procedures
- ❑ WSSCP Monthly Email Bulletin
- ❑ Through newsletters by other agencies (for example, WSCC Early Years Broadcast)
- ❑ Learning Briefings

Learning and Development - impact and challenges

Immediate impact of training undertaken

- 90% of those who completed evaluations reported an increase in their knowledge following training. Of those, 32% reported an increase of 2 points and 36% an increase of more than 2 points on a scale of 1-10.
- 88% of those who completed evaluations reported an increase in their confidence following training. Out of those, 33% reported an increase of 2 points and 32% reported an increase of more than 2 points.

Challenges

- The West Sussex Annual Conference: 'Online risk and harm' was supported by Community Safety Partnership colleagues and welcomed a keynote speaker from Grassroots, a suicide prevention charity. Whilst attendance was good (50 delegates) this is lower than in previous years, reflecting the ongoing adjustment to returning to 'in person' events. Delegates have mixed views about this, some stating that online events are time/resource efficient whilst others value the benefits of face-to-face interaction as a multi-agency cohort. 2023-24 will see a mixture of online/in person learning and development activity.
- WSCC professionals accounted for 80% of delegates; police attendance remained very low. Shift patterns play a significant role in the attendance at training from some organisations and more creative ways to share key messages via podcast and briefings were used this year and are planned for the year ahead. 221 practitioners did not attend training they had booked. In order to drive improved attendance, the WSSCP intends to reintroduce non-attendance charging.
- A key challenge for the Learning and Development group in 2023-24 is to address the discontinued Learning Platform and provide delegates with an affordable alternative easy access online replacement platform.

Delegates feedback

Online Safety and harm conference: "Today has given me the extra knowledge I need to signpost people to the appropriate support"

Addressing barriers to safeguarding children effectively: "Ask the right questions to explore alternatives"

Professional curiosity "I will continue to think about situations and be curious when I have a gut feeling that things are just not making sense

Safeguarding Hot Topics (Fabricated/ Induced Illness):"That there is no way of telling if a bruise is a new or old bruise"

Neglect: "I will be more confident in using my professional curiosity around potential issues of neglect"

Working Together to Safeguard Children Refresher: "Excellent.. so good to be able to speak to others about their roles outside of just being with Designated Safeguarding leads from schools"

Recognising and Responding to Child Exploitation Using a Contextual Safeguarding Approach: "I will be discussing this widely with my conversations in schools, ensuring they are offering relevant interventions and support where possible"

Working Together to Safeguard Children: "Applying relevant information when completing referrals applying knowledge process of escalating concerns applying knowledge when looking out for safeguarding concerns/issues"

Suicide Awareness – Working with young People Under 16 years: "This course helped me immediately talk to a parent and the risks to their child following a recent overdose and helped me to escalate my concerns to Children's Social Care"

Improving systems and practice

The WSSCP holds regular **child safeguarding liaison meetings**, enabling front line practitioners and managers to table practice discussions where they consider there may be:

- ❑ Multi-agency systems and practice learning from complex safeguarding issues.
- ❑ An opportunity to highlight good practice.
- ❑ Dissemination of wider learning and safeguarding activity.

The forum identifies improvements and shares across the Partnership. Subject matter tabled is varied; during this reporting year discussions included e.g. emotional health and wellbeing, gender identity, Child Sexual Abuse (CSA) and Female Genital Mutilation (FGM).

Key benefits:

- ❑ Well attended meetings, networking opportunities and promotes a shared understanding of risks and issues across systems and practice.
- ❑ Learning is identified swiftly.
- ❑ Direct links to front line practice and an understanding of barriers to effective multi-agency working to safeguard children.
- ❑ Opportunities as a wider Partnership network to consider national learning and its application locally.

Challenges

- ❑ Capacity to disseminate learning and across the partnership – whilst learning is quickly identified there is insufficient capacity within the group to expedite e.g. learning briefings/resources.
- ❑ Changes of Chair (three changes in under 6 months) impacted on continuity and also the group's sense of purpose and direction. The new meeting Chair has mitigated this by looking to refresh the groups' Terms of Reference to provide clarity e.g. around demonstrating improved outcomes for children are achieved though this sub-group's activity.

Established in 2019 as part of the WSSCP's neglect strategy, The **Neglect Champions forum** meets in person twice each year. Led by the Early Help Service, frontline practitioners 'champion' awareness of neglect and consistent use of neglect identification tools and how Neglect Champions from other agencies operate within their role.
In October 2022, the group looked at 'A day in the life' audit tool. Feedback about the day was positive e.g. there was "positive reinforcement (about the) … model of (addressing) ...neglect, sharing good practice examples."

Strengthening our Partnership Arrangements

Partnership Arrangements

The Partnership's vision and values can be found at Annex A. The arrangements, introduced in September 2019, remain under review. This section describes changes made to the arrangements during the reporting year, the rationale for doing so and the impact it is intended to have. Given that changes have been recently implemented, the difference it is currently making will be reviewed in the next annual report.

Key Partnership highlights over this reporting period included:

- A subgroup chairs forum was introduced to support strategic direction and coordination of WSSCP sub-group activity work and improved communication and tasking between groups. This leadership group meets between Steering Group meetings, enabling agenda planning and discussion of emerging issues and risks. The Independent Scrutineer chairs the forum ensuring independence whilst also acting as a critical friend.
- The Partnership reframed its approach to tackling child exploitation by reverting to the original governance arrangements developed in 2019. This move ensures that, whilst broader strategic work continues to address exploitation and extra-familial harm across the county, a strategic group solely about children ensures a keen focus. A workshop convened by senior leaders developed the scope of the group, now named the Extra-Familial Risk and Harm Group. It is chaired by Police and CSC.

Key areas for development during 2023-24

- The independent scrutineer and lay member roles remain vital to the ongoing development of the Partnership and are much valued. Developing (i) a robust scrutiny programme, including independent scrutiny of the impact of the business plan, delivery challenges and risks; (ii) lay member recruitment and (iii) a strategy to engage the voice of children will build on progress already made to date.
- Further development of the Partnership Group to ensure that all partners are represented, particularly the voluntary and community sector to strengthen our arrangements to support children and families across West Sussex.
- Ensuring that there is capacity within the partnership to prioritise taking forward recommendations from national learning and briefings in a timely way. For example, the Partnership Group identified further work needed around the Child Safeguarding Practice Review Panel report recommendations: the 'Myth of invisible Men'. Self-evaluation work commenced this year and will conclude in 2023-24.

WSSCP Business Plan Priorities

Priority work areas for 2022-23: Improved outcomes for children are at the core of what we do. Partners focussed on identifying new business plan priorities in 2022-23, resulting in a flexible three year business plan running between April 2023 to March 2026. In the intervening period partners continued to focus on existing priority work areas: neglect, child exploitation and effective multi-agency working. The following section of this report articulates how individual agencies contributed to these priority areas and how they have measured its impact. WSSCP work in these areas is described throughout the report, driven by sub-group activity. Whilst the Partnership strives to ensure effective multi-agency working, this needs to be strengthened.

Business Plan Priorities for 2023-26 were developed over this reporting period: twelve potential priority areas were identified. Five priorities were selected, using the evidence base described in the table below, encompassing local learning and data in conjunction with national learning, policy and legislation. The three year plan has sufficient flexibility to take on additional priority work identified as an emerging risk or issue.

Priority area	Evidence base
Strengthening effectiveness of our multi-agency practice	**Local:** Learning from local and national reviews and audit; recent examples: EHE audit (October 2022), rapid reviews (December 2022); Feedback from partner agencies; Local performance data. **National:** Ofsted: Solihull JTAI – benchmarking; National Panel: Child Protection in England recommendations; Children's Commissioner reports e.g. The Big Ask/Answer and Family Review.
Child Sexual Abuse: Protecting and safeguarding our children	**Local**: Learning from rapid/learning reviews; local performance data **National:** Ofsted report: Review of sexual abuse in schools and colleges Ofsted JTAI: Multi-agency response to child sexual abuse in the family environment; IICSA: Final report; CSA centre of expertise data
Tackling Child Exploitation	**Local:** reviews and learning activity; local performance data. Review of current strategic and operational multi-agency delivery structures. **National:** National Panel report: "It was hard to escape". Protecting Children from Modern Slavery and Trafficking; NRM data
Children as victims of Domestic Abuse	Local: Rapid Reviews (2022); Op Encompass compliance data and local performance data National: Domestic Abuse Act 2021; National Panel briefing: multi-agency safeguarding and domestic abuse
Children's emotional health and wellbeing	**Local:** learning from reviews rapid reviews (2021) and single agency reviews; local performance data. Pan Sussex Public research and review findings. National: Suicide in Children and Young People National Child Mortality Database Programme Thematic Report Molly Russell inquestCovid-19: children and young people

WSSCP Priority – Neglect

The table below summarises how WSSCP partners are raising awareness and evidencing the impact of the WSSCP's neglect strategy on front line practice.

Raising awareness	Impact
NHS Sussex: neglect is a key focus of Level 3 training during the last 12 months, including training delivered to NHS Sussex staff and Primary Care staff. Training included overview of the West Sussex neglect strategy and agreed escalation processes within the County.	Increased awareness of the WSSCP neglect strategy by frontline professionals working with children and families. All of our training now contains focus on Trauma Informed Practice, to ensure staff are aware of the impact of neglect and the importance of early identification and intervention. **Evidence:** Feedback from staff: training is informative and helpful. Facilitators observed challenges with our virtual offer and would like to offer a richer learning environment. Training will therefore move to face to face sessions in 2023/24, with a focus on 'lifespan'.
Sussex Police: key examples of policing responses to neglect include recognition of neglect; immediate safeguarding (use of emergency police powers); Partnership working to mitigate the ongoing risk and consideration of the suitability/feasibility of seeking a Criminal Justice outcome: ❑ "60 second briefings" identifying signs of child abuse and/or neglect; intranet articles including national review learning e.g. 'Arthur and Star', professional curiosity and capturing/recording the voice of the child (VotC). ❑ Review effectiveness of the use of police protection process ❑ Force wide survey, testing understanding of the need to seek the voice of the child and professional curiosity.	Training specifically delivered by Public Protection has given specialist investigators better awareness of risk and vulnerability factors in relation to neglect, what the role of the police is as stipulated within Working Together 2018 and the importance of the child's voice in neglect cases. **Evidence:** 157 survey respondents: ❑ 90% had heard the term professional curiosity and free text answers provided suggested that they understood what this meant in practical terms. ❑ 95% had heard of VotC; free text answers confirm officers understand what this means. ❑ 74% of respondents stated they would routinely speak with children when investigating/responding to an incident within which they were involved ❑ This falls to 66% when the questions are rephrased to focus purely on Domestic Abuse (DA) incidents.
Sussex Partnership Foundation Trust: has a neglect strategy directly influenced by the neglect work in West Sussex. Our strategy is embedded in policy, training and clinical consultation.	Raise awareness of neglect and use of 'day in my life' neglect tools, impact chronology and multi-agency working. Improved outcomes and understanding for practitioners and outcomes for families. **Evidence:** neglect strategy and improved interagency working.
Chichester District Council: level 2 safeguarding training in which neglect is covered in more detail, has been delivered to 150 front line staff.	Majority of participants felt better informed on how to recognise signs of abuse and the reporting on procedures. **Evidence:** Feedback from participants.

WSSCP Priority – Neglect (continued)

The table below summarises how WSSCP partners are raising awareness and evidencing the impact of the WSSCP's neglect strategy on front line practice.

Raising awareness	Impact
University Hospital Sussex: Neglect training is included in all safeguarding children training. A neglect checklist adapted for hospital staff to use to support recognition and response to neglect. Attendance to Hospital appointments is monitored utilising the 'Was not brought' to hospital appointments guideline.	Worthing and St Richard's Hospitals recognised and responded to concerns of neglect, as part of multi-agency arrangements, for over 660 children during the year 2022-23.
Queen Victoria Hospital: QVH has a neglect tool that was adopted from the tool used by the Worthing and St Richards Hospital safeguarding team. QVH prompt cards provide information to staff on safeguarding issues and how to manage these both internally and externally. Case studies are used in Steering Group (safeguarding link champions meeting). Collaborative work with medical students and a paediatrician from University Hospitals Sussex reviewed the children's burns database, identifying children whose burns were thought to be due to neglect.	The neglect tool supports raising awareness to staff of potential indicators of neglect. QVH Prompt cards are sent to all staff on enrolment in safeguarding training and available on the internal intranet. QVH's incident recording system is used to gather information about safeguarding incidents for recording purposes. This is used in a variety of forums to discuss and learn from QVH cases. **Evidence:** neglect tool is used in a limited way by staff. QVH is represented on the neglect health subgroup matrix, supporting multi-agency neglect work. Useful feedback was received from the latest safeguarding steering group when presenting a neglect case scenario. Results of the study indicated using a specialist burns multi-disciplinary team (MDT) to identify safeguarding concerns is a useful approach as many safeguarding concerns were not picked up at first presentation or assessment.
Sussex Community Foundation Trust (SCFT): Neglect champions - from Sept 21-June 22 we supported a group of staff who had been identified as Neglect champions. They were from different SCFT children's teams including Healthy Child Programme, Community Children's Nursing, and the Continence Team. We ran three in house training sessions discussing the differing types of neglect and supported them to be involved with the West Sussex neglect forums. Neglect is explored as part of safeguarding supervision.	This has work led to increased understanding of neglect and the differing types of neglect. Complexities of neglect explored and discussed including medical neglect. This has included the impact of COVID on health provision and therefore the lived experience of children. **Evidence:** 14% of calls to SCFT Safeguarding Children Advice line relate to Neglect. Safeguarding supervision records, including Looked after children's team.

WSSCP Priority- Neglect (continued)

The table below summarises how WSSCP partners are raising awareness and evidencing the impact of the WSSCP's neglect strategy on front line practice.

Embedding learning and improving practice	Impact
NHS Sussex: NHS Sussex held Joint Targeted Area Inspection (JTAI) workshops for health providers, who work across Sussex to benchmark their services and also preparedness for a JTAI. Due to the success of the JTAI workshops, these have been adapted to allow an ongoing working group develop shared approaches to each new JTAI topic as they have been released.	Sharing the learning from other areas in Sussex has helped to develop clear ownership and responsibility from 'health' in regards to a possible JTAI inspection in West Sussex. **Evidence:** Providers are already prepared in terms of having an evidence bank and a clear understanding of how such a process could impact on their work and what would be required of them.
Sussex Police: updated Force Policy and a crewmate neglect tab (crewmate devices provide officers with easy remote access to neglect guidance). Continuing Professional Development (CPD) sessions (available for all via recorded input on CPD site) include learning from national and local reviews with national / local review references. Work to improve the quality of Single Combined Assessment of Risk Forms (SCARF).	Force policies, staff knowledge up to date with best practice in relation to neglect. Refresh of policies and guidance documents allow us to inform staff and officers of best practice and learning identified from case reviews. SCARF improvement work has given officers an insight into the journey of the SCARF, with the intention of providing partner agencies with better quality information. **Evidence:** Recent SCARF and Signs audit showed that further work is required to improve the quality of SCARFs, including e.g. recording the voice of the child. A 'use of emergency powers' review is planned to ensure the power is used appropriately. A large proportion of officers are not clear as to the role of Partners nor their processes. There is a risk of reporting fatigue, this may lead to compliance rather than engagement.
Queen Victoria Hospital: Neglect discussed widely within training and in other safeguarding meetings. Dental neglect discussed widely within networks externally to the trust. NICE Guidance audit about when to suspect child maltreatment. Child not brought for appointment audit.	Training slides shared.
Sussex Partnership Foundation Trust: learning from LCSPRs continues to be impactful in our practice for example: the neglect of a child's primary health care has led to years of work around 'was not brought (WNB)' to appointments.	Improved awareness, changes systemically to how we record WNB and how we work with missed appointments. **Evidence:** Quality Improvement (QI) project underway.

WSSCP Priority- Neglect (continued)

The table below summarises how WSSCP partners are raising awareness and evidencing the impact of the WSSCP's neglect strategy on front line practice.

Embedding learning and improving practice	Impact
WSCC Public Health Directorate commissioned services place a duty on organisations to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. Examples include (not an exhaustive list) : Primary Care Smoking Cessation Services (GPs and community pharmacies) provide support to tobacco smokers aged 12 years and over who are resident or working in West Sussex (WS) and eligible for the service (includes support to parents). WS under 25 drug and alcohol service (includes support to parents). West Sussex Wellbeing Services is a predominantly over 18 service with those aged 16/17 seen by exception.	Service providers have safeguarding systems and procedures in place to recognise and respond to abuse, exploitation and neglect (including, but not limited to, child sexual and criminal exploitation, trafficking and modern slavery and female genital mutilation). Parental household support is important due to the major influence it has in children and young people starting smoking. 'Evidence: The service complies with the Pan Sussex Child Protection and Safeguarding Procedures. All staff who have contact with children, young people and families are properly selected and have appropriate checks in line with current legislation and guidance. Public Health provide leadership and input at the Combatting Drugs Partnership.
Sussex Community Foundation Trust (SCFT): ❑ Day in the life tools within Supervision ❑ Sharing concerns raised regarding three rapid reviews Nov/Dec 2022. ❑ Encourage Health Chronology to be written and shared. ❑ Allied Health Professionals have been offered group safeguarding supervision. ❑ Advice line – one contact point for staff. ❑ In depth case discussions.	The child/ren's lived experience is considered as part of supervision. **Evidence:** 24 'Day in the life' tools recorded within SystmOne as being completed by West Sussex health professionals. Staff encouraged to "think family" even when they are only involved with one child within that family. The importance of information sharing, and professional curiosity actively encouraged. **Evidence:** Content from Healthy Child Programme Safeguarding training events (Jan 23). Signposting from internal SCFT safeguarding adviceline to contact other services for information/to share concerns both internal and external to SCFT. Health chronology allows other professionals working within the family to see the extent to which health have worked to engage families. They support health professionals to analyse engagement and recognise when there is disguised compliance, drift, and delay. **Evidence:** Escalation of cases, strategy meetings called based on health information, multi-agency meetings undertaken to ensure a co-ordinated action plan regarding the health of a child.

WSSCP Priority - Exploitation

Exploitation Priority - the table below summarises how WSSCP partners are raising awareness of Exploitation to influence front line practice.

Raising awareness	Impact
NHS Sussex: held a safeguarding fortnight in November 2022, delivering several sessions around exploitation. An Exploitation Conference for multi-agency staff was also delivered free of charge with a key focus on CSE, with a range of expert speakers. The events reached around 1,165 attendees across the twelve sessions with representation from 120 different organisations (including from statutory, voluntary and the independent sector).	Increased awareness amongst staff and frontline professionals of the risks of CSE and how they can deliver a positive impact for children in their care**. Evidence:** Feedback from the fortnight indicates that the sessions were very well received, with attendees reporting that they were taking forward the related learning to embed into practice.
Sussex Police: Funding of an Exploitation Manager and Coordinators assist in ensuring subject matter experts are available to comment in a wide range of meetings. National Child Exploitation Awareness Day held. Operation Makesafe internal structures have been refreshed and material revised and redistributed to hoteliers.	The force are repeatedly using these mechanisms and forums to look at how we can better recognise, tackle CSE and CE and disrupt those responsible for the harm, as well as giving children a voice. **Evidence:** Exploitation Coordinators have increased capacity of thematic leads to deliver larger pieces of work. Increase in intelligence submissions being received by police from crime stoppers suggest that hoteliers are more aware and engaged than previously.
Queen Victoria Hospital: Four CSE questions used in Minor Injuries Unit (MIU) paperwork. QVH prompt cards contain a section on sexual exploitation.	Available for staff, but not often completed. **Evidence:** MIU children's proforma.
Horsham District Council: our Peer Group Conference (PGC), established in 2020, takes a contextual safeguarding approach to mitigate risks beyond the home i.e. peer group, online, wider community. Safeguarding Officers attend a range of partner meetings as appropriate. Training on CSE included in all scheduled refresher for staff.	Feedback from practitioners is that is has enabled them to make links with other agencies but also a safe place to discuss new emerging worries about children and places/'hot spot' locations. HDC noted there was strong partnership working for key partners. All staff aware and up to date on CSE. **Evidence:** Good attendance and buy in from agencies and partners. Compliance enforced around completion of relevant training.
Sussex Partnership Foundation Trust: our exploitation policy review resulted in a complete revision of the policy to ensure it is using appropriate language and is accessible.	With our understanding and development of all forms of exploitation our policy is now inclusive of the fundamental principles and comprehensive application to practice. **Evidence:** revised policy.

WSSCP Priority – Exploitation (continued)

Exploitation Priority - the table below summarises how WSSCP partners are raising awareness of Exploitation to influence front line practice.

Raising awareness	Impact
Adur and Worthing Councils: all types of extra familial harm are included in staff training. Weekly updates with internal and external partners, highlighting areas and activities where children might be at increased risk of harm. We host the monthly PGC with multiple partners, discussing locations and groups of concern, including adults who might pose a risk to children. We engage local businesses in neighbourhood audits and offer training to taxi drivers to spot children at risk of extra familial harm.	We have built solid relationships with the statutory, voluntary and commercial sectors in our area. This means that there is a steady flow of information sharing regarding children at risk. This supports an early intervention approach and ensures a co-ordinated, contextual safeguarding approach to reducing risk of extra familial harm. The PGC has become an integral part of mapping and responding to risk, with clear routes into statutory safeguarding processes. **Evidence:** ❑ All staff trained in safeguarding ❑ Monthly Peer Group Conference minutes ❑ Bi-monthly Junior PGC minutes ❑ Secure records of all safeguarding work relating to children and groups maintained.
Crawley Borough Council: All licensed drivers must pass a Safeguarding for Taxi Drivers course. Taxi Marshals in key locations in the town centre signpost vulnerable persons to licensed vehicles for their journey home in the evening/night time. A Contextualised Safeguarding Group set up to ensure key partners work together to proactively safeguard children in Crawley. Support was provided to an identified group of girls at risk of exploitation through partners. Targeted work with vulnerable children through Crawley College, AudioActive and Crawley Town Community Foundation delivered. Safeguarding training: Ablanda, Prevent, awareness raising on misogyny and incel.	Raises licensed drivers' awareness of safeguarding issues and responsibilities. The presence of Taxi Marshals offers public reassurance, is a deterrent and also "eyes and ears" to identify safeguarding issues. There is a multi-agency response when children are identified to ensure the whole picture is shared and agencies are working together, safeguarded them from exploitation. **Evidence:** the Knowledge Test Examination Process and ad hoc feedback from the Taxi Trade and WSCC Trainer and Course Learning Test. Feedback from Taxi Marshalls and wider businesses in the vicinity. Quarterly Contextualised Safeguarding Meetings. A mapping undertaken with children to identify where they feel safe and unsafe in Crawley in order to direct future activity of the group. Outreach was undertaken at identified hotspot areas to support children to engage in positive activities and safeguard them from exploitation.
Mid Sussex District Council: a CE session, incorporating CSE, CCE and county lines was delivered to MSDC staff. Also covered in our internal safeguarding training for front line staff. 6 sessions were carried out in 2022/23 training 79 staff.	Staff felt more confident about identifying the issue and raising concerns. **Evidence:** Through evaluation forms.

WSSCP Priority – Exploitation (continued)

Exploitation priority - the table below summarises how WSSCP partners are raising awareness of and evidencing how they are improving front line practice.

Raising awareness	Impact
Sussex Community Foundation Trust – ❑ Sharing information with MEOG and encouraging practitioners to attend. ❑ Discussion with Looked After Children's Team ❑ High priority reminder placed on SystmOne record – displaying risk of exploitation. **Arun District Council:** ADC commissioned external training using a subject matter expert to raise awareness of CE (May 2022). **University Hospitals Sussex**: youth workers are working alongside our front line practitioner support staff in recognition and response to exploitation work.	Increasing practitioners' awareness and understanding of risk. **Evidence:** Multi-agency Exploitation Operational Group (MEOG) meeting minutes. Increased awareness and understanding of risk. Children recognised as victims of exploitation – this team are already champions for these children. Evidence: Safeguarding supervision records. Anyone accessing SystmOne will be able to see the reminder. **Evidence:** SystmOne Standard Operating Procedures. High priority reminders are visible to all SystmOne users both internal and external to SCFT. They are visible on patient home screen, therefore the first view all users will see. Participants spoke of this powerful training being impactive: it helped frame positive language and to see the child first and safeguarding and not the behaviour and also understanding of 'adultification'. Evidence: Raised awareness of different types of exploitation and acknowledged how children may not always recognise they are being exploited.
Embedding learning and improving practice	**Impact**
NHS Sussex: we worked with NHSE and Sussex Police to improve the sharing of anonymised data for children who are at risk of exploitation. NHS Sussex provided training around CCE and CSE of children to Primary Care. During 2022-23 (Q4), NHS Sussex hosted a virtual conference including sessions on 'cuckooing', tackling serious and organised crime and 'honour-based' abuse. The conference was very well attended by a wide range of professionals and has been well evaluated, with learning being shared and developed into practice.	Increased awareness CE/CSE amongst health providers, who are working with e.g. A&E departments to ensure frontline staff are considering the impact of this on patients when they attend their settings. **Evidence**: This increased awareness has led to good buy-in from our health providers with the Extrafamilial Risk and Harm subgroup, where all key providers are engaged and supporting the action plan.

WSSCP Priority – Exploitation (continued)

Exploitation priority - the table below summarises how WSSCP partners are evidencing how they are improving front line practice.

Embedding learning and improving practice	Impact
Sussex Police: Improved Multi-Agency Child Exploitation (MACE) triage process. An online grooming audit was commissioned and completed. Police and Youth Justice held Parent forums. A Strategic Intelligence Review looking at repeat perpetrators of CSA/CSE was commissioned and completed.	Parent forums allow us to give parents the knowledge to spot the signs of exploitation in their children with the hope of supporting early intervention. Statistically repeat CSA/CSE perpetrators are young people/young adults; a significant proportion of assaults are committed within peer groups. Two thirds of identified perpetrators have also been recorded as a victim of crime. **Evidence:** Work being progressed more swiftly, and role specific child exploitation products have been designed and delivered to a variety of audiences. The online grooming report findings led to the creation of multiple materials to assist officers to conduct more robust investigations as well as refreshing safeguarding guidance. We now have a holistic overview of how we respond to reports of online grooming. This led to the creation of investigative guides, technical and safeguarding materials.
Sussex Community Foundation Trust: ❑ Advice line calls ❑ Supervision/Discussion with Team Leads from Healthy Child Programme, discussion with Family Nurse Partnership ❑ Exploitation Group and extra familial risk and harm subgroup attended by named safeguarding nurses. ❑ Health Needs Assessment (HNA) undertaken by School Nurses.	❑ Allows discussion and exploration of issues. Appropriate referrals made to Integrated Front Door/Police. **Evidence**: Advice line call logs. ❑ Increase in understanding and knowledge of practitioners with particular focus on lived experience. Reflection encouraged regarding personal bias. **Evidence:** Supervision records. Records - audit focusing on the voice of the child. ❑ Increased awareness within the organisation regarding the number of young people experiencing exploitation. **Evidence:** Meeting minutes. ❑ Sexual health explored as part of the HNA including, consent, whether sexually active, age of partner/s, contraception. **Evidence:** HNA template SystmOne
Adur and Worthing Councils are working in partnership with Early Help supporting families teams; we have a qualified social worker to support case management and help unblock issues.	Improving safeguarding pathways and growing a more safeguarding confident workforce, improving our practice and appropriate referral pathways. **Evidence:** More internal dialogue about cases that concern or worry staff, improved risk management, greater levels of workforce resilience and approaches to robust decision making.

WSSCP Priority – Exploitation (continued)

Exploitation priority - the table below summarises how WSSCP partners are evidencing how they are improving front line practice.

Embedding learning and improving practice	Impact
WSCC Public Health Directorate: ❑ The Healthy Child Programme Public Health Nursing teams work proactively in a prevention, identification and support capacity within pathways including: CSE, CSA, children who experience violence in the home or family, forced marriage and FGM. ❑ The Integrated Sexual Health Service (ISHS) ensures all under 18 year old service users have a safeguarding and risk assessment for CSE using the 'Spotting the Signs' template. In 2021-22, the Integrated Sexual Health Service (ISHS) expanded online testing pathways to under 18s, following the development and embedding of robust safeguarding arrangements for this age group.	**Evidence:** The service reports on this quarterly including learning from protocol. Baseline audit of ISHS demonstrated achievement of all local and national standards.
Sussex Partnership Foundation Trust: Recent Rapid Review highlighted learning for us where children are detained to police custody.	Quality Improvement (QI) project underway to ensure that we link in with operational staff.
Arun District Council: in September 2020 ADC established the PGC, a contextual safeguarding approach to risks occurring in the community as a place-based harm approach, beyond the family home. It recognises that young people are vulnerable to exploitation within their wider peer group, wider community, adults, and online harm.	Practitioners feedback is that it has enabled them to make strong partnership links with other agencies and a safe place to discuss new emerging worries for children they have and places/hot spot locations. **Evidence:** The PGC has sustained core partnership; in 2022 new partner agencies attended.
Chichester District Council: the PGC brings local school and other agencies together to discuss those children at most risk of sexual and criminal exploitation.	Action driven to keep children safe. Evidence: PGC meeting minutes.
Queen Victoria Hospital: Safeguarding training. NICE Guidance audit when to suspect child maltreatment.	**Evidence:** Training slides and numbers of attendees.

WSSCP Priority - Effective Multi Agency Safeguarding Practice

Summary of agency and organisation achievements including how they are raising awareness and embedding effective multi-agency safeguarding practice.

Raising awareness	Impact
The **NHS Sussex** Safeguarding team established system calls with provider organisations to enable sharing of trends/themes, peer supervision and a shared problem solving approach. Learning from SPRs was often discussed on such calls.	This approach has helped to promote effective multi-agency practice by identifying issues and themes that impact on the safeguarding of children early, thus ensuring appropriate changes can be implemented. **Evidence:** Learning around management of children on paediatric wards who require mental health placements/specialist social care placements has ensured acute wards are engaged with weekly CAMHS escalation calls held across the system.
Sussex Police: Working Together Briefing promoted via the intranet. We utilised a National Review Child Q to produce and disseminate a '60 second briefing'.	Officers are aware of guidance and how it relates to their role: professional curiosity; voice of the child. Sharing information with partners promptly to help better safeguard children. **Evidence:** Positive feedback received as officers have better understanding of Working Together.
Queen Victoria Hospital: QVH has adopted a policy of reporting all dog bites in children to the Police to ensure there is no risk of overlooking any issues or risks. QVH charity funded two domestic abuse (DA) sessions run by external provider, Safelives.	**Evidence:** Internal data reports. The DA sessions were well received and will be followed up with an additional session using QVH case examples and looking at the Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) risk assessment tool.
Horsham District Council: Anti-Social Behaviour (ASB) case workers are located within Horsham Police station.	Continued partnership work to ensure awareness. **Evidence:** Community safety and development teams work closely with Early Help, CSC and schools.
Sussex Partnership Foundation Trust: work we are undertaking regarding the role of men and other partners including the West Sussex Task and Finish group.	To ensure we have an effective response to these parents or carers and raise awareness to risk and related factors in practice. **Evidence:** This is an ongoing QI piece of work.

WSSCP Priority - Effective Multi Agency Safeguarding Practice

Summary of agency and organisation achievements including how they are raising awareness and embedding effective multi-agency safeguarding practice.

Raising awareness	Impact
Mid Sussex District Council: Mid Sussex PGCs are bi-monthly partnership meetings led by MSDC which consider risks to children outside the family home. Core partners include MSDC, Sussex Police (Youth officers, Neighbourhood Policing Team and Reboot), Children's Services (Early Help, Exploitation Team and Youth Justice workers), schools, town councils and service providers. We discuss groups of young people and places that are of concern in the community and consider interventions to mitigate.	The PGC meetings enabled partners to report in concerns around extra familial harm and identify ways to tackle this in partnership with other agencies**. Evidence:** information sharing at meetings.
Sussex Community Foundation Trust ❑ Participated in multi-agency Electively Home Educated (EHE) Audit.	❑ Increased awareness of EHE. Increased visibility within SystmOne of school provision. Highlighted the need to make all contacts count. The health professional maybe the only professional that a child has contact with. **Evidence**: Discussed during supervision with HCP Team leads- Supervision records; SystmOne templates and advice line call logs.
❑ Part of multi-agency working groups – SCARFs MASH	❑ Open and frank discussions facilitated regarding the ideal as opposed to the possible. Review of current practices and the impact within West Sussex of adding (to systems) the SCARFs relating to children over 5 years. Recognition of finite delivery resources. Evidence: meeting minutes.
❑ Practitioners working within Schools and other settings.	❑ Safeguarding concerns discussed within supervision and advice line calls where practitioners have a broader understanding of the child's lived experience. Increased information sharing by professionals particularly at Early Help level. Evidence: Supervision records; advice line call logs and Early help plans.
❑ Rapid reviews relating to child deaths during late 2022 via multi-agency events organised by WSCC.	❑ Highlighted the importance of both information sharing and gathering and professionals outside of 'health' maybe unaware that a contact could be virtual or by phone. **Evidence:** Minutes/action plan from multi agency learning events

WSSCP Priority - Effective Multi Agency Safeguarding Practice (continued)

Summary of agency and organisation achievements including how they are raising awareness and embedding effective multi-agency safeguarding practice.

Embedding learning and improving practice	Impact
Adur and Worthing Councils: we recently commissioned a two year capacity and capability plan to provide all case holding staff with non managerial clinical supervision through the National Centre for Behaviour change.	We are committed to promoting and supporting implementation of supervision into all front-facing and supporting roles in order to promote best-practice, accountability and increase emotional and physical well-being into workplaces that are increasingly stretched. **Evidence:** We will measure the following areas of practice: ❑ Supportive reflective function ❑ Managerial administrative function ❑ Educative: building strengths, skills and knowledge function ❑ Motivational function
WSCC Public Health Directorate: presented learning from Sussex wide research about the 'Views and experiences of fathers and non-birthing partners during the perinatal period' to the WSSCP.	The WSSCP are reviewing the learning from this research, together with the national report on 'The Myth of Invisible Men', to inform and develop to support for and inclusion of fathers and non-birthing partners during the perinatal and early years period.
Sussex Partnership Foundation Trust: Sharing learning briefings from LSCPRs across the organisation, on our web page and in link practitioner meetings. EHE Pan Sussex audit led to practice changes and integration of EHE in our systems and thinking.	Increased awareness and learning. We now have the function to record EHE within our electronic patient system. **Evidence**: learning is shared across our systems. We can now extract Pan-Sussex EHE data from our information system.
Mid Sussex District Council: We are continually looking at ways to improve our practice - we have developed tools to assist us such as templates on areas of concern and pen pictures of those discussed. We are proactive where partners are not regularly engaging and making direct contact and promoting interventions that will assist partners in helping the young people involved.	Partners are better informed of issues of concern enabling them to provide relevant information at meetings. **Evidence:** Quality of information brought to the PGC and greater engagement.

WSSCP Priority - Effective Multi Agency Safeguarding Practice (continued)

Summary of agency and organisation achievements including how they are raising awareness and embedding effective multi-agency safeguarding practice.

Embedding learning and improving practice	Impact
NHS Sussex: from April 1st 2022, the delivery of the 'health' input into the MASHs has come under the remit of NHS Sussex, along with increased staffing for the West Sussex MASH.	This change has led to increased staffing and leadership support for the 'health' offer into West Sussex MASH. This has developed information sharing pathways, improved input of health information into strategy meetings and greatly increased the quoracy of strategy meetings. **Evidence:** Strategy meetings: ❑ Improved sharing of DA SCARFS to the health system, greater engagement in multi-agency risk assessment conference (MARAC) meetings. ❑ Audit of MASH records has shown improvements including collecting Acute/MIU/UTC and mental health information under the new team, supporting a more holistic approach to risk assessment. ❑ We have improved the quality and speed in which health information is available to make threshold decisions - evidenced in MASH audit. ❑ The team trained local Primary Care teams in West Sussex to support sharing of information. ❑ Improved health analysis of risk to case discussions and decision making.
Sussex Police: ❑ Peer Group Conference set up for secondary schools ❑ Neighbourhood Youth Officers going into schools to deliver bespoke lessons around exploitation and keeping safe online. Police attend the school behaviour forum; they are piloting sharing details of children under five years of age involved in DA incidents with their GP. ❑ Regular meetings with CSC, Youth Justice (YJ) and the exploitation team around children who have come to notice ❑ Regular liaison with British Transport Police	Better information sharing with partners regarding groups of children who are a concern or particular hot spots. Teachers are better informed around signs of exploitation and able to provide parents and pupils with support. Ensures GPs are getting a better picture of what is going on in the family home when assessing risk to the child. Improved multi agency working and information sharing. **Evidence:** Good response from partners therefore we are looking to roll out a similar peer group conference for Primary Schools. .

WSSCP Priority - Effective Multi Agency Safeguarding Practice (continued)

Summary of agency and organisation achievements including how they are raising awareness and embedding effective multi-agency safeguarding practice.

Embedding learning and improving practice	Impact
Queen Victoria Hospital: safeguarding training and NICE guidance audit. The safeguarding children Named Nurse with two medical students from Brighton Medical School, and a lead Doctor from RACH reviewed MDT data.	The retrospective review evaluated patterns and types of injuries sustained by children where there had been identified safeguarding or child protection concerns**. Evidence:** The review was presented in several forums externally and won the QVH audit prize.
Horsham District Council: funding from VRP for interventions in schools which focus on exploitation, ASB, healthy relationships.	Safeguarding is at the core of this intervention work and will continue for at least another eighteen months.
Sussex Community Foundation Trust: ❑ Learning from SPR's shared with practitioners e.g. 'Star and Arthur'. ❑ Advice line – one point of contact for the Safeguarding Childrens Team ❑ Escalation of concerns.	❑ Evidence: Supervision records; Healthy Child Programme and Safeguarding Training. ❑ Cases/safeguarding concerns discussed, practitioners signposted to other agencies including Childrens Social Care, Early Help, Education and the Police. Increasing the support available/safety of the child discussed. Evidence: advice line; call log and SystmOne record. ❑ Enables honest conversations between professionals regarding concerns and preferred actions – this could be via manager-to-manager discussion, professionals' meetings or via strategy meetings. **Evidence**: SystmOne records; strategy meeting minutes and professionals' meeting minutes.
University Hospitals Sussex work alongside our partners in supporting children and young people admitted to hospital who have mental and emotional health needs and contributed to the development of supportive multi-agency guidance to ensure their needs are met, and that there is a collective responsibility in developing children's care, treatment and discharge plans.	

Effective multi-agency working - case study: Early Help

Management of a 'step down' to Early Help Service from Children's Social Care

Context:

- A Child and Family Assessment (CFA) was completed following worries about decline in mother's mental health and the impact on her and her children. Other referrals were made about concerns for the children's emotional wellbeing, in particular one child in the family.

- Safety plan arrangements already in place were reviewed by Early Help and the family. Mother realised when talking about her adverse childhood experiences she would benefit from support for her mental health; a priority appointment was arranged within one month.

Impact of multi-agency working

- By communicating with the child of particular concern via letters, the Early Help worker demonstrated care and her intent to be supportive using a method which worked for this individual child.
- A strong multi-agency network around the child contributing to planning and working together meant that the child received a timely response that met their needs. Services showed they could flex and stretch to prevent worries becoming harder to reverse or from worsening. Effective communication between Early Help and CAMHS team managers enabled a swift response and there is evidence of professional trust and working together. This meant that the child received a service in a timely way in an environment that suited them. Joint working between Early Help, CAMHS and the GP sharing the same worries meant that the child had access to additional, targeted support that will support them in the longer term.
- This support and intervention helped avoid the child's needs escalating to a likely hospital admission which may have caused the child further distress. Planning continues to progress with the ambition that the child will feel able to leave the house and return to education.
- Conclusion: the child and their family are engaged in the right support, there is a robust safety plan in place and the child continues to be a priority within CAMHS.

Feedback from mother: "None of this would have been possible without your support, you have listened and advocated for us and I feel I was able to build a relationship with you when I have not had good experiences in the past. I want to thank you so much for your support and I am sad that we will no longer have Early Help support but glad …(child) is now being seen and supported by CAMHS."

Working across Boards and Partnerships

The Pan Sussex Strategic Leads meet twice each year to agree priority areas for Pan Sussex join up. The Group's membership consists of lead safeguarding partner representatives across Sussex, i.e. West Sussex, Brighton & Hove and East Sussex. Key areas of focus include future partnership development and shared safeguarding opportunities include Learning and Development, audit and potential efficiencies.

Pan Sussex Learning and Development Group - following a restructure of NHS Sussex safeguarding leads, moving to a place based model, the Pan Sussex Learning and Development (L&D) group formed, meeting bi-annually to co-ordinate planning of Pan-Sussex L&D activity. Key focus areas are:

- ❑ Developing Pan-Sussex L&D opportunities and learning/sharing good practice e.g. learning from audit and Local/National CSPRs and co-producing Learning Briefings.
- ❑ Agreeing and monitoring a 2-year plan for Pan-Sussex L&D activity, including a 2 year cycle for a Pan-Sussex Conference/Section 11/Pan Sussex audit work.
- ❑ Considering the volume of information being shared with partner agencies and organisations, seeking efficient ways of communicating which avoids duplication and information overload.
- ❑ Agreeing and overseeing Pan-Sussex training, events and communications.

The benefits of this approach include ensuring consistency and recognising efficiencies across Sussex, which is particularly helpful to those providers who work across 2 or more local authority areas in Sussex. Key challenges are around agreeing and driving work across three local authority areas, additional time needs to be factored in and a willingness to compromise. One partner (who works across all three Sussex SCPs) commented that Pan-Sussex collaboration is a "welcome development" as this allows work to be connected/joined up and "better serves our patient population.. and our staff".

Pan Sussex audit activity included the two yearly section 11 audit, and an EHE audit described earlier in this report. Section 11 of the Children Act 2004 places a statutory duty on key persons and bodies to make arrangements to ensure that in discharging its functions, they have regard to the need to safeguard and promote the welfare of children and that the services they contract out to others are provided having regard to that need. The 2022 audit tool was streamlined to enable agencies and organises to move away from 'compliance reporting' towards identification of service improvement and development. This did result in less information available for scrutiny and challenge. Capacity issues across the Sussex Partnerships delayed the challenge event; this will be reported on in the 2023-24 yearly report.

The **Pan-Sussex Neglect and Poverty Task and Finish Group,** chaired by the East Sussex Principal Social Worker, completed a review of the neglect matrix used across East Sussex; West Sussex are focussing on updating the neglect toolkit and multi-agency training offer. The Pan-Sussex group considers best practice and learning across all three areas and the application of shared language and tools as appropriate to complement existing processes. This work will also be used to inform our refresh of the WSSCP's Neglect Strategy.

Working across Boards and Partnerships

The **Sussex child protection and safeguarding procedures** subgroup co-ordinates the development and timely review of policies, procedures and guidance for safeguarding and promoting the welfare of children and young people on behalf of the three Pan-Sussex SCPs. **Key Achievements include:**

- ❑ Excellent attendance and buy in from all lead agencies across Sussex. The Group signs off around 40 policies per year. All policies are currently up to date and reviewed in accordance with target times.
- ❑ Statement of professional differences in place and an updated escalation policy.
- ❑ Anti-racist statement agreed.
- ❑ New Pan-Sussex procedure for undertaking a RR and LCSPR.
- ❑ Regular Staff Briefings, with updates and changes to policies.

Key Challenges include:

- ❑ Ensuring individuals complete actions as agreed. This has improved over the year.
- ❑ Further work is needed to improve user experience on the host website. Liaising with PHEW (website host) during 2023-24 and using the annual staff survey will help us to understand website use and how people prefer to engage with the policies.

West Sussex Public Health have strategic oversight of the newly mandated **West Sussex Combating Drugs Partnership (WSCDP)**, a multi-agency forum and single setting for understanding and addressing the shared challenges of local substance-related harms. The WSCDP is defining its relationship with the WSSCP and other strategic and operational bodies, and bringing together action and oversight across the three strategic priorities and commitments of the national drug strategy:

- ❑ Breaking drug supply chains (including safeguarding and supporting victims of County Lines).
- ❑ Delivering a world class treatment and recovery system.
- ❑ Achieving a generational shift in demand for drugs (including evidence-based preventative interventions for school aged children, and support for children and young most at risk of substance misuse and/or exploitation).

The West Sussex Collaborative Working Agreement (CWA) provides a means to effect strategic join up/alignment across four Boards/Partnerships: Health and Wellbeing board, Safeguarding Adults Board, Safer West Sussex Partnership and the WSSCP. Strategic Leads met twice during the year to focus on joining up across four common areas:

- ❑ Emotional health and Wellbeing of Children: Mental Health
- ❑ Exploitation
- ❑ Transitions to Adulthood
- ❑ Shared learning

The CWA agreed approaches across these areas such as

- ❑ Mental Health - develop governance and accountability for leading a Partnership/Board response.
- ❑ Transitions: join up with Youth Justice to support their cohort.
- ❑ Exploitation: understanding links to violence reduction and substance misuse.

Shared Learning: Three CWA partners co-produced a podcast about learning from reviews, providing an overview of CSPRs, Safeguarding Adult Reviews and Domestic Homicide Reviews, posing questions for staff to consider and reflect on their practice.

Four common themes identified across our Reviews:

- ❑ effective multi-agency working;
- ❑ professional curiosity;
- ❑ assessment of risk
- ❑ the child's (or adults') voice.

WSSCP Budget

WSSCP annual budget 2022-23		
Income	**Amount (% of budget contributions)**	
West Sussex Local Authority	£200,500	(64%)
Integrated Care Boards	£71,861	(23%)
Sussex Police	£35,000	(11%)
District and Boroughs	£4,000	
National Probation	£1,969	
Total Income 2022/23	**£313,330**	
Carry forward: from 2021/22	£50,000	
2021/22 reserves	£163,000	
Total Budget	**£526,330**	
Outgoings	**Amount**	
Staffing/Independent Scrutiny	£245,000	
L&D/Training	£14,000	
Backoffice costs	£28,330	
Local Reviews	£101,000	
WSSCP development: consultancy	£8,000	
Total Expenditure	**£396,330**	
Agreed year on year carry forward: 2022/23	£50,000	
(2022/23 - remaining reserves to carry forward to 2023/2024)	(£80,000)	

The table (left) sets out headline WSSCP budget income and expenditure for 2022-23.

Income: of note is that the Local Authority contributes almost two thirds of the budget.

Outgoings: there was a significant amount of funding committed to review related work. The WSSCP intends to reduce spending on reviews in 2023-24 where it is appropriate to do so.

Annex A WSSCP vision, values and governance

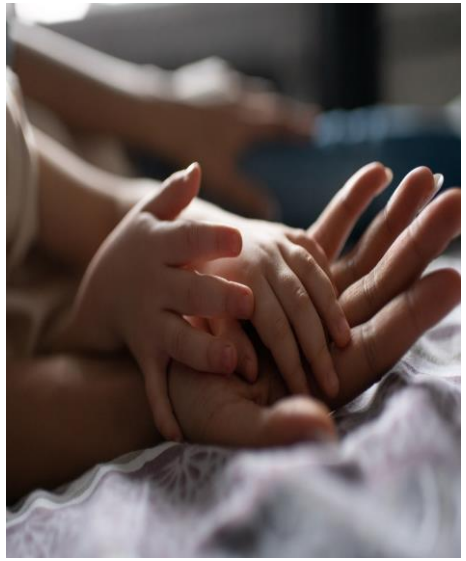
The West Sussex Safeguarding Children Partnership's (WSSCP) local arrangements

support the co-ordination of work across West Sussex to safeguard and promote the welfare of children and to ensure the effectiveness of the work member organisations undertake both individually and together.

Responsibility for this join-up rests with the safeguarding partners who have a duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area.

Our vision is to keep children young people in West Sussex safe by:

- ❑ Co-ordinating our local safeguarding activity
- ❑ Being a driving force to improve local practice
- ❑ Ensuring that all agencies fulfil their safeguarding responsibilities effectively



West Sussex Safeguarding Children Partnership - Governance Structure

Independent Scrutineer

Steering Group

Steering group: key decision-making forum, comprised of lead partners, lay member and the independent Scrutineer

Partnership Group

The Partnership Group consists of key representatives from relevant agency and organisation representatives

Subgroups

- Case Review Group
- Extra-Familial Risk and Harm Group
- Learning & Development Group
- Improvement & Assurance Group
- Child Safeguarding Liaison Group

Safeguarding Adults Board

Safer West Sussex Partnership

West Sussex Health & Wellbeing Board

Violence & Exploitation Board

Strategic & Operational Groups

Pan Sussex: Strategic Leads and Procedures Groups

Annex B WSSCP Training offer – 2022-23

This table lists the 2022-23 WSSCP training offer – some training is delivered across Sussex, recognising both efficiencies and consistency of approach.

Trainers are a combination of internal partner agency and organisation subject experts and commissioned trainers on e.g. adultification, suicide prevention and exploitation.

The training programme remains under review and is influenced by e.g. learning from audit and reviews as well as emerging risk and issues.

Working Together to Safeguard Children
Working Together to Safeguard Children Refresher
Working Together to Recognise and Respond to Child Exploitation
Recognising and Responding to Child Exploitation Using a Contextual Safeguarding Approach
Professional Curiosity
Safeguarding Hot Topics – Non-Accidental Injury
The Role of the LADO
Where Are All the Sexually Abused Boys? Implications for Mental Health, Policy and Practice
Improving Outcomes for Children Looked After
Safeguarding Hot Topics – Child Sexual Abuse
Safeguarding Hot Topics – Fabricated / Induced Illness
Suicide Prevention Awareness – Under 16 years
Suicide Prevention Awareness – Over 16 years
Harmful Practices – Femail Genital Mutilation / Breast Ironing
Harmful Practices – Forced Marriage / Honour Based Abuse
Substance Misuse and the Impact on Children and Families
Addressing Barriers to Safeguarding Children Effectively (adultification)
Reducing Parental Conflict – OnePlusOne
Reducing Parental Conflict – Advanced session
Multi Agency Public Protection Arrangements (MAPPA)
West Sussex Annual Safeguarding Conference – Online Risk and Harm
Positive Contributions to Safeguarding Reviews
Basic Awareness of Trauma Informed Practice
Motivational Interviewing
Neglect

Annex C acronym - key

Acronym	What it means
CE/CSE	Criminal Exploitation/Child Sexual Exploitation
CME	Children Missing Education
CSLG	Child Safeguarding Liaison group
CRG	Case Review Group
DA/DV	Domestic Abuse/Domestic Violence
EFRAHG	Extra-Familial Risk and Harm Group
EHE	Elective Home Education
IAG	Improvement and Assurance Group
ICB	Integrated Care Board
ICON	Babies cry, you can cope
IFD	Integrated Front Door for families
JTAI	Joint Targeted Area Inspections
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
L&D	Learning and Development Group
MASH	Multi-Agency Safeguarding Hub
MIU	Minor Injuries Unit
PGC	Peer Group Conference
QI	Quality Improvement
RR	Rapid Review
SCARF	Single Combined Assessment of Risk Form
TIP	Trauma Informed Practice
UTC	Urgent Treatment Centre
VotC	Voice of the Child
WNB	Was not bought (to an appointment)

Please also see the NHS England website for more information: acronym and jargon busters

Acknowledgements

With thanks to contributors to this report

Cathryn French	Arun District Council		Linda Steele	Children's Social Care, WSCC
Cathy Coppard	University Hospitals Sussex NHS Found Trust		Louise Jackson	NHS Sussex
Graeme Potter	Public Health, WSCC		Lucy Short	WSSCP Business Team
Jacqueline Clay	Public Health, WSCC		Mandy Cunningham	Mid Sussex District Council
James Brigden	Chichester District Council		Martin Ryan	Sussex Partnership NHS Foundation Trust
Jen Taylor	Children's Social Care, WSCC		Michael Brown	NHS Sussex
Jo Tomlinson	NHS Sussex		Miriam Williams	Children's Social Care, WSCC
Jon Gillings	Sussex Police		Nick Jenkins	Horsham District Council
John Thompson	Lay member		Nicky Reeves	Queen Victoria Hospital NHS Foundation Trust
Justin Grantham	Children's Social Care, Brighton & Hove City Council		Paula Doherty	Adur and Worthing Councils
Katie Bennett	Early Help Service, WSCC		Sharon Ward	NHS Sussex
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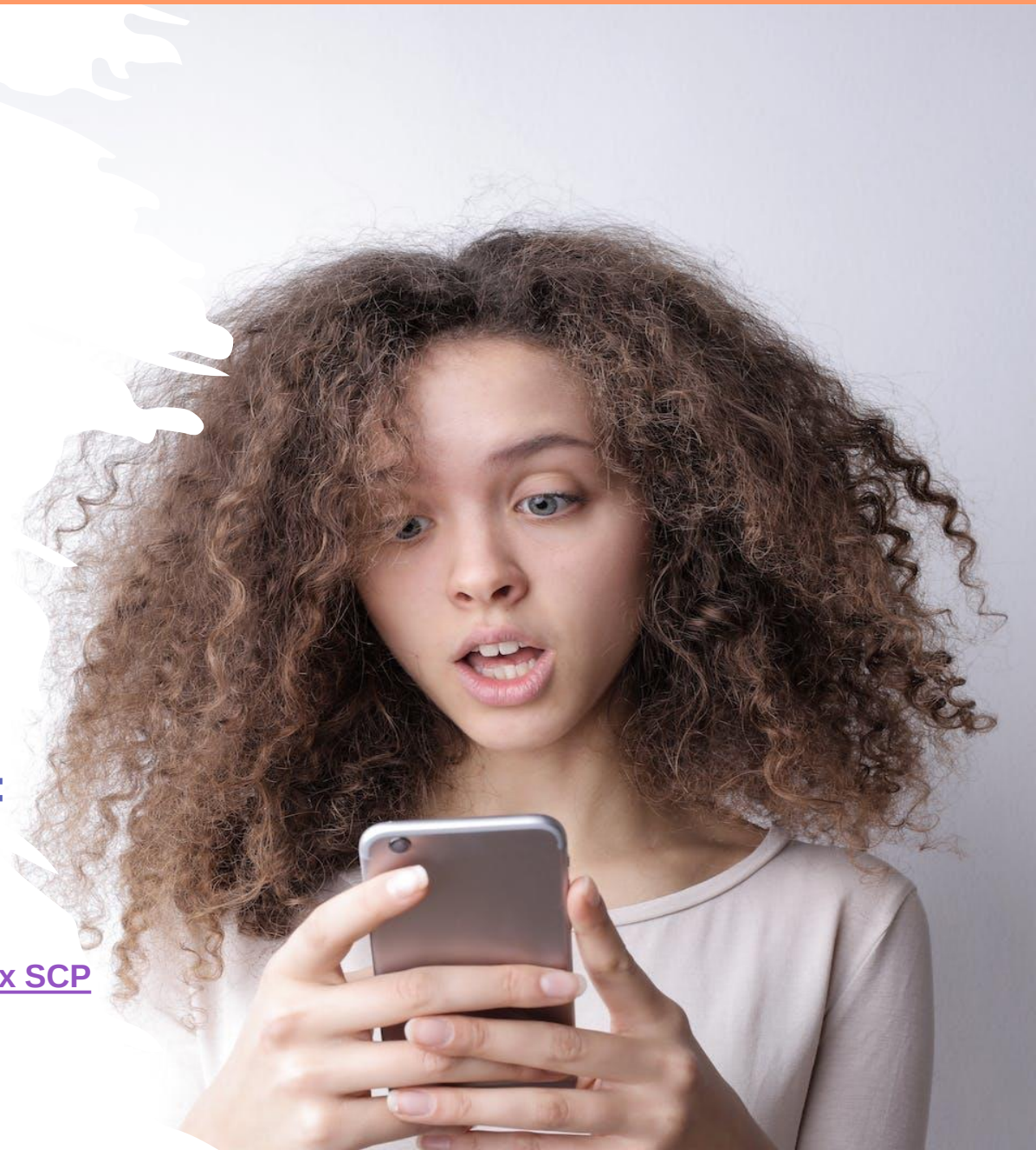
Contact us

West Sussex SCP Safeguarding Children Partnership



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