



East Sussex Safeguarding Children Partnership

Annual Report 2021/22



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Foreword

It is my privilege to present to you the third annual report of the East Sussex Safeguarding Children Partnership (ESSCP) for the period 2021/22, and my first as the Independent Chair.

I want to start by thanking all of the organisations, individuals and communities who have contributed towards safeguarding children and young people in East Sussex. Sometimes when we read these reports it can be easy to forget the one act of courage or kindness from a person that results in such a positive impact for a child and their family. Please be assured that as a Partnership we are grateful, and we recognise the important part everyone plays in ensuring our children are safe.

In East Sussex it is the statutory responsibility of the local authority, police, and health agencies to jointly oversee multi-agency arrangements to safeguard children in the county. As Independent Chair I assist this by providing independent challenge and scrutiny of those arrangements as well as helping to foment better multi-agency strategic working to protect vulnerable children and young people and ensure positive outcomes for them. I have been hugely impressed by the leaders of all three statutory agencies. They are committed, passionate and work tirelessly to achieve Partnership goals. Whilst it is not always possible to agree there is a clearly held aim to do all they can to safeguard children.

The Partnership has some real strengths that I would like to highlight. This is by no means an exhaustive list but it shows how commitment, professionalism, passion and excellent support can make a real difference. The leadership at all levels is excellent, this extends beyond the three lead partners with other individuals leading and actively participating to ensure we deliver in our priority areas. The wider non-statutory partners play an active part in all aspects of safeguarding providing challenge, support and leadership for a wide range of agencies. This contribution is essential to our success. The support given to the Partnership is exceptional. There are meetings, papers, administration and so many aspects of our work that rely on an exceptional team who support us, without them our effectiveness would be significantly diminished. I would describe ESSCP as a mature, effective, well-functioning Partnership that continues to strive for improvement.

An example of this commitment to continuous improvement can be seen when we look at the number of Rapid Reviews and Local Safeguarding Practice Reviews completed during the reporting period. These reviews arise from some of our most troubling cases where children die or are caused serious harm as a result of abuse. Where we believe we can learn we seek to do so, we are committed to continuous improvement and understand the benefit reviewing multi-agency practice can bring.

We are of course still dealing with a world that is recovering from a pandemic. This has brought challenges for us and the real impact on safeguarding continues to be assessed. Children's mental health, the impact of lockdown on children and families and the stark fact that some children remained hidden from the view of those who can safeguard them are all matters that the Partnership has considered and continue to deal with. Other challenges have developed not least the economic pressures we all face. What we have learned is that we need to engage with our communities and seek their help to safeguard our children.

This was a positive aspect of Covid-19 and as a Partnership we need to ensure we maintain the links we developed.

We continue to work hard to achieve in our four priority areas and the Partnership is updated on progress in each of them. You can read about these priorities in chapter four of the report. It is important to recognise that whilst these are key areas for us we continue to address all other areas of safeguarding. ESSCP is mature in its approach and will flex and respond to any other safeguarding threat.

The safeguarding arrangements for the diversity of children in East Sussex are complex. This report has a strong focus on what impact the partnership has had in priority areas and the evidence on which it bases its decisions in a way that, we hope, guides the reader through the complexity. I hope you find the report interesting and informative.



Chris Robson

Independent Chair of the East Sussex Safeguarding Children Partnership

1. Introduction

We are delighted to present this annual report on behalf of the three statutory partners of the East Sussex Safeguarding Children Partnership.

2021/2022 was the year in which we started to come out of the pandemic, with lock downs lifted. The context was nevertheless challenging. Workforce shortages tested all agencies with the most acute impact felt in the health visiting service, in which difficult decisions had to be taken about the targeting of resource, closely overseen by the Safeguarding Partners. Referrals to early help and social care increased and school attendance did not return to pre pandemic levels; numbers of children electively home educated increased.

Partners worked closely together, however, to ensure that children were safeguarded as well as possible. A number of important rapid and local practice reviews were undertaken, and readers of this report will see that a significant level of both learning and improvement activity took place, with measurable impact. Strengthening relationships between family members and with wider networks continues to be a major focus for the Partnership and there has been much successful practice innovation, for example in the work to support young people and families affected by exploitation and involved in the youth justice system.

We hope you find this year's report informative and reflective; many thanks to those who have put it together. Huge thanks as always are due to everyone in all agencies, statutory and voluntary, workers and volunteers, who work so hard to keep children and young people safe.



Naomi Ellis

Director of Safeguarding & Clinical Standards, NHS Sussex



Alison Jeffery

Director of Children's Services, East Sussex County Council



Jon Hull

Detective Superintendent – Public Protection, Sussex Police

2. Key Learning & Achievements 2021/22



3. Safeguarding Context 2021/22

Impact of multi-agency working

17,011 family contacts (to SPOA and other excluding MASH)
19,383 information gatherings by Multi-agency Safeguarding Hub (MASH)
4,169 referrals to statutory social care
45 Privately Fostered children

Children supported by statutory services

536 children with a child protection plan
628 Looked After Children
46 unaccompanied asylum-seeking children
5 young people at high risk of child exploitation
542 sexual offences against children

106,575 children aged 0-17 years
10,443 children claiming free school meals
9,675 black and minority ethnic pupils

2129 children living with domestic violence (MARAC)
371 vulnerable young carers
1355 children educated at home

19 children with disabilities with a Child Protection Plan
592 children attending A&E due to self-harm
3653 referrals to child mental health services

Children with health related vulnerabilities

1404 missing episodes
12 births to under-18 year olds
100 young people entered the youth justice system
11 occasions of young people held overnight in Police custody

Children with family related vulnerabilities

Children whose actions place them at risk

See **Appendix A** for more detailed information

4. Governance Arrangements

4.1 Overview of the Partnership

The East Sussex Safeguarding Children Partnership acts as a forum for the lead safeguarding partners ([Sussex Police](#), [East Sussex County Council](#), and the [Sussex Clinical Commissioning Group](#)) to:

- agree on ways to coordinate safeguarding services in (the geographical local authority borders of) East Sussex.
- act as a strategic leadership group in supporting and engaging other agencies across East Sussex; and
- implement local, regional, and national learning, including from serious child safeguarding incidents.

From the 1 July 2022 the Sussex Clinical Commissioning Group will cease to exist and the new lead safeguarding partner will be NHS Sussex.

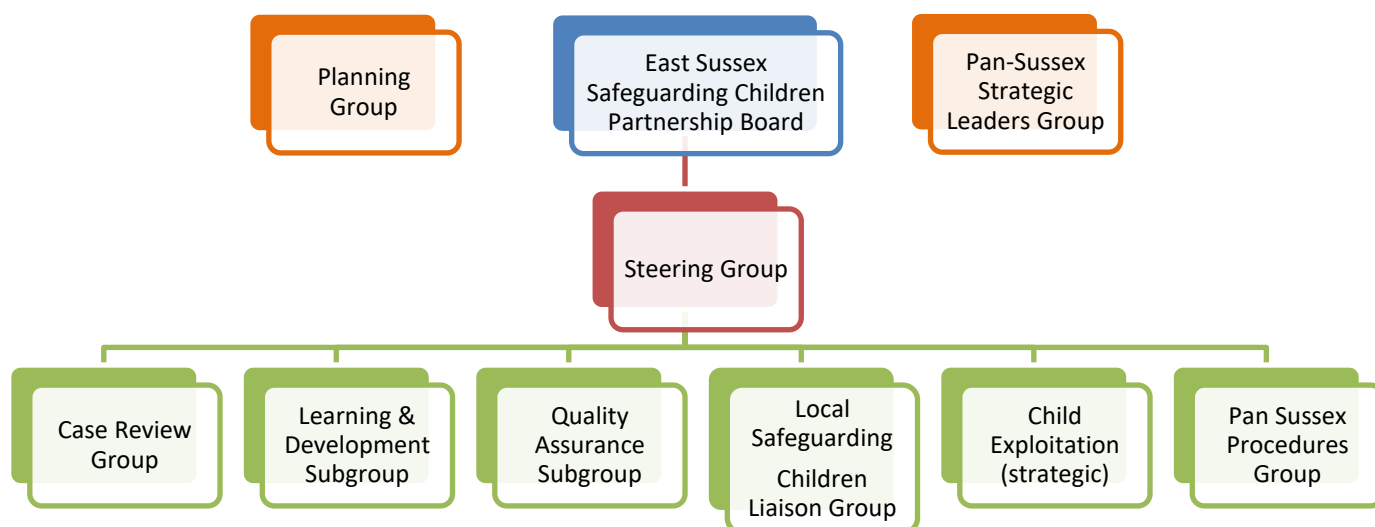
4.2 Partnership Structure and Subgroups

The Board is chaired by an Independent Chair, meets four times a year and is made up of the statutory safeguarding partners and relevant agencies (full list of board members is included in Appendix B). The Independent Chair also chairs the ESSCP Steering Group which meets four times a year. The Independent Chair fulfils the role of the Independent Scrutineer and acts as a constructive critical friend to promote reflection to drive continuous improvement.

The main Board is supported by a range of subgroups that lead on areas of ESSCP business and are crucial in ensuring that the Partnership's priorities are delivered. These groups ensure that the Partnership really makes a difference to local practice and to the outcomes for children and young people. Each subgroup has a clear remit and a transparent mechanism for reporting to the ESSCP, and each subgroup's terms of reference and membership are reviewed annually.

The three ESSCP safeguarding leads and the Independent Chair form the Planning Group, which also meets quarterly. The Planning Group discusses and agrees the short-term agenda for the work of the partnership and addresses any emerging safeguarding issues requiring strategic input. It also agrees the budget for the ESSCP (see Appendix C).

The Pan-Sussex Strategic Leaders Group membership consists of lead safeguarding partners across East Sussex, West Sussex, and Brighton & Hove. The group's purpose is to focus on setting the 'road map' for future partnership development and identify shared safeguarding priorities and opportunities across the three areas.



Terms of Reference for all the groups are in the process of being refreshed and will be shared on the ESSCP's website here: [Subgroups - ESSCP](#)

4.3 Links to Other Partnerships

The Partnership has formal links with other East Sussex and Pan-Sussex strategic partnerships, namely the Health and Wellbeing Board; Pan Sussex Child Death Overview Panel (CDOP), Safeguarding Adults Board (SAB); Safer Communities Partnership; West Sussex and Brighton & Hove Safeguarding Children Partnerships; Children and Young People Trust (CYPT) and Local Head Teacher Forums. Links to other significant partnership documents are highlighted in Appendix D.

The ESSCP Independent Chair is also the Independent Scrutineer for the West Sussex and Brighton & Hove Safeguarding Children Boards which will enable and facilitate greater joint working between the three areas. The Chair also maintains regular liaison with other key strategic leaders, for example, the Police and Crime Commissioner, Adult Partnership Chairs and Government inspection bodies.

The ESSCP annual report is presented to the East Sussex County Council People Scrutiny Committee, East Sussex SAB, the Safer Communities Board, the Police and Crime Commissioner and other ESSCP member organisations' senior management boards.

In 2021/22 the ESSCP worked with the Safeguarding Adults Board (SAB); Safer Communities Partnership; Children and Young People Trust (CYPT) and the Health and Wellbeing Board to develop the '[East Sussex Partnership Protocol](#)'. The protocol sets out the relationships between key partnerships to promote the health and wellbeing of East Sussex's communities. In relation to safeguarding, the protocol aims to secure coordinated partnership working that avoids duplication and achieves better outcomes for the people of East Sussex.

4.4 Pan Sussex Working

Although the ESSCP's focus is on safeguarding children in East Sussex, it should be expected that child protection and safeguarding procedure continue to be developed at a Pan Sussex level, and opportunities for joined up working across Sussex will be promoted where appropriate. Examples of Pan Sussex working in 2021/22 include:

- **Pan-Sussex Learning & Development** opportunities:
 - *2021/22 training:* Multi-Agency Public Protection Arrangement (MAPPA), Improving Outcomes for Looked After Children, Harmful Practices. Suicide Prevention is a Pan Sussex offer via Grassroots – four sessions, two looking at under 16 year olds and two at 16-18 year olds.
 - *Planned training in development:* Cultural Competency
- **Safeguarding Children Under 5** – The three SCPs delivered a very successful 'Safeguarding Under 5s' virtual conference in November in which nearly 200 professionals attended.
- The three SCPs have worked together to support two publicity campaigns: "**ICON Week**" held at the end of September 2021 and "Its Your Call Campaign", including working with the NSPCC to promote community and wider partnership awareness of safeguarding children
- **The Pan-Sussex procedures working group** reviews, updates and develops safeguarding and child protection policies and procedures in response to local and national issues, changes in legislation, practice developments and learning from LCSPRs and quality assurance activities. Since March 2020 approximately 95 policy/procedures/protocols/guidance have been reviewed by the group (some policies will have been reviewed more than once in this timeframe. Since March 2021 a number of new policies have been published. These include:
 - A new procedure has been published which sets out the actions to be taken in relation to children and families who move across local authority boundaries, either on a temporary or permanent basis.
 - A policy in relation to safeguarding children in hospital.
 - A Children Missing Education Procedure.
 - Responding to a potential cluster of suicides for those aged under 18.

There has also been some significant re-drafting of existing policies and procedures. This includes:

- Bringing together existing guidance around criminal and sexual exploitation with serious organised crime and gangs.
- An updated Safeguarding Children impacted by Domestic Abuse policy, following the Domestic Abuse Bill receiving Royal Assent.
- An updated Fabricated or induced illness (FII) and Perplexing Presentations (including FII by carers) policy following learning from local cases.

After each meeting, a short briefing is disseminated to the Group for onward cascading across their agencies to front line professionals.

- **Suicide Prevention and Emotional Health and Wellbeing** - there is an emerging picture of increased pressure on already pressed CAMHS and acute services across the Sussex. Acute hospital settings have also seen a rise in self-harm presentations. A Sussex Strategic Self-Harm and Suicide Prevention group has been established to take forward a pan-Sussex strategy and take responsibility for actions arising from a spike in child suicides during May/June 2021. This group is

Chaired by the Director of Public Health in East Sussex. A cluster response plan was developed by West Sussex County Council to address local risks.

- **Pan Sussex LCSPR Procedures** – work is progressing on the development of a Pan Sussex procedure for conducting LCSPRs. All three areas have met and discussed with local CRG reps to review the proposed procedure. Edits to be made to final version.

4.5 Ongoing review of Partnership Arrangements

Lead Safeguarding Partners Self-Assessment

At the end of 2020/21 the ESSCP lead safeguarding partners undertook a self-assessment as part of the activity to review the effectiveness of our partnership arrangements. The self-assessment tool was developed based on the University of Bedfordshire research *'six steps for independent scrutiny of safeguarding children partnership arrangements'*. Leads separately self-assessed the partnership, followed by a collective discussion at the Planning Group to agree a red, amber, or green rating against specific questions linked to the six statements. The process will be repeated again at the end of 2022/23.

For 2021/22 a Partnership Development Action Plan was created to address the areas rated as amber or red. A number of actions included *'involving children, young people and families in plans for safeguarding children'*. Examples of progress made include:

- Improvement was made in *'involving young people in the review of safeguarding activities'* by inviting a young person to be part of the panel for the section 11 audit.
- A young people panel was held for the recruitment of the Independent Chair
- In late 2021/22 work started on developing the role of a young person scrutineer.

Review of arrangements with Board Members

At the end of 2020/21, the ESSCP Chair, Business Managers and Lay Members spoke to a total of 14 board members to consider the effectiveness of current partnership arrangements. Specifically, those board members were asked about their role and the support to fulfil the expectations of that role, and the functioning of partnership board meetings.

Generally, the feedback was very positive with all board members interviewed commenting on the effectiveness of the partnership and board meetings in general. A few Pan Sussex agencies commented that the East Sussex SCP feels particularly well-functioning and collaborative, with good attendance by agencies. Given the diversity of agencies interviewed, it was encouraging that all members understood and valued their membership of the board, and how this supported the safeguarding of children across the whole system.

Identified areas for improvement were added to the Partnership Development Action Plan. Examples of progress in 2021/22 include:

- Publication of the East Sussex Partnership Protocol between the ESSCP and other East Sussex Partnerships, to ensure that opportunities to share learning are maximised.
- The Partnership's Induction Guidance for New Members was formalised and shared.

- A new Independent Chair and Lay Member were recruited.
- The ESSCP Learning and Improvement Framework was refreshed.

4.6 ESSCP Priorities for 2020/23

Following the formation of the ESSCP in September 2019, discussions took place to determine our priority areas of focus for 2020 to 2023. The partnership felt strongly that priorities should relate to key areas of child safeguarding; those identified as of highest risk in the county, where multi-agency working is essential and where significant change and/or commitment is necessary to reduce risk.

Priority development took place at the start of the year, with both the Steering Group and Board, and were agreed by the three safeguarding partners in May 2020. More information on the priorities is contained in the impact and evidence sections of this report. The agreed ESSCP Priorities for 2020-2023 are:

- **Safeguarding in Education**
Lead: Senior Manager, Safeguarding and Assessment, Standards and Learning Effectiveness Service (SLES), Children's Services
- **Child Exploitation**
Joint Leads: Detective Chief Inspector, Safeguarding Investigation Unit, Sussex Police / Head of Specialist Services, Children's Services
- **Embedding a Learning Culture**
Lead: Managers, East Sussex Safeguarding Children Partnership
- **Safeguarding under 5s**
Joint Leads: Designated Nurse Safeguarding Children, Sussex CCG / Consultant in Public Health, Public Health

It is considered that ensuring the voice of the child is heard, and taking a contextual safeguarding approach, should be cross cutting over all the ESSCP priorities.

5. Learning

The ESSCP is committed to creating and strengthening a learning culture across all agencies in East Sussex who work with children and young people. A culture which is open, and able to challenge all partner agencies, will be able to identify learning, improve, and then evaluate effectiveness.

Below are examples of 'learning' within and across the ESSCP in 2021/22.

5.1 Learning from Rapid Reviews and Serious Case Reviews

Case Review Activity 2021/22

In 2021/22 the ESSCP undertook eight Rapid Reviews following serious safeguarding incidents, where a child had died or been seriously injured, and where abuse or neglect is known or suspected. Of the eight rapid reviews undertaken:

- ✓ Four progressed to LCSPRs (Family CC, Child AA and a Thematic Review based on two cases);
- ✓ Four did not lead to a LCSPR. In these cases learning was shared via learning briefings and individual agency actions from rapid reviews are monitored by CRG

One outstanding SCRs – Child V (Infant injuries) due to be published imminently following completing of criminal procedures (expected Sept 2022).

During 2021/22 the three safeguarding leads and ESSCP Board signed off the following LCSPRs:

<p>Child X (not published locally due to on-going safeguarding vulnerabilities, anonymous report published on NSPCC repository)</p> <p><u>Child X Learning Briefing 2022 (esscp.org.uk)</u></p> <p>Key learning:</p> <ul style="list-style-type: none">✓ Enhance safeguarding for electively home educated children✓ How agencies respond to safeguarding concerns about children from minority faith groups such as the Jehovah's Witness community✓ Information sharing✓ Access to health resources	<p>Child Y (not published locally due to on-going safeguarding vulnerabilities, anonymous report deposited on NSPCC repository)</p> <p><u>Child Y Learning Briefing 2022 (esscp.org.uk)</u></p> <p>Key learning:</p> <ul style="list-style-type: none">✓ Importance of communicating with the child✓ Convening multi-agency meeting✓ Improving practice and quality of Achieving Best Evidence (ABE) interviews✓ Building effective relationships with families
<p>Child Z (delay in publication due to ongoing criminal proceedings)</p> <p><u>Child Z Learning Briefing 2022 (esscp.org.uk)</u></p> <p>Key learning:</p> <ul style="list-style-type: none">✓ The legacy of relationships characterised by domestic abuse	<p>Thematic Review (publication expected Sept 22)</p> <p><u>Thematic Review Learning Briefing 2022 (esscp.org.uk)</u></p> <p>Key learning:</p> <ul style="list-style-type: none">✓ Knowing and considering a parent's history and vulnerabilities

<ul style="list-style-type: none"> ✓ Information sharing about adults who may pose risks to children ✓ The importance of assessing background information ✓ Assessing risk to children from risky adults who are not household members, but part of the child's wider network 	<ul style="list-style-type: none"> ✓ Working with hard to engage families who refuse to cooperate with child protection planning ✓ Recognising if there is no further police investigation of an issue does not mean that a child is not at risk ✓ The impact on children of reoccurring domestic abuse and parental mental health issues ✓ Vulnerable children approaching adulthood ✓ The impact of COVID-19
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The **Child W Serious Case Review** was also published in July 2021, following completion of the criminal proceedings. The SCR was conducted following the death of an eight-week old baby, known as Child W, who died from non-accidental injuries in 2018.

The full report and learning briefing can be found here: [East-Sussex-SCP-SCR-report-Child-W-FINAL-.pdf \(esscp.org.uk\)](#) and [Newsletter \(esscp.org.uk\)](#)

Key learning:

- ✓ Infant injury and promotion of ICON programme
- ✓ Support to care leavers as parents
- ✓ Proactive information seeking and sharing
- ✓ Challenge to families and professionals

Rapid Review learning

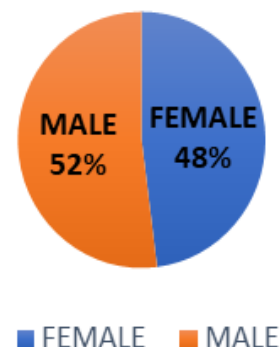
<p>Child 1</p> <p>Child 1 Rapid Review Learning (esscp.org.uk)</p> <p>Key learning:</p> <ul style="list-style-type: none"> ✓ Children who have disabilities are at an increased risk of being abused compared to their non-disabled peers ✓ Professionals to better identify, consider and work with fathers and male partners ✓ Impact of caring on parent's mental health 	<p>Child 2</p> <p>Key learning:</p> <ul style="list-style-type: none"> ✓ The importance of adhering to the bruise protocol ✓ Appropriate action to be taken by GP on receipt of discharge letter
<p>Child 3</p> <p>Key learning:</p> <ul style="list-style-type: none"> ✓ Better collaboration between services when risk is known ✓ The negative impact poor living conditions has on children's wellbeing 	<p>Child 4</p> <p>Key learning:</p> <ul style="list-style-type: none"> ✓ Over optimism of professionals that parent could maintain a safe environment considering known risks ✓ Exploitation of vulnerable parent

✓ Responding appropriately to the learning needs of parents

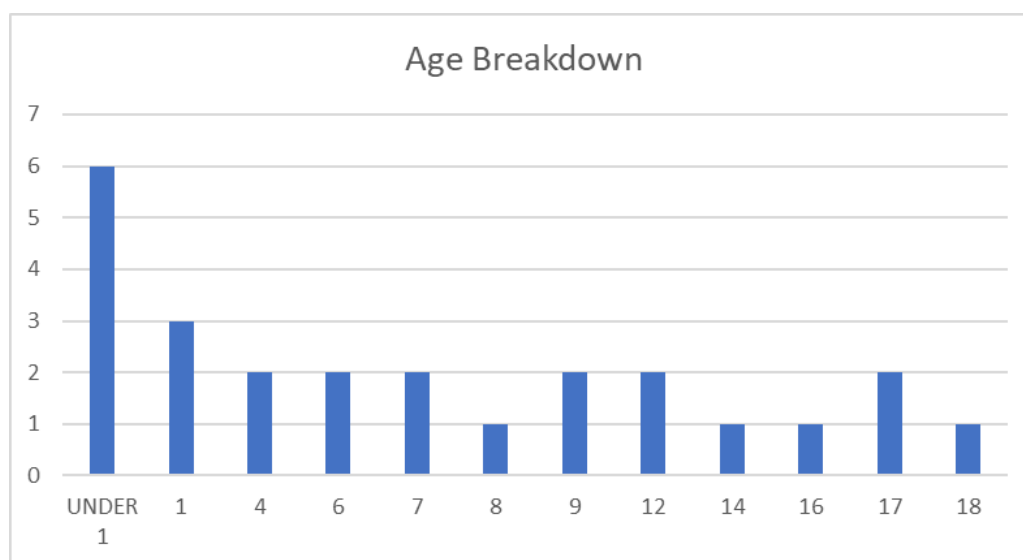
✓ Impact of parental substance misuse, domestic abuse and exposure to sexual activity between mother and partners

Analysis of Case Review Activity

Since the Safeguarding Children Partnership arrangements began in East Sussex in October 2019, the partnership Case Review Group (CRG) has undertaken **14 Rapid Reviews**, resulting in **6 Local Child Safeguarding Practice Reviews** (figures up to March 22). A total of 25 children are the subjects of the 14 Rapid Reviews, with the gender split of the children being almost equal.

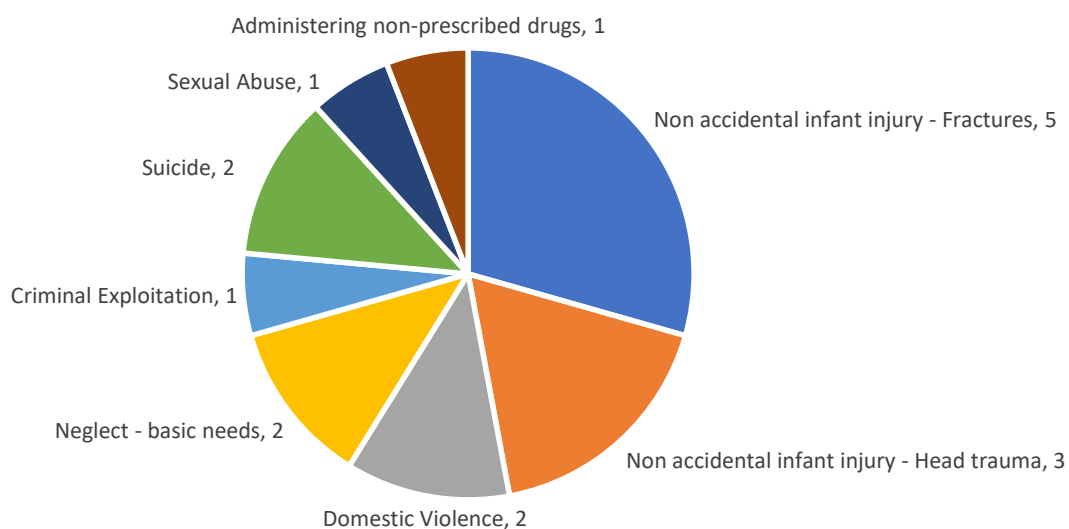


The most common age group for Rapid Reviews in East Sussex is under 1-year olds (6 of 25 children considered within rapid reviews; 24%). This age group featured predominately due to experiencing non-accidental injuries, such as fractures and abusive head trauma. When under 1s and 1 year olds are combined they represent 38% of all children considered within rapid reviews. This is in keeping with the national picture which also shows a predominance of infants under 1 amongst children involved in serious incidents notified to the National Child Safeguarding Practice Review Panel (35% of 514 children notified in 2020)



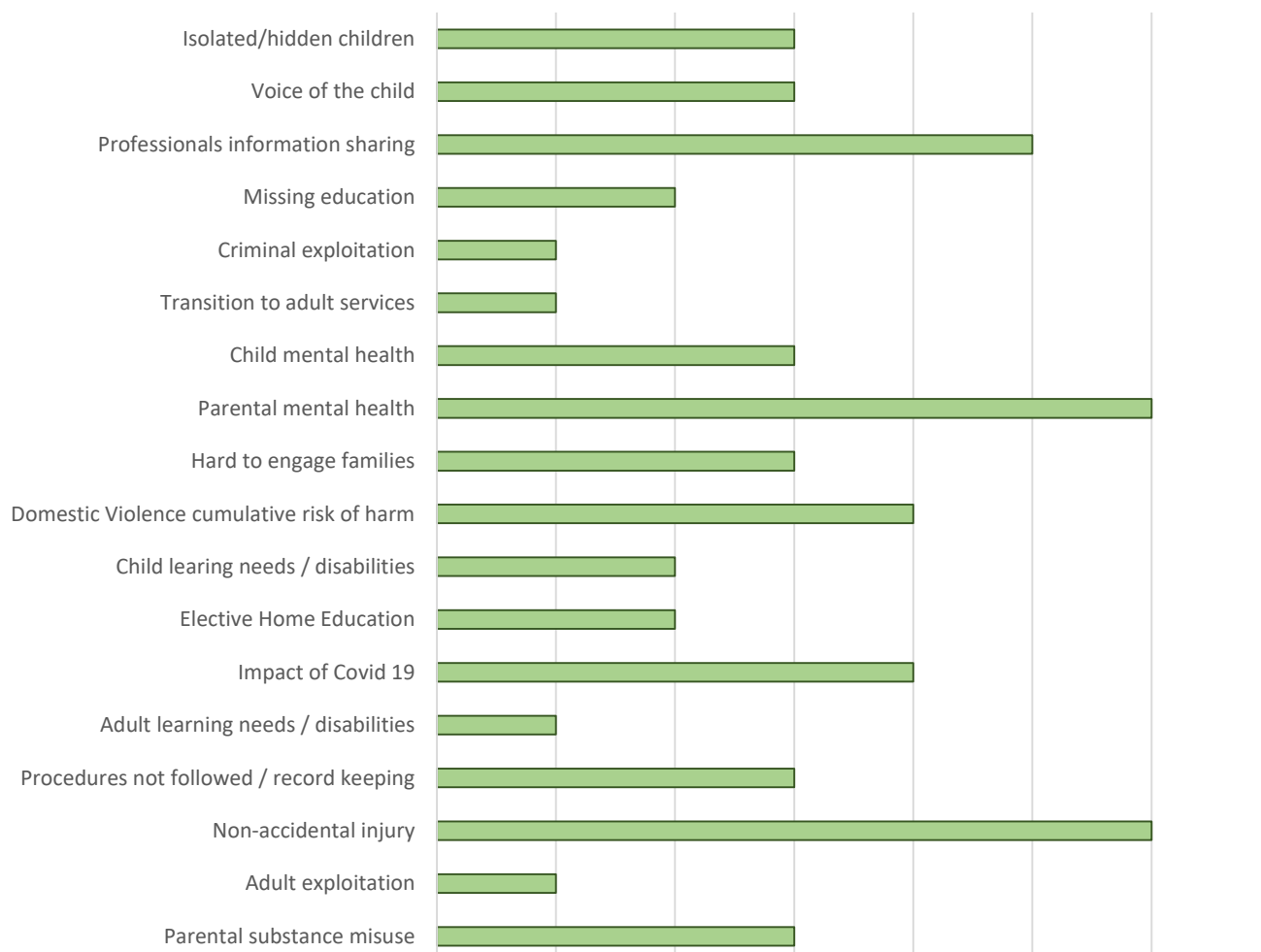
When the rapid reviews were analysed by the primary types of abuse and/or neglect known in the family at the point of notification of the serious incident, non-accidental infant injuries (fractures) featured in 5 of the cases; non-accidental infant injuries (head trauma) featured in 3, followed by suicide (2), neglect (2) and domestic violence (2). However, most cases involved complex families with multiple factors contributing to the safeguarding risk to the child/children.

Primary Types of Abuse/Neglect recorded in Rapid Reviews



Each Rapid Review can result in a number of key themes for learning. The table below shows the breadth of learning themes captured across the 14 Rapid Reviews:

Key Themes for learning captured in the Rapid Reviews



The three most commonly occurring learning themes in Rapid Reviews and Local Child Safeguarding Practice reviews are:

- Poor or unmanaged parental mental health
- Fatal and non-fatal non-accidental fractures and head trauma injuries in under 2 year olds
- Inadequate information sharing between agencies

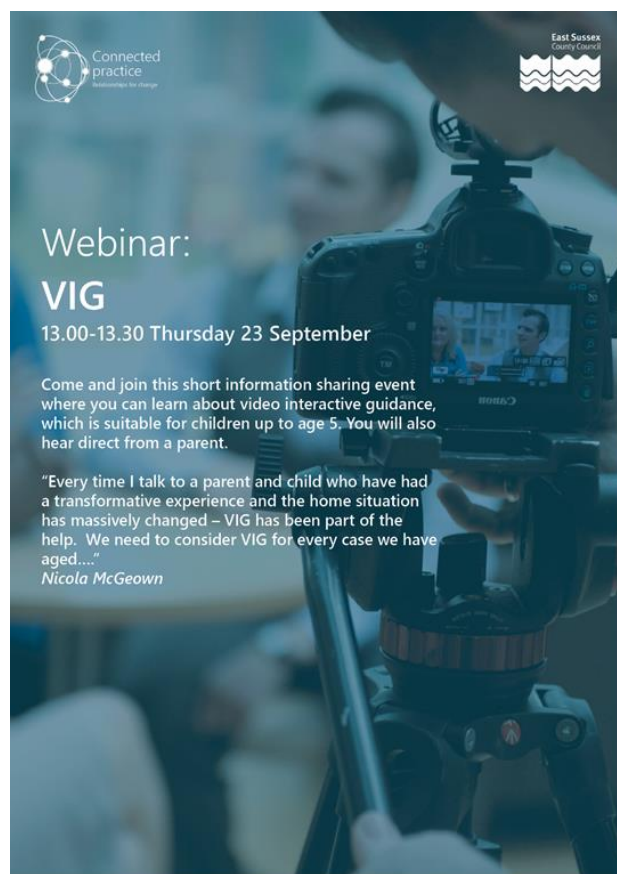
In 2021/22 the CRG further developed the local Rapid Review process to capture the necessary information to undertake a swift but thorough analysis of the serious incident, identifying key learning, developing effective action plans and ensuring learning is shared widely and embedded in local practice. Feedback from the National Panel has supported the CRG to improve the approach to explore the learning for improving practice without the requirement for a full LCSPR.

5.2 Quality Assurance Audits

The QA subgroup held **three audits** during 2021/22 on non-accidental injury to children under 2, the step up and step down between statutory social care and Early Help, and a regular case file audit. Learning from the audits is shared at the ESSP Steering Group and one page learning briefings are shared with the wider ESSCP network and on the ESSCP website here: [Quality Assurance Group - ESSCP](#). QA audit reports and one page learning summaries are now routinely shared at the Learning & Development Subgroup to ensure that learning arising from audit activity is more efficiently and effectively embedded into local training and learning activity.

Two examples of action taken following learning arising from QA audits in 2021/22 include:

- As identified as good practice in the deep dive audit into non-accidental injuries in infants, it was agreed that the use of Video Interaction Guidance (VIG) should be promoted as an intervention in Children's Services, as it helps to enhance relationships between parents and children. The Principle Social Worker ran a webinar in September 2021 which is available for social workers to access via the intranet.
- To promote the importance of professional challenge and escalation of concern, the Pan Sussex Procedures Group agreed that a 'Professional Difference Statement' is read out by the Chair to reiterate that all professionals have a responsibility to challenge anything that they do not think is right. The statement will be read out at Strategy meetings, initial child protection conferences, and repeat child protection conferences.



5.3 Learning from Child Death Overview Panel

The Chair of the Sussex Child Death Overview Panel (CDOP) attended the ESSCP Board in November 2021 to present the CDOP Annual Report. Key headlines from the work of the panel included:

- *Between April 2020 and March 2021, the CDOP was notified of 54 deaths of children who were residents within Sussex. This is a decrease in the numbers of deaths since last year for all areas, with the lowest number to date at a Pan Sussex level since CDOPs were established 11 years ago. East Sussex had the lowest number of deaths (17).*
- *The age profile of child deaths reviewed in Sussex has shown there were no significant differences in rates of child death in Sussex compared to England, when analysed by age group.*
- *Locally, the mortality rate for children aged under eighteen in Brighton & Hove and East Sussex combined is significantly higher in the most deprived 40% of areas compared to the least deprived areas.*
- *Across Sussex, perinatal/neonatal event was the largest category of death (38% of reviews) followed by chromosomal, genetic and congenital anomalies (15%).*
- *Cancers are the largest cause of death in children aged 1-17 years ranging from 26% of deaths in East Sussex to 35% in Brighton and Hove.*
- *27 (34%) deaths reviewed in 2020/21 had identified modifiable factors, a decrease from the last year (45%).*

During the process of reviewing child deaths, CDOP identified learning that the ESSCP was asked to consider, including:

- What further work is required to improve effective communication that builds understanding, trust and has consideration of cultural sensitivities to better understand and respond to personal need? Discussion commenced with the Learning & Development sub group to address this learning alongside extensive single agency investment into equality and diversity resources.
- Reassurance that there are inadequate services for mothers who are using (misusing) substances. ESSCP were asked to consider if services adequately met the need. This was discussed at the ESSCP Board in April 2022 and assurance was received that there are no gaps in provision in East Sussex.

5.4 ESSCP Learning & Improvement Framework

The ESSCP Learning and & Improvement Framework was refreshed in 2021/22, with additional chapters on how the partnership uses 'Independent Scrutiny' and the 'Voice of the Child' to learn and improve local practice. The refreshed framework includes a stronger focus on how learning will be disseminated and how partners will review and evaluate the impact learning has on practice. The ESSCP steering group agreed the framework and proposals:

- ✓ For an ESSCP response to the findings of LCSPRs to be drafted and published, in order to achieve better transparency about how the partnership is responding to and learning from reviews.
- ✓ To produce short presentations and podcasts, available on the ESSCP website and agency's internal websites, which professionals can watch at any time on key themes and learning from LCSPRs.

- ✓ To explore conducting 'evidencing impact' LCSPR events with front-line practitioners and managers, including those involved in the original case. The event will be used to consider how the review has impacted on practice and outcomes for children and families. It is proposed that two of these events are held in 2022/23 – one on the impact of learning from the Child T serious case review and a further event on the theme of infant injuries.
- ✓ To explore the potential of a Young Person Scrutineer, to work alongside the Independent Chair, to attend Board meetings, relevant subgroup meetings and lead on other scrutiny activities.

5.5 ESSCP Learning Strategy

'Embedding a Learning Culture' was identified as a priority for the ESSCP for 2020-2023, which includes effective strategic development of training, shared learning and improved multi-agency training links. The aforementioned ESSCP Learning and Improvement Framework outlines the partnership activity undertaken across various sub groups to identify learning, improve, and then establish effectiveness.

The work of the ESSCP Learning and Development sub group is to ensure that East Sussex workforce and volunteers working with children, young people and/or adults who are parents/carers are provided with appropriate and effective multi-agency training to meet their needs, and that practice is underpinned with appropriate policies and procedures. The Learning Strategy was developed and published at the end of 2020 to ensure that ESSCP has a clear and shared vision as to the priorities for safeguarding learning and training and how this will be achieved. The Strategy aims to:

- ✓ Ensure that safeguarding training/learning activities are based on local necessity and enable practitioners to recognise and respond to need and risk.
- ✓ Measure the impact of safeguarding training on practice and improving outcomes for children and young people.
- ✓ Ensure that learning from Local Child Safeguarding Practice Reviews, Audits, the Child Death Overview Process (CDOP) and the Voice of the Child is embedded into practice and ensures continuous learning and improvement.
- ✓ Ensure key safeguarding messages (local, pan-Sussex and national) are communicated.

These requirements are delegated to the ESSCP Learning & Development Subgroup which produces quarterly training reports, which form the basis of the Annual Learning & Development Report to the ESSCP Steering Group.

5.6 ESSCP Training Programme

Throughout 2021/22 the ESSCP Learning, and Development (L&D) Subgroup continued to respond proactively and effectively to the ongoing challenges posed by the Covid-19 Pandemic. It was hoped to resume some classroom-based training for Safeguarding Children Partnership partners from September 2021, however due to the ongoing risks brought by Covid-19, trainers have continued to use MS Teams as the format for meetings/training. In January 2022, the situation was reviewed, and classroom-based training will now be phased in from April 2022.

Between 1st April 2021 and 31st March 2022, 61 virtual training courses ran with 869 participants which equates to an attendance rate of 67%. A large majority of participants continue to rate courses as either Excellent (63%) or Good (35%). There are specific questions in the evaluation form relating to the delegates experience of Virtual training. Overall, the feedback continues to be very positive with participants having become accustomed to remote delivery, and appreciative of the trainer's efforts to resolve any technical issues. The use of break-out rooms enhanced the training experience as did regular breaks and whole group discussion, as opposed to 'lecture style' presentations. However, for many participants virtual training is not their preferred learning medium, and those specifically mentioned finding the length of 'screen time' tiring, missing the 'classroom experience' and the networking opportunities gained through face-to-face training.

New courses introduced in 2021-2022 training programme were:

1. ESSCP: Safeguarding Issues in an LGBTQ Context: Domestic Abuse, Exploitation, Substance Misuse and Sexual Health
2. ESSCP: Improving Outcomes For Children in Care – Pan Sussex
3. ESSCP: Female Genital Mutilation (FGM) and Breast Ironing - identifying and challenging harmful traditional practices – Pan Sussex
4. ESSCP: Safeguarding Under 1's Bite Size Briefing
5. ESSCP: Harmful Practices - Honour Based Abuse and Forced Marriage – Pan Sussex

6. Impact of Partnership Activity

This section aims to convey the impact of multi-agency and partnership activity on outcomes for children and families. The examples of impact are structures around the ESSCP's four priority areas.



6.1 Safeguarding in Education:

<i>"Whole Schools" approach to the prevention of Child Criminal Exploitation.</i>	
<i>What was the multi-agency area of need identified/responded to?</i>	Identified gaps in schools' knowledge and understanding of the issues surrounding County Lines, and the lack of a coherent package of preventative education for East Sussex students.
<i>What action was taken to address that need?</i>	<p>The Multi-Agency Criminal Exploitation Panel (MACE) secured funding from Project Adder, Children's Services Department (CSD) and Public Health to be able to offer all state-funded secondary schools in East Sussex (to include special schools) a comprehensive and fully funded package of support.</p> <p>A two-phase project was developed around providing specific support and resources regarding County Lines and Harmful Sexual Behaviour. Phase 1 of the project relates to 'gangs, peer influence and coercion, including county lines' and phase 2 relates to 'consent, relationships and harmful sexual behaviours'. The full package included 5 key elements:</p> <ol style="list-style-type: none"> 1. Mandatory CPD webinar - Following attendance of the webinar, schools received materials including 15-minute pre-recorded video to

	<p>support cascading information to PSHE staff in school, lesson plans, letter templates and other resources</p> <ol style="list-style-type: none"> 2. Pre-performance lesson 3. Theatre in Education performance 4. Post-performance lesson 5. Evaluation <p>The Schools Learning and Effectiveness Service (SLES) co-ordinated the project and all 26 secondary schools and 7 special schools participated.</p>
<i>What was the impact of that action on Children, Young People and Families? How have you measured this impact?</i>	<p>An Evaluation which included direct feedback from school staff and pupils recognised the improved value of taking a whole school response to CCE risks. Evaluation feedback has generated learning for professional agencies which includes planned improvements for student reporting of concerns. PSHE Leads fed back very positively, commenting that this was a coherent package that helped ensure County Lines was high on the PSHE agenda. The final report includes a set of recommendations which include the need for primary schools to be supported with similar-type preventative education materials.</p>
<i>Voice of the child – provide feedback from service users on impact the project/initiative has had.</i>	<p>From the 6,300 students that took part in the project, 1,138 evaluation responses were received. Students were able to demonstrate an improved knowledge and understanding of County Lines and that they now knew where to go for help and support.</p> <p><i>“They helped us to see the early warning signs of a groomer and what to watch out for. They also gave us information on how to get out if you are ever in a dangerous situation with a groomer”</i></p> <p><i>“It helped me to see how serious it gets and that it is ok to tell people and report it if it happens to you or someone else you know. You will not be in trouble for it if you ask for help”</i></p>

The expansion of Mental Health Support Teams (MHSTs) in schools

<i>What was the multi-agency area of need identified/responded to?</i>	<p>The (MHSTs) are an important strand of the Government’s 2017 Green Paper ‘Transforming Children and Young People’s Mental Health Provision’. The NHS-funded teams provide a vital source of support in schools for children and young people experiencing mild-moderate mental health /emotional well-being issues.</p>
<i>What action was taken to address that need?</i>	<p>East Sussex currently has 4 MHSTs operating in 52 schools and a post-16 college. Further expansion is planned for, resulting in coverage of approximately 52% of ES schools by 2024. The teams work with individual children and young people, and groups of pupils, as well as providing support for developing whole-school approaches and direct support for parents and carers.</p>
<i>What was the impact of that action on Children, Young People and Families?</i>	<p>To date, 1,300 children and young people have been referred to the service. East Sussex MHSTs are developing comprehensive data sets on individual pupil outcomes following interventions, as well as analysis of referral data which provides learning for the whole county. In terms of outcomes, The end of</p>

	<p>intervention Revised Children's Anxiety and Depression Scale (RCADS) scores show an average -25% reduction in anxiety and depression scores.</p> <p>The majority of referrals to the MHST are for anxiety; this led to the development of an Anxiety Toolkit for use by all schools and colleges in East Sussex. MHSTs are also working with 3 special schools and are broadening the scope of work to include children and young people with SEND and specifically, autistic spectrum condition across all participating mainstream schools.</p>
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6.2 Child Exploitation

Hastings Pathfinder – Session Youth Group	
<i>What was the multi-agency area of need identified/responded to?</i>	<p>During the first national lockdown, we saw an increase and changes within the risk presentation of those children victim to criminal exploitation in the Hastings area. Changes included increased and extended missing episodes out of county; offending relating to drug supply and possession of weapons; and intelligence linking children to county lines and gang activity.</p> <p>Sussex Police identified seven children to be the focus of a police operation – Operation Wagon. Despite all the children having open interventions with Children's Services, there was a gap in information about how the peer group interacted with each other, partly due to the lack of engagement with professionals. Due to this gap and the police hypothesis that the children were linked in a peer group, the Youth Offending Team (YOT) undertook a peer group assessment using the approach adapted by the Contextual Safeguarding Network. A key theme from the assessment was that the children were very reluctant to engage with professionals and none of the children were willing to share any information about their experiences in a 1 to 1 situation.</p>
<i>What action was taken to address that need?</i>	<p>Over the spring/summer of 2021 YOT youth centre-based staff encouraged targeted children from the Operation Wagon cohort to attend for YOT appointments/appointments with professionals. Naturally, they came with their friends and workers actively sought to engage them as a group. The group started with 6 children and, at its highest, the group was made up of 10 children. The profile of this group is such that they are likely to be excluded from the universal youth work offer either because a) they wouldn't see it as relatable or b) their behaviour is too risky. All of the cohort have had negative experiences of education, including multiple exclusions, and would struggle in a traditional group setting.</p> <p>The initial focus was on developing a relationship with the group and building trust and confidence. Workers allowed the group to set its own agenda and sessions were very informal which was incredibly important for the group and as soon as they felt we were trying to "educate" them, they closed and became immediately suspicious. Over time however, workers from the Youth</p>

	Employability Services (YES) and Substance misuse services were invited to join the group.
What was the impact of that action on Children, Young People and Families? How have you measured this impact?	<p>One of the workers described the session as engaging the “un-engageable”. Despite the best efforts of some very skilled and tenacious workers, some of the group had persistently refused to engage with professionals. Bringing them together as a group enabled them to build positive, trusting, and enduring relationships with staff. Engaging with the children as a group enabled professionals to develop their understanding of their lifestyle and experiences in a way that more formal assessments had not.</p> <p>Most of the children engaged with the YES worker and some were supported into employment and college. All the children started to talk positively about doing something constructive with their day and seeing their peers succeed seem to motivate them as a group.</p> <p>None of the children are now on MACE and there has been a reduction in crime and anti-social behaviour among the group.</p>
Voice of the child – provide feedback from service users on impact the project/initiative has had.	<p>Feedback from group members:</p> <p><i>“We need the session to help us with day-to-day life. All the time we have jobs, we are off the street. It was one of the most beneficial things that happened to our group”</i></p> <p><i>“Everyone likes coming here... we get treated like human beings. The school system has treated us really badly but here we get treated like we are teenagers. We are not naughty people just because we might have a different vocabulary”</i></p> <p><i>“We all need somewhere to go where we can relax for a bit”</i></p> <p><i>“It’s a bit of Mindspace, you can go and play football for a little while and know it’s okay”</i></p>

MACE Family Key Work	
What was the multi-agency area of need identified/responded to?	<p>An increasing number of young people are identified as being exploited both criminally and sexually. Many of the risks were identified as coming from outside the family home.</p> <p>There was an additional identified area of need that the parents/carers of the identified young people needed targeted input to increase their protective skills, as well as the service providing intensive support to the individual young person.</p> <p>Many of the individuals who receive support through the MACE Family Key Work service are engaged in anti-social behaviour in their local areas.</p>
What action was taken to address that need?	<p>The service is embedded within the MACE and VARP (Vulnerable Adolescent Risk Panel) and takes direct referrals via these forums.</p> <p>The service delivers an intensive assertive outreach approach to young people and their parents/carers always working with at least one other lead professional i.e. Social Worker, Youth Justice Practitioner.</p>

	<p>The service aims to engage young people in education and positive activities as well as upskilling the parents/carers protective abilities. The Key Worker support is provided to both the young person and to the family. Some sessions are with the young person, some are with the family, and some are joint. This ensures the family is fully engaged and empowered to better support their child. The support is flexible and tailored to the individuals involved and can happen in the home, or out in the community. Support can be every day, or every few days, and can involve check ins on the phone as well as face to face visits. The intensive nature of the support means that the Key Worker provides a level of consistency for families, which is important when dealing with multiple agencies, and they become the trusted professional who can continually reinforce the messages. The Key Workers aim to get young people involved in activities in the community, and to provide them with opportunities they might not otherwise be able to access. The CACE (Collaboration against child exploitation) parents support intervention has been developed across East Sussex providing parents and carers of children who are experiencing exploitation access to a six week educative programme, monthly support groups and mentors with 'lived experience'.</p>
<p>What was the impact of that action on Children, Young People and Families? How have you measured this impact?</p>	<p>Data is provided monthly via the VRP and is reviewed by the MACE Panel and includes the number of 101 and 999 calls made, school attendance, RAG rating on MACE (or VARP), number of A&E attendances, number of missing episodes and the number of arrests. The Key Workers also pass on partnership intelligence directly to Police. An independent evaluation took place in 2021:</p> <p><i>'The family is like a different family. The mum's protective capacity has improved and her ability to protect and parent her daughter has increased. The relationship between mother and daughter has also improved and the daughter is back in full time education after being on a reduced timetable. One of the key things we did was to disrupt the relationships the daughter had, but once she stopped seeing those friends, she felt lonely and isolated, so it was important to replace that contact and social environment with a more positive one and the diversionary activities the key worker organised where great'</i></p> <p>(Social Worker)</p>
<p>Voice of the child – provide feedback from service users on impact the project/initiative has had.</p>	<p>An independent evaluation of the service took place in 2021:</p> <p><i>'Our son was completely out of control. He had been groomed by a local group we didn't know what was going on initially, we lost him, he wasn't allowing us to be his parents. It was so frightening whilst we were in it. The keyworker put into words what was happening and gave us the mental strength and tools to help him, they had seen it before and help us to stay positive. When the keyworker started working with him as it was them, us, the social worker and the school all 'singing from the same hymn sheet'. The keyworker had regular one to one time with him took him out they were superb with him. Now he has a job its an absolute transformation our 'chatty' boy is back'</i></p> <p>(Parent)</p>

6.3 Embedding a Learning Culture

Safeguarding Under 5s Conference	
What was the multi-agency area of need identified/responded to?	Local and national learning tells us that babies and young children are particularly vulnerable to abuse and neglect. Following two serious case reviews locally, the East Sussex Safeguarding Children Partnership decided to focus on 'safeguarding Under 5s' as one of its key priorities. The partnership also conducted three rapid reviews in the early months of the first COVID-19 lockdown, involving non-accidental injuries in babies. The identified need was increase professional knowledge and understanding of the safeguarding risks to infants from all agencies, not just those from health backgrounds.
What action was taken to address that need?	The Partnership agreed to host an all-day learning event, in collaboration with the Brighton & Hove and West Sussex Safeguarding Children Partnership's, as an opportunity to share and learn from colleagues across the Sussex area. The event included presentations from Annie Hudson (Chair of the National Safeguarding Panel) on learning from the 'Myth of Invisible Men' review of non-accidental injuries in children under 1; John Harris, lead reviewer of the 'Out of Routine' review of Sudden Unexplained Infant Death, and Sally Hogg, Head of Policy and Communication at the Parent-Infant Foundation, on the importance of infant mental health and early parent/child relationships. There were breakout groups allowing discussion on the challenges and strengths of practice across Sussex, and Strategic Safeguarding Leads were involved in a plenary session at the end of the conference.
What was the impact of that action on Children, Young People and Families? How have you measured this impact?	Over 200 staff from across partner agencies attended the event and feedback from those who attended has been overwhelmingly positive. During the event polls were taken to demonstrate improvement in practitioner knowledge and understanding of the key issues, with average confidence increasing from 3 out of 6, to 5 out of 6 for all topic areas. <i>"Greater knowledge of risks for the vulnerable under 5's will make me more aware of signs & indicators & how to impart safety advice to parents/carers"</i>

Impact of training on practice
<i>"I have already used what I learned in my work, particularly when looking at referrals and assessing level of need within these. I hope that this means improved outcomes for children from a safeguarding perspective"</i> Learning from Serious Safeguarding Practice Reviews - Key Themes and Learning briefing attendee
<i>"Through my role as Head of School across two schools and as Deputy DSL. I will apply the learning in interviews, induction of new staff and through interactions with all stakeholders, staff, parents, and governors"</i> Managing Allegations Against Staff course attendee

<p><i>"With greater awareness of the Gypsy, Roma and Traveller (GRT) culture, engagement with families should be easier and therefore service delivery can be more consistent resulting in better outcomes. Before starting the training, I had limited understanding and knowledge of the GRT community and found majority of my knowledge was based on stereotypes that are just not true"</i></p> <p>Working with Gypsy, Roma and Traveller Communities – Safeguarding, Risk planning and intervention course attendee</p>
<p><i>"I feel more confident in challenging poor practice, and I have a greater understanding of the value different professionals play in building a bigger picture"</i></p> <p>Child Protection Conference and Core Group Process course attendee</p>
<p><i>"The learning will directly impact my practice with children and young people identifying as LGBTQ+ through changing how I approach the topic of identity and providing support"</i></p> <p>Safeguarding Issues in an LGBTQ Context course attendee</p>

6.4 Safeguarding under 5s

NHS and Sussex Partners ICON week 2021	
What was the multi-agency area of need identified/responded to?	To promote ICON messages to reduce the incidence of Abusive Head Trauma. A weeklong multiagency approach to promoting the ICON programme via social media and other communication routes to expectant and new parents, wider family and grandparents and professionals with a focus on fathers and non-birthing partners day. 27 September to 1 October 2021.
What action was taken to address that need?	<ul style="list-style-type: none"> • Communication and engagement focusing upon one week of intensive activity, reinforcing key messages. • Embed ICON as a preventative programme that supports and educates new and expectant parents to cope with the challenges of parenting and promote safe handling and safe sleeping. • Worked as a partnership to Identify and agree key audiences to target and collaborated to produce, own and implement plans that detail planned communications and engagement activities. • Enabled Primary Care providers, partners and stakeholders to promote key messages through their networks via a campaign toolkit.
What was the impact of that action on Children, Young People and Families? How have you measured this impact?	<p>The data suggested there was some real traction in ICON week, leading to increased awareness of the ICON programme within East Sussex:</p> <p>Conversations readily occurring between professionals.</p> <p>Conversations are taking place at key opportunities and contacts with parents/expectant parents as well as the wider family and support network.</p> <p>Twitter engagement was up 30% while Facebook page had an increase of visits by 297%.</p> <p>There was a cascade to the website with an average of 600 users. This is compared to a normal average of 400 users within our ongoing campaign and under 100 outside of those periods.</p>

	The biggest increase in traffic to one page was the parent's advice page. To be expected as this was the main link used in the social media. This increased by 117% (1636 page views) in the week. Other pages of note were the resource pages where downloads saw an increase of between 100% and 200%.
<i>Voice of the child – provide feedback from service users on impact the project/initiative has had.</i>	Babies and young children need consistent nurturing and safe care to be able to thrive, develop and reach their full potential. By raising the profile of the vulnerability of babies and young children to parent's, carers and professionals with simple strategies to cope with crying, the impact helps to keep babies and young children safe from potential harm. Further work is planned to measure the impact of ICON over the coming year.

Public Health - Reducing childhood unintentional injuries	
<i>What was the multi-agency area of need identified/responded to?</i>	To increase awareness of the issue of childhood unintentional injuries (and key home safety messages) with both professionals and families in order to help prevent and reduce childhood unintentional injuries in East Sussex (particularly in the under 5's)
<i>What action was taken to address that need?</i>	In the 2020/21 Annual Report a number of initiatives were outlined, including: <ul style="list-style-type: none"> • 'Keeping Children Safe' social media toolkit. • The East Sussex Child Home Safety Advice and Equipment Service (ESCHSAES). • A virtual accident prevention training offer. • The 'Staying Safe with Sam' resource for infant/primary schools. • Communications to highlight the significance of childhood unintentional injuries, including Child Safety Week and 'Keeping Children Safe' social media toolkit. • HALO Accident prevention training.
<i>What was the impact of that action on Children, Young People and Families? How have you measured this impact?</i> <i>Voice of the child – provide feedback from service users on impact the project/initiative has had.</i>	<p>Keeping Children Safe social media toolkit: Between March 2019 and Feb 2021, 285 social media posts were shared via the ESCC corporate social media page, with a reach of 10,295 and generating 949 reactions and 717 shares. Across all ESCC children's services social media accounts, a total of 779 social media posts were shared, with a reach of 158, 087 and generating 145 reactions and 174 shares.</p> <p>East Sussex Child Home Safety Advice and Equipment Service: In 2020/21, referrals to the service and ability of the ESFRS to fit home safety equipment was significantly impacted by the COVID-19 pandemic. During 20/21 a total of 194 referrals were made to the service which was a reduction from the 303 referrals made in 2019/20. However at the end of 2021/22, the total number of referrals had risen to pre pandemic levels (302).</p> <p>CAPT Accident prevention training: Between March 2021 and March 2022, 13 x 'Supporting Home Safety for Under 5's' courses were delivered, with just over 200 staff participating. Analysis of 172 pre and post course questionnaires demonstrate significant increases in knowledge and</p>

confidence. For example, in terms of *'knowledge and understanding of the current national and local context regarding accident prevention for children (0-4)'*, using a scale of 1-5 (with 1 being very low), the average participant self-rating pre course was 2.8, with this increasing to 4.1 post course. When asked to rate their agreement with a number of statements post course, 97% agreed or strongly agreed with the statement *'I now feel more able to provide home safety messages and recommendations to the families that I work with.'*

Staying Safe with Sam: Due to the COVID-19 pandemic, it particularly challenging to gain feedback from education settings regarding use of the Staying with Same resource with reception year children (responses to an evaluation survey for schools were extremely limited). Use of the resource was evaluated with schools as part of the CAPT pilot (prior to COVID-19 pandemic and results can be found [here](#)).

HALO Accident prevention training: Between June 2019 and March 2022, 13 accident prevention training courses have been delivered, with a total of 134 participants from across 80 early years settings. Just over 50% of these settings were located in the 40% most deprived areas of East Sussex (based on Index Deprivation Affecting Children Index). Analysis of pre and post course knowledge questionnaires demonstrate a substantial increase in accident prevention knowledge post course, with 82% of participants who completed a post course questionnaire (n = 132) rating their confidence to relay accident prevention information to parents and carers as either 5 or 6 (1 = 'Not confident' and 6 = 'Very confident')

6.5 Updates from activities included in 2020-2021 Annual Report:

Accident & Emergency (A&E) self-harm pathway with schools for children and young people (C&YP)

To help keep children safer and to share their difficulties with their school, in 2020/21 a multi-agency task and finish group developed a pathway for information sharing from A&E to secondary schools, with consent. Agreement that if a parent or child has signed consent that their CAMHS care plan would be sent securely to their school.

Data is collated monthly regarding numbers of care plans sent on and to which schools. Any themes relating to individual schools are liaised with the schools safeguarding team.

The original pathway was for age 11+, however it has been proposed that it should be developed to include any child who is seen by CAMHS after attending emergency department with mental health or self-harm concerns. Usually for this age group (under 11) co-morbidities exist and it is common for the child to be awaiting a diagnosis for autism and social communication disorders.

Elective Home Education (EHE) communication and training task & finish group

In 2020/21 a task & finish group was commenced to address an uncoordinated and inconsistent approach to communication with the EHE team regarding potential safeguarding risks. Inconsistent

levels of knowledge and understanding were identified across teams within the partnership. Since reported in 2020/21;

- ✓ A network of EHE Leads has been developed (on the same model as SPoA) across other partnership teams, such as Duty and Assessment Team (DAT), MASH and Youth Support Teams. Health colleagues have committed to nominate EHE Leads
- ✓ ESCC EHE policy document has been embedded into current practice and was published on ESCC website in March 2021. The policy has been reviewed by an independent Practice Review author and agreed as best practice
- ✓ The vulnerability criteria was reviewed
- ✓ Communication links made with wider agencies, such as dentistry
- ✓ EHE training resources – a short series of training videos devised and delivered to raise awareness of EHE safeguarding risks

<https://web.microsoftstream.com/video/309be393-7271-46a2-90b3-6b1886a15b5d>

EHE National update:

- **21st July 2021 Education Select Committee published its report which states** *‘We are convinced that a statutory register of children who do not receive their principal education in a mainstream school, including home-educated children, is essential and that they call on the government to implement this as soon as possible’.*
- **December 2021 Case Law Change** subject of the High Court’s consideration in Goodred v Portsmouth City Council. This now gives local authorities (LA) the legal basis to request evidence from parents of a suitable home education without a cause for concern. The ESCC EHE policy is currently being changed with the support of the legal team and an Equalities Impact Statement.
- **3rd February 2022 Published consultation results Children Not in School.** The government will now legislate the following four duties following the necessary time in parliament:
 - A duty on LAs to maintain a register of children of compulsory school age who are not registered at school, including flexi-schooling arrangement.
 - A legal duty on parents to provide information to a register. It will also include securing resources to implement this.
 - Place a duty on unregistered settings to register children accessing settings for the majority of a child’s week.
 - A duty on local authorities to provide support to EHE families where this has been requested.
- **1st March 2022** Further government consultation completed by Teaching and Learning Partnership on the proposed costs for a register and the potential support offer for families.

Multi-agency safeguarding Hub - Specialist health provision

In 2020/21 a 6-month pilot took place for a Multi-Agency Safeguarding Hub (MASH) Specialist Nurse Safeguarding Children (SNSC) and Admin Assistant. The purpose was to strengthen the process of health information gathering around children and young people to inform decision making within

the MASH. Following the successful pilot, permanent funding has now been agreed for 2 Specialist Nurse/health practitioners in MASH, and a health administrator. Posts are recruited to and will be in post by end May 2022.

Whilst permanent funding has just begun, we have already received positive feedback about contribution to decision making; this is particularly relevant in cases where it is not clear about threshold for example impact of neglect on a child's health and welfare; or where there may be an impact on a child's developmental trajectory - for example very young children and impact of domestic abuse/parental mental ill health.

7. Evidence

This section of the ESSCP Annual Report sets out how the partnership are using evidence to determine its priorities; shape the way multi-agency partners have taken actions or adopted specific practice models; and evaluate the impact of partnership work. Examples of how the partnership have used evidence are also given in section 3 (Impact).

ESSCP priorities for 2020-23 were chosen because they were identified as of highest risk in the county, where multi-agency working is essential and where significant change and/or commitment is necessary to reduce risk. It is in such areas where the partnership can be most effective in scrutinising and supporting.

The following priorities were agreed for ESSCP focus for 2020-2023:

- **Safeguarding in Education**
- **Child Exploitation**
- **Embedding a Learning Culture**
- **Safeguarding Under 5s**

7.1 Safeguarding in Education

Why is safeguarding in education a priority?

Everyone who encounters children, and their families, has a role to play in safeguarding children. Early years, school and college staff are particularly important as they see children daily and can identify concerns early and provide help for children, to prevent concerns from escalating. Schools and colleges and their staff form a key part of the wider safeguarding system for children.

Strengthening safeguarding in schools has been a priority for East Sussex Safeguarding partners since 2015. During that time, many developments have been made to ensure that schools are able better to appropriately identify and respond to child protection concerns and effectively safeguarding children in school.

The ESSCP agreed that by making this area a priority for 2020-2023, there will be a continued focus on effective joint working between local agencies and schools, strategically and at a school level. The COVID-19 pandemic and extended school closures for most children highlighted to many services the critical importance of schools' role in safeguarding.

Safeguarding in education in East Sussex

East Sussex schools responded well to the requirements for remote safeguarding throughout the pandemic. All schools engage with the local authority wide systems for monitoring and supporting the most vulnerable children during school closures/partial closures and encouraging their attendance at school to mitigate risks.

Key achievements during 2021/22 include:

- The January 2022 revision of East Sussex guidance to schools encourages schools to “be the EYES and EARS” in order to promote direct contact and communication with children temporarily not at school.
- All statutory safeguarding training for Designated Safeguarding Leads (DSLs) has now reverted to in-person training delivery and this is very welcome in terms of enhancing networking and building relationships with new DSLs. In some cases however, the training programme has been enhanced and improved through the virtual delivery; a new training module, *Advanced DSL programme*, has been developed to support DSLs manage complex safeguarding issues such as managing disclosure of Child Sexual Abuse.
- Joint funding from the Police and Public Health has provided for two county-wide preventative curriculum programmes for secondary and special schools. These programmes have focussed on County Lines, and peer on peer Sexual Harassment, including PSHE training and resources, and Theatre in Education performances for students.



Video of pupils discussing the AlterEgo productions regarding healthy relationships

Focus for safeguarding in education in East Sussex

This academic year has provided on-going challenges for school leaders with regards to safeguarding. Most schools report that new safeguarding issues for different groups of children have emerged. These include higher incidences of children witnessing domestic abuse, demonstrating harmful sexual behaviour, and experiencing mental health issues.

Planned activity for 2022/23 includes:

- Continuing the ESSCP Task and Finish group focusing on Harmful Sexual Behaviour (HSB) in schools.
- A Police and Public Health funded preventative education project on Violence Against Women and Girls for all secondary and special schools.
- The development of toolkits for schools such as the Self-harm Toolkit.
- Training for DSLs, including the Sexual Risk Leads Programme and the Advanced DSL Programme

USING EVIDENCE: Ofsted Review of sexual abuse in schools and colleges (June 2021)

The “Everyone’s Invited” national campaign highlighted the issues of peer-on-peer harmful sexual behaviour (HSB) in schools and colleges and led to Ofsted conducting a review of sexual abuse in schools and colleges. That review recommended that local safeguarding partners should work to improve engagement with schools on this issue.

Following agreement at the ESSCP Steering Group, a Task & Finish Group was formed, with broad multi-agency engagement and representation from all types of schools. This group reviewed learning from the Review, existing multi-agency data sets – which captured incidents of peer-on-peer abuse – as well as gathering further specific data directly from schools.

The work of this group will continue in to 2022/23, however it has made recommendations for additional resources and training for schools which will strengthen and add to the existing East Sussex Protocol for Managing Peer on Peer Harmful Sexual Behaviour in Schools. Schools already receive guidance and support with their PSHE/RSE provision through Public Health funding. A recent round of Theatre in Education for secondary schools has supported classroom learning around HSB. An emerging recommendation is around sustaining intervention for secondary schools, as well as developing additional and specific input for primary schools.

To inform the work of this group local organisation ‘Priority 1-54’ completed a pilot project of creative workshops across five educational settings in East Sussex, to explore children’s perceptions, understanding and experiences of HSBs.

Schools have been involved in the LCSPRs of a number of children during 2022/23. Some key learning for education has been identified through a couple of reviews and these will result in multi-agency action plans. One example of this is the development of the Vulnerable Learners’ Protocol to support schools and colleges in managing transition to post-16 education.

Evidence to measure success (2021-22)

- ✓ **The number of schools where Ofsted has rated ‘safeguarding’ as effective.**
All OFSTED Inspections of state-funded schools to date this academic year, safeguarding has been judged as effective. One independent special school’s residential provision was judged as ineffective in terms of safeguarding.
- ✓ **Increase in the proportion of schools who complete their annual s175/157 safeguarding audit.**
Of the 190 state funded schools, 182 have returned their audit. For Independent schools, only 9 out of 34 have so far returned.
- ✓ **The proportion of secondary and special schools that participate in the multi-agency project on County Lines and Harmful Sexual Behaviour and evaluation data on impact.**
All 26 secondaries and 7 eligible special schools took part in the County Lines and Harmful Sexual Behaviour projects. The ‘County Lines’ production reached 6300 students and ‘Unacceptable’ reached 6470 students.
- ✓ **The development and implementation of a multi-agency action plan to address HSB in schools arising from the work of the task and finish group.** This work is on track for completion July 2022.

7.2 Child Exploitation

Why is child exploitation a priority?

Child Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or threat of violence. The victim may have been criminally exploited even if the activity appears consensual.

'County lines' is a form of criminal exploitation. It is a police term for urban gangs supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines or 'deal lines'. It involves child criminal exploitation (CCE) as gangs use children and vulnerable people to move drugs and money.

East Sussex Safeguarding Children Partnership has a strategic focus on child exploitation due to the geographical location of East Sussex, its transport links with London and the mix of rural and city conurbations.

Tackling child exploitation in East Sussex

The MACE action plan is focused on four areas:

- **PREVENT** - Raising awareness and delivering targeted responses to Criminal Exploitation
- **PREPARE** - Working in partnership, with strong leadership, effective systems, and professional support to tackle CSE
- **PROTECT** - Safeguarding young people
- **PURSUE** - Intelligence gathering, disruption and prosecution

Key achievements during 2021/22 include:

- Development of multi-agency disruption training, and disruption toolkit implemented. Audit of cases demonstrated an increase in use of disruption techniques from 12% to 58% of all MACE plans at the end of quarter 3.
- No looked after children have been permanently excluded in 2021/22
- Sharper focus on recording of risk, recognition of protective factors, education, action plans – including disruption – clear timescales and accountability.
- Implementation of CACE Programme (Parent/Carer trauma informed programme) offering a bespoke support offer to children at risk of exploitation over a 6 week group sessions.
- Co-location of Police 'Missing and Exploitation' Officer in MASH, allowing dedicated resource to focus on all missing strategy meetings and improved use of data and information software to target children at highest risk.
- Implementation of Education Review Meetings for children discussed at MACE, to secure resources from Violence Reduction Partnership to support individual student plans.

USING EVIDENCE: Project ADDER

Project ADDER is a Home Office initiative to tackle drugs in Hastings which stands for Addiction, Diversion, Disruption, Enforcement and Recovery. It sees local agencies (Sussex Police, East Sussex County Council and health services) focus on coordinated law enforcement activity, alongside expanded diversionary programmes, to divert people away from offending.

Using the funding from the Home Office, agencies have developed a Sussex Police led campaign targeting young people in Hastings, to raise awareness of the personal implications and consequences of drug-related activity. The campaign will look to increase awareness of drug exploitation and educate on drug use amongst parents and carers. The campaign is called 'choose your future', where agencies hope to empower young people to think about the choices they are making through educating them on the risks of drug use and signposting to support services, where they can seek help.

As part of the campaign, Sussex Police have sought support from secondary schools and colleges, as well as health agencies and youth community groups in Hastings to distribute and share the campaign material and key messages. Sussex Police have also used out of home advertising, where the locations in Hastings have been informed by operational information/hot spots to reach those most vulnerable and at risk of drug harm and exploitation.

The campaign initially launched in Hastings and in early 2022 will look to be expanded force wide across Sussex.

Evidence to measure success

- ✓ At the end of March 2022 there were 12 children registered on the MACE cohort, and a total of 34 children discussed at MACE in the 2021/22 financial year. During the year there has been a **44% reduction in 'red' cases and a 25% reduction in MACE cases overall**.
- ✓ Over the course of the 2021/22 year, 8 children have had their concern rating increased from amber to red, and **20 children have had their concern rating decrease** (only 1 child saw a RAG rating increase in the last 8 months, during which time 11 have decreased).
- ✓ The average time for a child to be removed from MACE due to lower risk is 11 months. 59% of the March 2022 cohort have been considered at MACE for four months or less.
- ✓ In 2021/21 only there were only **11 incidences of young people held overnight in police custody** compared to 26 incidences in 2020/21.
- ✓ There was a **slight increase in the number of children's social care assessments completed where 'gangs' is a factor**; 124 in 2021/22 compared to 115 in 2020/21.
- ✓ There was an **increase in the number of East Sussex hospital admissions for assaults with a knife or sharp object among victims aged under 25** – a rise from 9 in 2020/21 to 15 in 2021/22.
- ✓ Across Sussex, there has been a reduction of -36% in the number of offenders of serious violent crime, aged under 25, compared to the previous year.

7.3 Embedding a learning culture

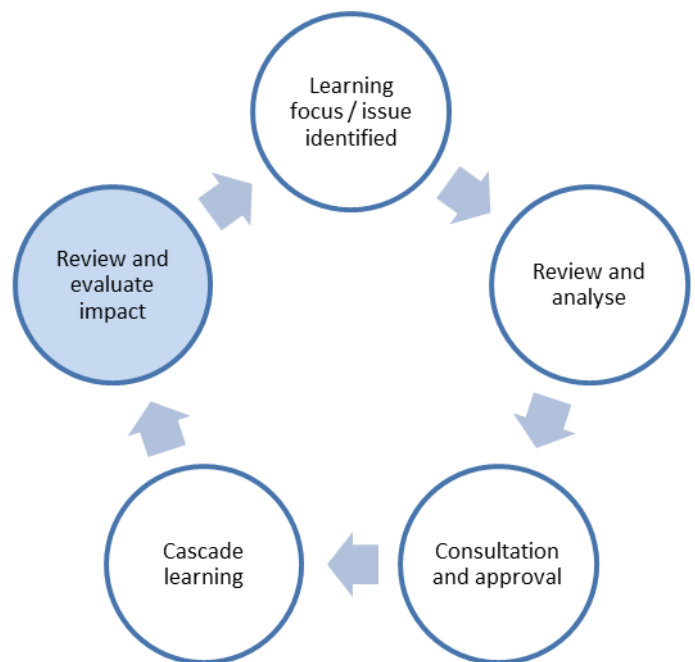
Why is embedding a learning culture a priority?

The ESSCP is committed to creating and strengthening a learning culture across all agencies in East Sussex who work with children and young people. A culture which is open, and able to challenge all partner agencies, will be able to identify learning, improve, and then evaluate effectiveness. The ESSCP agreed to make 'embedding a learning culture' a priority to ensure that the partnership becomes better focused on learning with the following three aims:

- the learning reaches the right people.
- we have effective mechanisms for sharing learning.
- and we test that learning is embedding into practice and outcomes for children.

Embedding a learning culture in East Sussex

One of the roles of the ESSCP is to ensure the effectiveness of safeguarding practice, which it does through evidence-based auditing, performance management, and self-analysis. The SCP ensures that there is continual evaluation of the quality of services being provided, as well as effective communication and joint working between all SCP partner agencies. The arrangements for assuring the effectiveness of safeguarding practice are set out in the **ESSCP's Learning & Improvement Framework**.



In addition, the partnership has focused on:

- Supporting the dissemination of multi-agency learning from Rapid Reviews, Local Child Safeguarding Practice Reviews, and audits (multi-agency and single agency) and the multi format ESSCP training offer.
- Linking learning to the other 3 ESSCP Priorities: Child Exploitation, Education Safeguarding and Safeguarding under 5's.
- Linking learning to wider agencies, such as the Safeguarding Adults Board, the National Safeguarding Children Panel and Child Death Overview Panel.
- Provide a simple 'one stop shop' for SCP professionals to access learning resources.

USING EVIDENCE: Wood Report – Sector expert review of new multi-agency safeguarding arrangements (May 2021)

Following feedback from the Alan Wood Review and the National Safeguarding Panel's analysis of SCP's annual reports, the ESSCP Annual Report for 2021/22 has been restructured so that it is more clearly focused on the impact of partnership working; the evidence used to inform multi-agency working; how the lead safeguarding partners are given assurance of local safeguarding practice; and the learning arising from partnership review activity.

Examples of activity in 2021/22 include:

- Refresh of the ESSCP Learning and & Improvement Framework, with additional chapters on how the partnership uses 'Independent Scrutiny' and the 'Voice of the Child'. The refreshed framework includes a stronger focus on how learning will be disseminated and how partners will review and evaluate the impact learning has on practice.
- Quarterly communication plan for the ESSCP shared with the L&D subgroup.
- Learning briefings produced on completed LCSPRs and rapid reviews. 1 page learning briefings have also been published on learning from the Quality Assurance subgroup's multi-agency audits.
- Three 'Learning from Review' lunchtime seminars held in May, October and November 2021. These include learning arising from the Child Y and Child X LCSPRs.
- Board briefings from each quarterly board meeting shared with ESSCP network and uploaded on to ESSCP Website.

Evidence to measure success

- ✓ Front line staff and leaders/managers in every agency to know what the ESSCP is can recall learning themes from recent learning briefings
- ✓ Front line staff to feel confident in how to respond if they have a safeguarding concern.
- ✓ Staff to know where to look for more information/resources on safeguarding themes.
 - to be evidenced via 2022 Section 11 process or other survey.

7.4 Safeguarding under 5s

Why is safeguarding under 5s a priority?

Local and national learning tells us that babies and young children are particularly vulnerable to abuse and neglect. Following on from two local serious case reviews involving babies and young children, the ESSCP decided to focus on 'safeguarding Under 5s, as one of its key priorities, to ensure that action arising from the reviews was coordinated and the profile of safeguarding under 5s was raised across partner agencies.

Nationally, babies under 12 months old continue to be the most prevalent group notified to the national safeguarding panel following serious incidences, with around 40% of serious case reviews involving children aged under 1. There were also a high proportion of cases involving non-accidental injury and

sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk. In the first few months of the 2020 Covid lockdown the ESSCP also completed three rapid reviews following serious safeguarding incidents involving non-accidental injuries involving children under the age of one. Learning arising from these reviews was compiled in a learning briefing for professionals and a combined action plan produced, which has informed ongoing work in this priority area, and is monitored regularly by the ESSCP Case Review Group and Steering Group.

Learning from the Pan Sussex Child Death Overview Panel has also highlighted the need for a multi-agency response to the number of incidences of sudden and unexplained infant deaths where modifiable factors were identified.

Safeguarding in Under 5s in East Sussex

The 'Safeguarding Under 5s' action plan is jointly owned by the Designated Nurse for Safeguarding in the CCG and the Children's Lead in East Sussex Public Health. The leads were supported by a short-life Task and Finish Group to drive ahead action in this area. In 2021/22 the Task and Finish Group agreed it had met its objectives and ended the group, however the network of key professionals still exists to share information and resources on this topic.

Key achievements during 2021/22 include:

- Embedding of ICON across multi-agency network to reduce abusive head trauma – this included the launch of the first national ICON week in September 2021, to raise awareness of infant crying and how to cope amongst professionals and the general public, lead by Sussex CCG and the Sussex Safeguarding Children Partnerships. Direct training sessions have also been delivered to different groups of professionals, including GPs, midwifery, Sussex Police, health visitors, early help, and children's social care.
- Updating of Pan Sussex procedures on non-accidental injuries (including bruising) and leaflet for parents on 'bruising on non-mobile babies – what happens next?'
- Launch of a social media toolkit to raise awareness amongst professionals and the general public to reduce and prevent childhood unintentional injuries, highlighting how many accidents can be prevented with the right knowledge.
- Research conducted on fathers and non-birthing parents. Learning to be embedded into partnership training.
- Sussex wide conference for front-line staff, managers and strategic leads on Safeguarding Under 5s. Over 200 staff attended the virtual event which included key note speakers on learning arising from the National Child Safeguarding Panel reports on 'The Myth of Invisible Men' (non-accidental injuries in under 1s), 'Out of Routine' (SUDI in families where children are at risk of harm), and the importance of early years mental health.

Evidence to measure success

- ✓ There has been a very **small reduction in the number of women in East Sussex who smoke at the time of delivery** (12.2% compared to 13.2% at the same point in 2020/21), however this is still much higher than the England average of 8.5%.
- ✓ There have been **no child deaths across Sussex involving abusive head trauma (AHT)**, over the past 2021/22 and 2020/21 years. This follows three suspected AHT in 2019/20.
- ✓ Reduction in the number of children aged under five with a child protection plans

- ✓ The **number of children aged 0-4 attending East Sussex hospital A&Es due to accidents has increased** by 11.8% from 2,507 in 2020/21 to 2,803 in 2021/22. Poisonings accounted for 122 of those attendances; falls from furniture accounted for 511 attendances.

USING EVIDENCE: The Myth of Invisible Men – Safeguarding children under 1 from non-accidental injury caused by male carers (September 2021)

The National Child Safeguarding Review Panel report The Myth of Invisible Men published in September 2021 outlined the pressing need to engage with fathers and father figures more effectively:

“In summary, we believe that those leading and commissioning services and practitioners active in this work should do more, much more, to make the seemingly invisible visible and the hidden known. Much more must be done to offer the necessary support, challenge and engagement with the men with whom they work or with whom they should be working in order to prevent more babies suffering the harm described in this report.”

“It is the recommendation of this review that all local safeguarding partnerships respond comprehensively to these challenges and develop local strategies and action plans to support improved practice and effective service responses.”

Coupled with learning arising from recent Serious Case Reviews and rapid reviews, between October 2021 and February 2022 independent researchers were commissioned to complete qualitative interviews to gain a greater understanding of the views and experiences of fathers and non-birthing partners (FNBP), health professionals and pregnant women/mothers to help inform how, as a local system, we can improve our support to FNBPs during the perinatal period.

8. Assurance

One of the roles of the ESSCP is to ensure the effectiveness of safeguarding practice, which it does through evidence-based auditing, performance management, and self-analysis. The SCP ensures that there is continual evaluation of the quality of services being provided, as well as effective communication and joint working between all SCP partner agencies.

The **Quality Assurance (QA) Subgroup** has the lead role, on behalf of the Partnership, for monitoring and evaluating the effectiveness of the work carried out by partners. It does this through regular scrutiny of multi-agency performance data and inspection reports, and through an annual programme of thematic and regular case file audits. This subgroup is chaired by the Detective Chief Inspector of the Safeguarding Investigation Unit in Sussex Police.

Examples of assurance undertaken by the ESSCP during 2021/22 include:

- The **ESSCP has an Independent Chair** whose function is to provide challenge and scrutiny of the effectiveness of the lead partners and other relevant agencies, via the Board and Steering Group meetings, and to also work with the lead partners to ensure the effectiveness of the safeguarding work carried out by partners. In January 2022 the ESSCP recruited a new Independent Chair. Lay Members and Members of the Children in Care Council were part of the selection panel. The approach of both Chairs throughout year has been to act as a constructive critical friend to promote reflection and continuous improvement and to provide support to that improvement. Examples include: endorsing the need to conduct three Local Child Safeguarding Practice Reviews (LCSPRs) in arising from four serious safeguarding incidents; liaising with the National Child Safeguarding Panel on the rationale for decision making in rapid reviews; facilitating resolution of agency conflicts, championing local issues at national and ministerial level, and raising for action and scrutiny by Board of emerging issues.
- In addition to the Independent Chair, **three Lay Members** play a critical role in the partnership. The Lay Members act as further independent insight, on behalf of the public, into the work of agencies and of the partnership. As well as acting as critical friends at Board meetings, providing additional challenge and scrutiny, one Lay Member is a standing member of the SCP Case Review Group (CRG), and Lay Members are involved in the panel meetings for all LCSPRs. Their role has been critical at CRG – via the rapid review process and subsequent LCSPR process - in advocating the voice of the child. In 2022/23 the ESSCP will recruit new Lay Members as two of the three Lay Members will be leaving in summer 2022.

“I have been a lay member on the Partnership Board for four years now. I continue to be impressed by the dedication and care with which all the agencies approach children’s safeguarding and their collaborative approach. This has not wavered even in the face of the stresses and demands of Covid. Everyone has settled into a pattern of virtual meetings which seem to work well and certainly reduces travel. Much of my time this year has been taken up with the Case Review Group. The number of rapid reviews and local child safeguarding practice reviews has been increasing in recent years and this group has a heavy workload. I have been pleased to see that there is focus

on monitoring changes in practice that come out of the learning from these reviews. There are detailed action plans drawn up from the recommendations and these are followed up. A number of the reviews have emphasised the importance of hearing the voice of the child and understanding children's lives from their perspective. This is an important issue for me and I hope, now that we are able to be out and about more, we might be able to re-look at how we consult children and young people about safeguarding. I continue to find the role of lay person interesting and would like to contribute in some way for a while to come".

- The QA Subgroup reviews the '**ESSCP Performance Dashboard**' on a quarterly basis. The dashboard includes 60 performance indicators which are presented by: impact of multi-agency practice; children supported by statutory services; children with family related vulnerabilities; children with health-related vulnerabilities; and children whose actions place them at risk. Indicators are reviewed by the QA subgroup and escalated to the Steering Group if required. During 2021/22, performance indicators escalated by QA included the increase in referrals to Early Help; the significant decrease in the numbers of children held overnight in Police custody and in secure units; the rise in the numbers of unaccompanied asylum-seeking children – due to changes in government guidelines and arrivals via Newhaven Port; the continued rise in the numbers of children electively home educated, and the rise in the number of sexual offences recorded against children. The typical action is illustrated below:
 - **Action** The rise in sexual offences against children was escalated as a specific item for focus at the Steering Group. The Detective Chief Inspector of the East Sussex Safeguarding Investigation Unit in Sussex Police, with responsibility for rape and serious sexual offences, commissioned the Sussex Police Intelligence Team to undertake a specific piece of analysis looking at the profile of sexual offences across Sussex. The report was scrutinised at Steering and the QA subgroup and it was agreed that further work would be commissioned to support the work of the Harmful Sexual Behaviours (HSB) in Schools/Colleges Task & Finish Group.
 - **As a result**, the HSB Task & Finish Group has been able to target resources and support to schools where there have been reported incidences of sexual offences.
- The QA subgroup held only **three audits** during 2021/22, as two audits were cancelled due to capacity within Sussex Police to undertake non-statutory audits (this situation was closely monitored by the Independent Chair and Lead Safeguarding Partners). The three audits completed included a 'deep dive' audit on non-accidental injury to children under 2, one thematic audit on the step up and down between statutory social care and Early Help, and a regular case file audit looking across the whole front door safeguarding process. Key learning included:
 - ✓ The importance of professional challenge and escalation of concern.
 - ✓ The need for GPs to follow up with families when a child misses an appointment.
 - ✓ Providers should not use family members for translating and should access translator services.
 - ✓ To ensure agencies document the voice of the child in their assessment. Children's views are integral to evidence-informed practice.
 - ✓ The need for all agencies to engage fathers and significant men in their work with families.

- The Partnership has a key role in **evaluating the effectiveness of support for looked after children and care leavers** – it does this via the annual scrutiny of the ESCC Annual Looked After Child & Care Leaver Report, the Annual Independent Reviewing Officer (IRO) report, regular monitoring of key performance information in the ESSCPs quarterly dashboard, and via the Section 11 process.
- The Partnership has a key role in **evaluating the effectiveness of early help services** – it does this via the regular monitoring of key performance information in the ESSCPs quarterly dashboard and, in 2021/22, via a QA Subgroup audit on the robustness of the step-up and step-down between early help and statutory social care.
- In 2022/23 the ESSCP, along with Brighton & Hove SCP and West Sussex SCP, will hold its seventh bi-annual '**section 11' audit**. All organisations represented on the ESSCP are asked to complete a self-assessment and provide evidence of how they comply with s11 when carrying out their day-to-day business. The audit provides an indication of how well organisations are working to keep children safe. During 2021/22 representatives from the three lead safeguarding partners have been developing the tool, following feedback from agencies, to ensure it is more proportionate for agencies to complete and provides stronger assurance for safeguarding partners of the quality and effectiveness of safeguarding in individual agencies. The 2022 section 11 audit will be framed more as an 'improvement' tool, rather than simply demonstrating compliance with the standards, and more focus will be given to the scrutiny and follow up of agency and partnership actions.
- The Annual **Schools Safeguarding Audit Report (s175)** was presented to the ESSCP Board for scrutiny and challenge in January 2022. All schools (including maintained, independent, academies, free schools, and colleges) in East Sussex are requested to complete the safeguarding audit toolkit on an annual basis – assessing their practice in line with statutory guidance and local good practice. Engagement with the process is strong with 97% of state funded schools returning their audit. The audit provides schools with a robust framework against which they can evaluate their practice and identify areas for development as necessary and the data gathered by SLES Safeguarding, through having the audits returned to them, informs the ongoing development of guidance, training and support to schools. In the 2021/22 audit, online safety remains an area for development for schools. SLES Safeguarding is supporting practice in this area, having produced an [Online Safety Toolkit](#) for schools. Schools are in general very good at raising awareness around online safety with children, within the curriculum. The ongoing challenge for schools is raising awareness with parents. Despite best efforts most initiatives only land with a narrow band of parents, who are often 'tech savvy', and fails to reach the families who could most benefit from additional support, acknowledging this issue is broader than just schools' responsibility.
- Other examples of assurance work undertaken include:
 - ✓ **Health Visitor numbers and service capacity** has been a regular item at the ESSCP Steering, Planning and Board during 2021/22. Over the past year, the service continues to experience high vacancy rates with implications on the capacity of the service to identify safeguarding concerns with the families on their caseloads and provide support to prevent concerns escalating. In partnership with other agencies in May 2021, the service made the decision to suspend routine HV attendance at child protection conferences and core group meetings for children on child

protection plans and to suspend conduct of universal and enhanced HV antenatal care/services (such as the pre-birth contact). Lead Safeguarding Partners have closely monitored the situation, ensuring all relevant agencies are aware of the situation, and agreeing strategies to reduce and mitigate safeguarding risks.

✓ **Engagement of General Practice in Child Protection Conferences** was escalated to Steering Group following continued concerns about lack of GP engagement in CP conferences. Following consultation, to address the situation the:

- Safeguarding Unit has asked locality Social Work teams to invite and request information from GP practices 3 weeks in advance of Review Conferences to allow time for information to be collated and shared. Whilst the timescale for circulating professional invites and requests for information for Initial Conferences is unavoidably very tight the GPs receive the Strategy Discussion Record to alert them to safeguarding concerns.
- CP Chair has been contacting the GP practice if a report is not received in time for Conference, or if the information is not what is required, to explore the reasons and explain the importance.
- Safeguarding Unit also monitors late GP reports and where necessary the named GP for Safeguarding is made aware.

The Safeguarding Operations Manager and Named GP for Safeguarding have liaised closely to monitor and improve practice in this area. Whilst GP participation in person (virtual) is still rare, some progress has been made in information sharing and written participation. The improvements in direct communication between the CPAs and GPs has contributed to a better understanding of family need and risks to children which in turn informs safer decision making and planning. There is now improved GP input in to conferences. In Quarter 1 2020/21 there were a total of 19 late GP reports, compared to only 7 in Quarter 2 2021/22.

✓ **Scrutiny at Board of the report from the Manager at Lansdown Secure Children's Home**, highlighting safeguarding and behaviour management practice at the unit over the past year. Annual presentation of this report to the ESSCP is a regulatory requirement given the significant vulnerability of young people in secure establishments. The Board noted how the unit uses and monitors techniques such as enforced separation and restraint; and how a more values-based style at the unit had impacted on the continued reduced use of these techniques. The Partnership agreed to support further scrutiny of the use of these techniques through a quarterly review by representatives of the Partnership.

9. Appendices

9.A Safeguarding Context

Impact of multi-agency working		
Family contacts (to SPOA and other excluding MASH)	↑	The total number of Contacts is up 29% on last year (17,011 compared with 13,218). Contacts did not show the same drop in Jan/Feb as the previous year.
Information gatherings by Multi-agency Safeguarding Hub (MASH)	↑	MIG's is also up for the same period (19,383 compared with 17,452)
Referrals to statutory social care	↑	In 2021/22 the number of referrals to statutory social care was up 10% from last year (4,169 compared to 3,811)
Privately Fostered children	↓	Despite some fluctuations, the number of Privately Fostered children shows a gradually increasing trend, from 22 in Jun 20 to 45 in Mar 22
Children supported by statutory services		
Children with a child protection plan	↔	The number of CP plans has remained consistently below target this year, averaging 527 plans per month. Overall, the number of children with a CP Plan at the end of March was slightly higher than last year (536 compared to 525).
Looked After Children	↑	The number of looked after children has slightly increased to 628 at the end of March 2022, compared to 612 at the end of March 2021.
Unaccompanied asylum seeking children	↓	There were 46 unaccompanied asylum seeking children in East Sussex at the end of March 2022, slightly lower than at the same point in March 2021 (53)
Young people at high risk of child exploitation	↓	There were five children at high risks of child exploitation at the end of March 2022, compared to 9 at the end of March 2021. Overall, in the past 12 months there has been a 44% reduction in 'red' cases and a 25% reduction in MACE cases.
Sexual offences against children	↑	The number of sexual offences (penetrative and non-penetrative) has increased over the past year, from a total of 438 in 2020/21 to 542 in 2021/22 (24% increase)
Children with family related vulnerabilities		
Children living with domestic violence (MARAC)	↑	The number of MARAC cases is up 12% overall on last year (1,105 in 2021/22 compared to 986 in 2020/21). There were a total of 2129 children recorded on those cases.
Vulnerable young carers	↑	There were 371 children's social care assessments completed in 2021/22 where young carer was identified as a factor, this is an increased compared to 317 in the previous year.

Children educated at home	↑	1355 children were recorded as being electively home educated at the end of March 2022, compared to 1227 at the same point in 2021.
Children with health related vulnerabilities		
Children with disabilities with a Child Protection Plan	↑	At the end of March 2022 there were 19 children with disabilities with a child protection plan. This represents an average of 4% of all CP plans compared to 3% at the end of 2020/21.
Children attending A&E due to self-harm	↑	592 children in 2021/22 attended A&E in East Sussex hospitals due to deliberate self-harm, an increase from 445 the previous year.
Referrals to child mental health services	↑	A total of 3,653 new CAMHS referrals were received in 2021/22 a 39% increase on 2020/21 figure of 2,629.
Children whose actions place them at risk		
Missing episodes	↑	There were a total of 1,404 missing episodes in 2021/22, a slight increase (7.6%) on the previous 2020/21 figure of 1,305.
Births to under-18 year olds	↑	Awaiting Qtr 4 data. There were 12 live births in East Sussex hospitals to children under the age of 18.
Young people entering the youth justice system	↑	100 young people entered the youth justice system for the first time in 2021/22 compared to 91 in 2020/21.
Young people held overnight in Police custody	↓	There were only 11 occasions of young people being held overnight in Police custody in 2021/22, compared to 26 in 2020/21.

9.B: Board Membership

NAME	TITLE, ORGANISATION
Reg Hooke (Chair)	Independent East Sussex SCP Chair (To Feb.22)
Chris Robson (Chair)	Independent East Sussex SCP Chair (From Feb.22)
Louise MacQuire-Plows	Manager, East Sussex SCP
Victoria Jones	Manager, East Sussex SCP
Graham Cook	Lay Member, East Sussex SCP
Harriet Martin	Lay Member, East Sussex SCP
Jacqueline Muntzer	Lay Member, East Sussex SCP (From Oct.21)
Maxine Nankervis	Admin Support Officer, East Sussex SCP

Domenica Basini	Assistant Director for Safeguarding and Quality, Nursing and Quality Directorate NHS England
Gareth Knowles	SECamb Trust Safeguarding Lead, Clinical Supervisor
Jayne Bruce	Deputy Chief Nurse, Sussex Partnership Foundation Trust (SPFT)
Jo Tomlinson	Assistant Head of Safeguarding Children/Designated Nurse, Sussex CCGs
Judith Sakala	Named GP for Child Safeguarding
Martin Ryan	Named Nurse/Associate Director Safeguarding Children (Interim)
Naomi Ellis	Head of Safeguarding and Looked After Children, Sussex CCGs
Tracey Ward (Dep. Chair)	Designated Doctor Safeguarding Children, East Sussex
Vikki Carruth	Director of Nursing, ESHT

Andrea Holtham	Service Manager, Sussex CAFCASS
David Kemp	Head of Community Safety, East Sussex Fire & Rescue Service
David Satchell	National Probation Service, Sussex (To Jul.21)
Jon Hull	D/Sup Sussex Police
Debbie Knight	National Probation Service (From Jul.21)

Annabel Hodge	Dir. Of Safeguarding, Bede's Senior School
Kate Bishop	Head Teacher, Rotherfield Primary School
Richard Green	Deputy Head Teacher, Chailey Heritage School
Richard Preece	Executive Head teacher, Torfield & Saxon Mount Federation

Ben Brown	Consultant, Public Health, ESCC
Catherine Dooley	Senior Manager, Standards and Learning Effectiveness (5-19), Children's Services
Douglas Sinclair	Head of Safeguarding and Quality Assurance, Children's Services
George Kouridis	Head of Service, Adult Safeguarding (To Jan. 22)
Justine Armstrong	Safer Communities Manager
Liz Rugg	Assistant Director (Early Help & Social Care), Children's Services (To Feb.22)
Kathy Marriott	Assistant Director (Early Help & Social Care), Children's Services (From Mar.22)
Stuart Gallimore	Director of Children's Services (To Sep .21)
Alison Jeffery	Director of Children's Services (From Sep.21))
Sylvia Tidy, Cllr	Lead Member for Children and Families (To May .21)
Bob Bowdler, Cllr	Lead Member for Children and Families (To Jul.21)
Vicky Finnemore	Head of Specialist Services, Children's Services

Jeremy Leach	Principal Policy Adviser, Wealden District Council
Malcolm Johnston	Executive Director for Resources, Rother District Council
Oliver Jones	Strategy and Partnerships Lead, Eastbourne District Council (To Jul.21)
Seanne Sweaney	Strategy and Corporate Projects Officer, Lewes DC and Eastbourne BC
Verna Connolly	Head of Personnel and Organisational Development, Hastings Borough Council

Kate Lawrence	Chief Executive Home-Start East Sussex
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9.C ESSCP Budget

ESSCP – Actual Income and Expenditure 2021/22:

Actual Income 2021/22		Expenditure 2021/22	
Sussex Police	£35,000	Independent Chair	£28,618
Sussex CCG	£53,400	Business Manager(s) 1.4 FTE & Administrator	£106,063
East Sussex County Council (ESCC)	£114,300	Administration	£1,586
Training Income	£10,613	Trainer	£54,386
National Probation Service	£1,434	Training Programme and Conferences	£3,603
ESSCP brought forward from 20/21	£55,553	Projects	£15,000
		Pan Sussex Procedures	£7,455
		IT Software & Hardware	£64
		Safeguarding Practice Reviews	£29,670
		carry fwd (balancing fig)	£23,855
Total	£270,300		£270,300

Projected Income and Expenditure 2022/23:

Projected Income 2022/23		Projected Expenditure 2022/23	
Sussex Police	£35,000	Independent Chair	£24,500
Sussex CCG	£53,400	Business Manager(s) 1.4 FTE & Administrator	£107,500
East Sussex County Council (ESCC)	£114,300	Administration	£1,500
Training Income	£7,500	Trainer	£58,000
ESSCP brought forward from 2021/22	£23,855	Training Programme and Conferences	£7,000
National Probation Service	Not yet advised	Projects	£15,000
		Pan Sussex Procedures	£7,500
		IT Software & Hardware	£1,500
		Safeguarding Practice Reviews	£9,870

		Carry fwd (balancing fig)	1,685
Total	£234,055		£234,055

9.D Links to other documents

[East Sussex Health and Wellbeing Strategy](#)

This strategy is a framework for the commissioning of health and wellbeing services in the County. The Health and Wellbeing Board will consider relevant commissioning strategies to ensure that they have taken into account the priorities and approaches set out in the Health and Wellbeing Strategy.

The main priority is to protect and improve health and wellbeing and reduce health inequalities in East Sussex, to enable us to do this over the next three years the strategy will focus on: Accountable care; Improving access to services; Bringing together health and social care; Improving emergency and urgent care; Improving health and wellbeing; Improving mental health care; Improving primary care; Better use of medicines; Better community services.

[Sussex Police and Crime Commissioner – Police and Crime Plan 2021-24](#)

The Commissioner has identified the following four policing and crime objectives:

- Strengthen local policing
- Work with local communities and partners to keep Sussex safe
- Protect our vulnerable and help victims cope and recover from crime and abuse
- Improve access to justice for victims and witnesses

[East Sussex Safer Communities Partnerships' Business Plan 2020-23](#)

The East Sussex Safer Communities Partnership undertakes a strategic assessment of community safety every three years with an annual refresh in order to select work streams and plan activity for the year ahead.

Colleagues from the ESSCP and ESCC Children's Services work closely with the Safer Communities Partnership to respond to the broader threat of exploitation. Sustaining existing work within the partnership and developing new and existing relationships with partners is of particular importance to ensure that we are supporting vulnerable individuals within the community and helping them feel safe and confident in their everyday lives.

[East Sussex Safeguarding Adult Board Strategic Plan 2021-24](#)

The ESSCP works closely with the SAB on the overlapping themes of Modern Slavery, Domestic Abuse, and Cuckooing. The two boards are also collaborating on a needs analysis for the cohort of 18-25 year olds who may be at risk of exploitation to identify any current gaps in service provision

9.E Acronyms

ABE	Achieving Best Evidence
AMH	Adult Mental Health
B&H	Brighton & Hove
BC	Borough Council
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CC	County Council
CCG	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CQC	Care Quality Commission
CRG	Case Review Subgroup
CSARC	Children's Sexual Assault Referral Centre
CSP	Community Safety Partnership
CYPT	Children and Young People Trust
DAT	Duty and Assessment Team
DC	District Council
DfE	Department for Education
EET	Education, Employment, or Training
EHE	Electively Home Educated
ESCC	East Sussex County Council
ESFRS	East Sussex Fire & Rescue Service
ESHT	East Sussex Health Trust
ESSCP	East Sussex Safeguarding Children Partnership
GP	General Practitioner
JTAI	Joint Targeted Area Inspection
LA	Local Authority
L&D	Learning & Development
LAC	Looked After Children
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
LSCLG	Local Safeguarding Children Liaison Groups
MACE	Multi-Agency Child Exploitation Group
MASH	Multi-Agency Safeguarding Hub
NHS	National Health Service
NPS	National Probation Service
QA	Quality Assurance
SAB	Safeguarding Adults Board
SCARF	Single Combined Agency Report Form
SCP	Safeguarding Children Partnership
SCR	Serious Case Reviews
SECamb	South East Coast Ambulance
SLES	Standards and Learning Effectiveness Service
SPFT	Sussex Partnership Foundation Trust
SPOA	Single Point of Advice
STP	Sustainability and Transformation Plan
SUDI	Sudden Unexpected Death in Infancy
SWIFT	Specialist Family Services
T+F	Task and Finish
YOT	Youth Offending Team