Annual Report 2012/2013

Introductory comments from the PSCB Independent Chair

I am very pleased, once again, to introduce the Portsmouth Safeguarding Children Board Annual Report 2012/13.

The production of the Annual Report provides an opportunity to review the impact of the work of PSCB to ensure effective safeguarding arrangements for children and young people in Portsmouth.

The expectations on parents, carers and professionals to ensure a safe environment for children and young people are demanding. Nationally we continue to hear about complex abuse situations in different parts of the country. The task of safeguarding children and young people presents a continuing challenge for us all to ensure that the essential work of the Local Safeguarding Children Board in Portsmouth is maintained and is effective.

During the past year Portsmouth Safeguarding Children Board has undertaken a number of key tasks. Some of these have been completed in full and others remain as 'work in progress' consistent with the priorities of the Board. These have included:-

- Maintaining our monitoring and review of safeguarding arrangements across agencies through audit, self-assessment and scrutiny
- Working to promote learning and improvements in practice based on case reviews as well as the communication of 'safeguarding' messages to professionals and the wider community
- Continuing to work with Schools, parents and young people to promote messages about e-Safety
- Participating in the Local Authority Research Consortium and reviewing how Portsmouth is supporting families who have experienced neglect
- Developing a strategy and action plan to address the risks of child sexual exploitation

Revised national safeguarding guidance 'Working Together to Safeguard Children' (2013) reinforces the expectations of Local Safeguarding Children Boards in terms of co-ordinating safeguarding arrangements and evaluating the impact of those arrangements in each local area. The importance of effective joint working by partner agencies requires us to continue to have clear priorities, hold one another to account and ensure we continue to learn from serious case reviews, audits of practice and quality assurance of what we do.

These challenges re-emphasise the continuing task for Portsmouth Safeguarding Children Board in supporting that work. This Annual Report provides a review of the work of our Board during 2012/13 and I commend it to you for your consideration.

I would also like to take this opportunity to acknowledge the ongoing hard work and commitment of the members of Portsmouth Safeguarding Children Board, the Executive and Sub-groups during the past year and to acknowledge their contribution with appreciation and thanks. In particular, I would wish to acknowledge the excellent support of our Business Manager, David Hogg and Administrator, Aileen Blakely throughout the year.

Jimmy Doyle, PSCB Independent Chair

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1. Executive Summary

This report reflects a year of consolidation and development of the work undertaken by Portsmouth Safeguarding Children Board. There has been a strong focus on child sexual exploitation and e-safety with considerable investment and effort invested in raising awareness and the promotion of safe practice.

There has been a continued effort to strengthen scrutiny and evaluation of practice through ongoing audit work and scrutiny of services through the Board's scrutiny calendar arrangements.

Dissemination of lessons from a Serious Case Review has been achieved through workshops and group briefings.

Research has been undertaken in collaboration with the Local Authority Research Consortium5 – LARC5 into parents/carers experiences and professionals' views on early intervention with child neglect. Further work will be undertaken to utilise the findings and recommendations for local practice.

PSCB has supported work to enhance multi-agency early intervention and to support the strengthening of usage of the common assessment framework.

The Board has continued to assess how it operates through an annual development workshop with the aim of strengthening areas for development and promoting continuous improvement.

N.B: This annual report is produced under the new Working Together Guidance 2013 which requires the LSCB annual report to cover the previous financial year (April 2012 to March 2013). This has meant that there is a degree of overlap with the time period covered in the last Annual Report (April 2011 to November 2012) which was published prior to new national guidance being available. .

2. Local background and context

Portsmouth is the UK's only island city, with Portsea Island accounting for 62% of the city's land mass. A port city located on the south coast of Hampshire, Portsmouth is the most densely populated area in the UK outside of London, with an estimated population of 208,889[1] residing within 15.5 square miles[2] (a population density of 13,477 per sq. m compared to London's 13,891 per sq. m). The distance from the north of the city to the south is 5.6 miles and the distance from east to west is 3.1 miles.

[1] Source: 2011-based Sub-national Population Projections (ONS)
[2] http://www.portsmouth.gov.uk/yourcouncil/1487.html

Based on the 2010 Indices of Multiple Deprivation (IMD), Portsmouth is ranked 76th most deprived out of 326 local authorities in England, with 15% of the city's population experiencing income deprivation. However, this masks significant differences at ward and LSOA level, with seven of Portsmouth most income deprived LSOAs (where 35 – 47% of the population is income deprived) in Charles Dickens ward, which tends to be the most deprived ward in the city across all of the various domains.

Based on the latest census data (2011), the city's ethnic profile has changed significantly since 2001:

- 84% of the population is White British (down from 92% in 2001)
- Portsmouth's BME community accounts for an estimated 16% of the population (up from 5.3% in 2001)
- 4.3% of the population is Other White (up from 2.2% in 2001 - reflecting increased immigration from EU accession countries including Poland)

Bangladeshi, Indian and Chinese remain among the top six ethnicities in Portsmouth, but since 2001 they have been joined by Black African, Mixed White & Asian and Polish ('Other White').

There are an estimated 50,400 children aged 0 - 19 living in Portsmouth, accounting for 24% of the usual resident population. Between 2001 and 2011, the 0 - 4 population increased by 22.7%, reflecting the increased birth rate from the mid-2000s. In 2011, the live birth rate was 13 per 1,000 resident population - down from a high of 13.7 in 2008, but forecast to go up again from 2012 and not return to levels seen in the mid-2000s until 2018[3].

Based on information collected in the 2013 School Census), 17.8% of Portsmouth's school children (in maintained primary and state secondary schools) are from an ethnic group other than White British, which indicates greater ethnic diversity amongst the city's young people.

Based on the latest child poverty data4, 24.4% of all dependent children under the age of 20 are living in poverty (compared to the England average of 20.1%), although this masks significant differences at ward level, where child poverty rates range from 6.2% (Drayton & Farlington, in the north of the city) to 47.5% (Charles Dickens, in the heart of the city).

Social care services includes the support of 118 fostering households and the Local Authority directly provides children's residential care through 3 residential units situated within the city offering placements for up to 19 young people 13 years and above. One of these beds is for 72 hour provision. In addition there are foster care and residential placements commissioned from the independent sector. There is also a short break residential unit for children with disabilities offering care for up to 45 children.

[3] Source: Portsmouth JSNA http://www.portsmouth.gov.uk/living/19062.html (Live Birth Rates and Trend)
[4] Source: HMRC Child Poverty Data (August 2011)

Community based services are provided by 7 social care teams, 1 Children with Disabilities Team, 1 Young Persons' Support Team, a Fostering Recruitment and a Fostering Support Team and an Adoption Team. Private fostering services are provided through a dedicated worker situated in the Fostering Support Team.

Additional preventative services are delivered through children's centres. The Joint Action Team oversees all new contacts to children's social care and safeguarding and supports a team around the child approach on a needs led basis. There are 2 Family Support Teams providing support to vulnerable families across the city. There is a Children Looked After Team that promotes the corporate responsibilities across the partnership for looked after children. This team also has approximately 2.5 FTE equivalent Education Consultants who provide more specialist advice and intervention to promote the educational achievement of looked after children. [Note: An annual report should not give data in the following year. There were 307 LAC at end March 2013.

3. Statutory and legislative context

Since 2009 there has been a requirement in national guidance that the Chief Executive and the Leader of the Council should make an assessment of the effectiveness of local governance and partnership arrangements for improving outcomes for children and supporting the best possible standards for safeguarding and promoting the welfare of children.

In addition, the Apprenticeships, Skills, Children & Learning Act 2009 introduced a requirement for Local Safeguarding Children Boards to produce and publish an annual report on the effectiveness of safeguarding in the local area. Subsequent statutory guidance ('Working Together to Safeguard Children' DfE, 2013) indicated that 'The report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services'.

This annual report of the Portsmouth Safeguarding Children Board and the formal reporting to the specified bodies provide the accountability framework to meet these responsibilities.

4. Summary statement of sufficiency of local safeguarding

4.1 Improvements in safeguarding during 2012-2013

Some of the improvement highlights from this period are:

- Strengthening awareness raising activity about child sexual exploitation (e.g. 'spot the signs' leaflets made available to all secondary school students and their parents/carers; on line CSE training made available to all professionals.)
- Establishment of a regular, systematic and multi-agency oversight of individual young people known to be at risk of (or experiencing) child sexual exploitation in addition to single agency responses.
- Involvement of children , their parents and school staff in the continued development of on-line safety awareness raising resources for primary aged children and their parent/carers in preparation for a city wide 'Troll' campaign.
- Supporting professionals in improving their practice in safeguarding through reflective practice forums led by the Professional Practice Committee.
- Disseminating the lessons from the Serious Case Review on Child D to a wide range of professionals through workshops, group briefings and individual supervision. This was done well ahead of the planned publication of this SCR in September 2013.
- Published comprehensive guidance on early intervention including agreed thresholds for specialist services and supporting awareness of this through interactive conferences for professionals from all agencies.
- Commissioned independent evaluation of families' experiences of the child protection system.
- Commissioned external evaluation of the processes around allegations management and secured increased Local Authority Designated Officer (LADO) capacity for managing allegations against staff or others working with children and young people.
- Completed audits of service/team/establishment compliance with the Safeguarding Compact standards, 2 Deep Dive Audits (on children experiencing domestic abuse and on children subject to repeat child protection plans)
- Support for the implementation of the Joint Action Team to provide improved multi-agency early intervention and ensuring the good access to Children's Social Care for those cases where this is genuinely warranted.
- Completed research on parents'/carers' experiences and professionals' views on early intervention with child neglect as part of national research collaboration (Local Authority Research Consortium5 - LARC5)
- Secured improvements in monitoring and review of child deaths and of the Child Death Overview Panel functioning through the appointment of a CDOP manager and new work streams arising from this appointment.

4.2 The PSCB's self-assessment of its strengths and weaknesses

As part of a PSCB development process in June 2012 the Board members identified the following strengths regarding the functioning of the Board:

- Good multi-agency commitment and contribution including positive joint work through a number of PSCB committees
- Clear structure with good information provided to members which supports efficient operation.
- A clear business plan assisting with a sense of purpose and forward direction.
- Agencies are held to account through their participation in the Board and the challenges that this brings.

Board members also identified the following general areas for strengthening the operation of the Board:

- Need for a stronger picture of the experience of practitioners at the frontline.
- A desire to connect more consistently with members of the public
- Embedding the notion of the Board as a learning partnership
- Using the views of children and young people to inform the work of the Board

More specific areas for development included:

- Strengthening links with adults services, with the Health and Wellbeing Board and with schools
- Evaluating how well the published thresholds for children's social care are understood by front line practitioners
- Strengthening the assurance process that the recommendations from the Board and its committees are implemented and are having the desired outcomes.

4.3 Overall evaluation of effectiveness of safeguarding

The various strands of evaluation activity summarised in the annexes to this report lead the PSCB to identify the following summary judgements about the effectiveness of safeguarding arrangements in Portsmouth.

OVERVIEW

There is evidence that agencies work together effectively to deal with child protection enquiries and that interventions are generally effective and robust.

A priority for 2013/14 is to ensure that multi-agency plans address the underlying causes in family difficulties as indicated by the high level of repeat child protection plans and evidence from the two recent serious case reviews, which highlight the difficulties and complexities of adequately addressing neglect.

Challenge and Escalation - Agencies at all levels work effectively together; however on occasions it is necessary to challenge another's professional judgment or particular process of an agency. There is further work required to support and encourage agencies to raise and escalate concerns as indicated in the two recent serious case reviews where frontline practitioners had concerns but did not escalate these to senior managers or to the Safeguarding Board.

Considerable progress has been achieved by agencies in Portsmouth in preventing children suffering significant harm through improved early intervention and the development of early help services. Two successful multi-agency 'Early Help' conferences held during the year helped to underpin the importance of appropriate early intervention for all professionals working with children and included the launching of a refreshed Common Assessment Framework approach.

A priority going forward is to ensure that 'early help' interventions are holistic and multi-agency (where required) in addressing the duty to 'promote the welfare of children'. In particular agencies and practitioners need to make the link between safeguarding and educational achievement.

Good progress has been made in relation to generating awareness and building effective processes for tackling child sexual exploitation (CSE). Further work is required in relation to identifying the full extent of CSE in Portsmouth and communicating key messages amongst all practitioners and more broadly, the wider community.

SPECIFIC AREAS FOR MAINTAINANCE AND DEVELOPMENT

Particular strengths in safeguarding arrangements and practice that we would wish to maintain and further develop are:

Leadership:
Clarity of leadership and vision as evidenced in strategic development of structures, resources and change programmes to meet future priorities and expectations, for example, the development of actions to protect vulnerable children and young people who may be at risk of Sexual Exploitation or other forms of abuse

Partnership working:
Strong partnership working and an enthusiastic and committed workforce e.g. the maintenance and development of a multi-agency delivery of the safeguarding training programme

Early help and Intervention:
An improving picture regarding early help and intervention practice and a strong multi-agency commitment to develop this further, for example, the implementation of the Joint Action Team and embedding the use of the Common Assessment Framework

Focus on improvement:
A proactive approach towards the identification and recognition of where improvements may be needed and a readiness to learn and improve as evidenced by strengthened processes for data analysis, audit activity and enhanced case review processes, for example, the adoption of a PSCB learning and improvement framework.

On line safety:
A substantial awareness raising programme for school staff and pupils, other professionals and the general public that provided high quality information resources.

Despite these clear strengths there is no place for complacency and our analysis identifies the following areas as priorities for improvement in the coming period and for focused work by the Board:

Evaluating impact:
To establish and develop a clearer focus on evaluating and understanding the impact of interventions and expected outcomes by ensuring that the 'voice of the child' features in future activity to support the Board's strategic evaluation and understanding of the impact it is having.

Developing scrutiny:
To strengthen the Board's data collection to support analysis and scrutiny of safeguarding arrangements in Portsmouth that ensure a better understanding of the 'child's journey'.

Early Help:
To promote and strengthen the engagement of universal services in early help and intervention processes such as team around the child, the common assessment framework and safe sleeping advice.

Allegations Management:
To secure enhanced capacity and leadership for dealing with allegations against adults working with children, to promote cross agency awareness and maintain consistency in managing such allegations

Reduction in repeat Child Protection Plans:
To support multi-agency work to reduce the number of children who require a child protection plan for a second time.

NHS Reforms:
To ensure that health partners and commissioning arrangements are adequately focussed on the safeguarding children agenda at a time of NHS organisational change that inevitably brings risks to partnership working.

These areas for improvement together with other areas highlighted elsewhere in this report will form the basis for business planning and a co-ordinated effort across Board partners in the coming period.

5. Challenges for the Children's Trust Board and Health and Wellbeing Board

The analysis of the effectiveness of safeguarding locally leads the PSCB to present the following challenges to the Children's Trust Board / Health and Wellbeing Board as important and influential issues to be taken into account in the planning and commissioning of services for children and young people in Portsmouth in 2013-2014:-

- to ensure that safeguarding arrangements are secure in the context of austerity measures and the resulting changes to organisational structures
- to commission and plan for services to ensure that childhood sexual exploitation is prevented or dealt with effectively where prevention is not possible
- to continue to promote and develop effective multi-agency early help and early intervention services in the local area
- to ensure that the voice of children and young people is taken account of in shaping services and their delivery
- to ensure that the Children's Trust Board and the Health and Wellbeing Board work effectively together to drive improvements in children's' safeguarding outcomes

6. PSCB Priorities for 2013-2014

The work of the Board during the past year has led to the identification of the following priorities for 2013-2014:

1. Evaluating impact:
To establish and develop a clearer focus on evaluating and understanding the impact of interventions and expected outcomes in plans for individual children and young people to support the Board's strategic evaluation activity.

2. Developing scrutiny:
To strengthen the Board's data collection and further develop the analysis and scrutiny of safeguarding arrangements to ensure a better understanding of the 'child's journey'.

3. Early Help:
To promote and strengthen the engagement of universal services in early help and intervention processes such as team around the child and the common assessment framework.

4. Allegations Management:
To secure enhanced capacity and leadership for dealing with allegations against adults working with children, to promote cross agency awareness and maintain consistency in managing such allegations

5. Reduction in repeat Child Protection Plans:
To support multi agency work to reduce the number of children who require a child protection plan for a second time.

6. NHS Reforms:
To ensure that health partners and commissioning arrangements are adequately focussed on the safeguarding children agenda at a time of NHS organisational change that inevitably brings risks to partnership working.

7. Child Sexual Exploitation:
To maintain a focus on addressing the risks to children and young people and to build on current work to strengthen and develop the CSE Strategy.

These priorities set the context for agreeing objectives and work planning for the Executive and the other Committees of the PSCB. The Chairs of the Executive and other Committees have identified objectives for the work of their committee over this period. These are presented in the PSCB Business Plan as a series of action plans for each Committee and are available at:

http://www.portsmouthscb.org.uk/user_controlled_lcms_area/uploaded_files/PSCB%20BusinessPlan%202013-2014%20FINAL.pdf).

The delivery and impact of the Business Plan is monitored by the Executive.

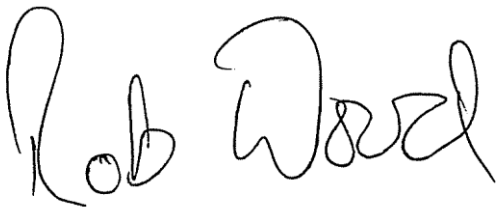
This Business Plan is presented as a series of action plans for each Committee. The delivery of the Business Plan will be monitored by the Executive.

7. Concluding comments from the Lead Member for Children and Families

I am pleased to add a concluding comment to this fourth Annual Report of the Portsmouth Safeguarding Children Board (PSCB) which provides an analysis of the effectiveness of safeguarding in the local area. There are encouraging examples of good local practice that shows how this is leading to better outcomes for children.

However there are no grounds for complacency and this report sets out the key areas where future efforts need to be concentrated. It is important to know that local arrangements for safeguarding and promoting the well-being of Portsmouth's children are as good as they can be and that there is a constant effort to improve how this works. The information in this report is helpful in my task of holding all agencies to account for how this essential work is taken forward and in ensuring that these arrangements are well co-ordinated.

Keeping Portsmouth's children safe relies on statutory and non-statutory agencies working closely together to improve their contribution to safeguarding. I would like to thank the members of the PSCB and its committees for their commitment, effort and determination in their work to achieve effective safeguarding arrangements and practice.



Cllr Rob Wood
Lead Member for Children and Families

8. Where to find further information and detail about the work of the PSCB

Visit our website at www.portsmouthscb.org.uk

9. How to contact us if you have a comment or question about the content of this report

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Appendix 1: What the LGA Safeguarding Children Peer Review (October 2012) told us about local safeguarding

In October 2012 a Peer Review of safeguarding arrangements for children was conducted by a team of 8 peer reviewers, experienced professional from across England who visited us for a week to evaluate the effectiveness of local safeguarding arrangements.

The main strengths and the areas for further consideration that were highlighted are:

Summary strengths

The Council and its partners have pro-active and rigorous leadership which has set a clear direction that is known and understood across the partnership

Clear evidence of a commitment to modernise and grasp the Munro and Social Work reforms

There is strong evidence that business planning links to the vision, priorities and is transmitted at every level and that performance management runs alongside this

The council and partners have aligned the service structures, resources and change programme to focus on the priorities for safeguarding and the delivery of strategic priorities

Evidence of strong partnership working including PSCB and CT as well as Safer Portsmouth Partnership and Health and Wellbeing Board

Evidence of the positive impact of some of the changes in delivery is apparent and deal with problems at an early stage e.g.

Increased CAF/ Team around the Child (TAC) across agencies
Joint Action Team (JAT) created
Improved Children in Need work
Improved practice in social care process and procedures

Pressures have decreased in social work case loads and vacancies

Committed and enthusiastic workforce across the partnership

Summary areas for consideration

Practice, process and procedures have improved but plans and interventions need a greater focus on the impact and intended outcomes

The Council should consider examining and ensuring that the restructuring of the Social Care Service is not in some instances leading to multiple transitions and changes in case holding causing potential drift and disruption

The IT social care system is reported as time consuming and affecting the efficiency of staff and potentially thoroughness of recording

The use of strategic information is good but data from the frontline should also be used more effectively to inform the re-shaping of services

The ambition of the Council and the partners is to provide services collaboratively and at an early stage. A long term financial plan would help to deliver a strategic shift of resources to support this.

Although the strategic vision and the priorities are well established and owned across the partnership, there is evidence of a less well integrated approach to the joining up of the strategic strands across the council's services.

There is a risk to engagement of health commissioning within the partnership due to NHS organisational change

Appendix 2: Key issues we have learned from any serious case reviews

The PSCB completed and published a serious case review on Child D. The inter-agency recommendations and actions are as follows:

1. The Board should consider introducing multi-agency quality assurance initiatives directly aimed at appraising how well agencies are working together.

   PSCB are maintaining a programme of multi-agency 'deep dive' audits every six months. These are focused on the effectiveness of working together in different aspects of safeguarding and lead to recommendations for improvements and monitoring of changes in practice.

2. The Board should support the renewed delivery across all partner agencies of initiatives to promote “safe sleep”.

   A programme for promoting safe sleep by all partner agencies was re-launched last year and evaluated as successful in getting key messages consistently communicated to parents, carers and practitioners.

3. The Board should review the progress made in tackling issues identified in the previous Serious Case Review of Child C which have also presented in this case, and utilise the planned Peer Review exercise to complement this.

   PSCB has examined the common issues between the two reviews, is assured of progress that has already been made and has made clear recommendations for further improvements.

4. The Board should commission a multi-agency review of local practice and arrangements to support child protection agencies in working together effectively outside “office hours”.

   A review of the out of hour's services for all agencies has assured the Board of their adequacy and effectiveness. Recommendations for further improvement were acted upon and there is a regular audit of effectiveness of out of hours working together arrangements.

5. The Board should evaluate the reports arising from this review of unsatisfactory working relationships between Children’s Social Care services and a school, and, if necessary, develop a protocol to strengthen effective communications and understanding of the arrangements for escalating concerns.

   The relationship between the school and children's social care has been reviewed and found now to be satisfactory. A new multi-agency referral team has improved schools' access to information and advice about vulnerable children. Guidance for

schools about escalating concerns has been strengthened and they have been reminded of the existing protocol for resolving professional disagreements.

6. The Board should review arrangements for considering cases which may require a Serious Case Review, to ensure that agencies and families are aware that this has been considered.

   Since August 2012, the Serious Case Review Committee's consideration of cases has been strengthened by using improved structures that provide clearer feedback to agencies and ensuring that families are more involved in the process. Draw upon press statements

Appendix 3: What our on-going monitoring of all child deaths has told us

Outcomes for children and families over the last 12 months:
The Child Death Overview Panel does not provide a direct service to children and their families; however the action of the panel does assist in preventing further deaths and identifies modifiable factors to improve the well-being and lives of young children. The CDOP covers Hampshire, Isle of Wight, Southampton and Portsmouth's LSCB areas and the learning in terms of preventing harm or deaths is across all four areas.

Lesson learned over the past 12 months:
Out of approximately 80 cases across the four areas reviewed by CDOP in a twelve month period there is a low percentage with modifiable factors which may have contributed to a death and therefore recommendations were made to reduce future deaths. Portsmouth had 9 deaths notified in this period. . The safer sleeping campaign continues to be visible and evidence does suggest that this assists in maintaining the low numbers of death by overlay.

DfE return completed this year has not raised any specific issues.
An audit completed on approximately 30 cases has highlighted the need for multiagency working and information sharing to enable the rapid response to work effectively.

Improvements made in practice/service arrangements over the past 12 months:
CDOP is now fully functioning with specialist members of the panel being successfully recruited to advise the panel when reviewing deaths in particularly Neonatal and Perinatal deaths.

A manager is now in post and visible to agencies and all four safeguarding boards. Attendance at board meetings where relevant and appropriate to give feedback, updates and present the Quarterly reports is now a regular occurrence for CDOP.

The CDOP process has been fully reviewed and the function of the panel is following the governments guidance for panel functioning. Deaths are fully reviewed and the correct format used.

The DfE returns has been successfully completed and highlighted some issues of outstanding cases from 2010-2013. A plan of action has been agreed and implemented to address this. An additional panel meeting has been scheduled for February so that these cases can been categorised.

A full review of the Rapid Response procedures has been undertaken, this will be published immanently.

Challenges facing the service area:
CDOP has been functioning without a manager in post for approximately 8 months until the post was recruited to in Feb 2013. Therefore the service had drifted somewhat. Processes and procedures are out of date, reports and business plans require updating and this will take time however, a plan of action is in place to address this and the above is currently work in progress.

The role of Designated Doctor remains vacant and this will continue to be a challenge for the Child Death Overview Panel and other professionals reliant on the input of a Designated Doctor.

Future plans:
CDOP intends to raise the profile of processes, procedures and functioning within the local authority and healthcare settings. This will be achieved through short training sessions to local authority staff and meetings with paediatricians to cascade the awareness and information down to frontline staff.

Training of rapid response professionals is in the planning stage and will be facilitated over the next 8 months in collaboration with police colleagues. An audit tool of unexpected deaths will be completed to ascertain if the procedures are being adhered to and to evidence that training has been effective.

Support from the PSCB:
The role and function of CDOP is not widely known in children services and raising the awareness of CDOP would greatly assist the panel when gathering information for a review. Support in cascading this information would be of benefit. CDOP will be providing some bespoke sessions to inform professionals of the work CDOP undertakes and attendance where possible would be appreciated.

Where possible, ensuring that the message of safer sleeping is given to parents and carers via child protection conferences/plans, Child in Need plans and parenting/family support sessions and assessments.

Appendix 4: How effective is safeguarding in local services and establishments?

1. The MESC has completed the second annual audit against the Portsmouth Safeguarding Compact. Key headlines are as follows;

    a) 125 services were asked to complete a self-assessment

    b) 47% were returned on time, rising to 77% following some chasing

    c) 100% of those providing feedback on the usefulness of the audit process were positive. (70% gave feedback on the process)

    d) 29 services did not return an assessment at all, a significant rise on last year. These services have been written to and informed they will be included in the 2013/14 audit

    e) PSCB members have been written to by the Chair to seek reasons why these 29 agencies did not reply

    f) Of the 97 that did complete the audit, 29 services were triggered by the criteria that require them to submit an improvement plan to MESC. Last year it was 45 services so this could be taken as some level of improvement

    g) (Again, data should not be included that refers to the next year - if this is essential to include then suggest this goes in as footnote, otherwise delete.)

    h) Key issues highlighted are much the same as the first audit;

        - Understanding of the LADO role
        - Embedding Early Help practices (CAF, lead professional and Team Around the Family) into everyday business
        - Key staff having undertaken Safer Recruitment training

2. The information from the audit is used to inform the Integrated Working and Safeguarding Training Programme and the work of the Joint Action Team.

Appendix 5: What routine analysis of safeguarding data told us about the effectiveness of local safeguarding practice

The MESC has designed and implemented a Dataset with 70 indicators. These have been split into 10 blocks as follows:

Child protection processes
Children in need
Earlier Intervention
Children's workforce
Child deaths
Wider safeguarding
Section 11/compact audit
Allegations
Looked after children
The PSCB

There has been some concerning movement in some figures which we are currently looking at a bit more closely to see if they are 'blips' or 'trends', notably;

- numbers of Looked After Children
- numbers of child protection plans
- permanent exclusion from school
- a shift from emotional abuse to neglect as key concern
- recorded domestic abuse
- risk assessments of young offenders

There are some positive movements in the following areas

- numbers of CAFs
- repeat referrals to Children's Social Care
- quality of Child in Need case planning
- crimes against young people
- allegations management - timeliness of strategy meeting
- LAC participation in their reviews

Appendix 6: Progress that has been made against the challenges offered to Children's Trust Board in the last Annual Report

To ensure that safeguarding arrangements are secure in the context of austerity measures and the resulting changes to organisational structures

Budgetary constraints and the need to achieve savings have been a reality for all partners throughout the past year. Nevertheless, there has been an ongoing commitment to seek to protect safeguarding activity at both a strategic and operational level across the partnership. The activity of PSCB has been sustained through maintaining budget contributions and importantly, through contributions in kind to support training, committees of the board, conferences and the dissemination of lessons from serious case reviews. The links which PSCB has developed with the Children's Trust Board have contributed to an appreciation of the importance of the safeguarding agenda in the city and a commitment from partners to seek to maintain that position.

To commission and plan for services to ensure that childhood sexual exploitation is prevented or dealt with effectively where prevention is not possible

The Children's Trust Board has continued to maintain a focus on the vulnerability of children and young people who may be at risk from exploitation. The Pan-Hampshire 4 LSCB group has maintained its work on Missing, Exploited and Trafficked Children guided by the DfE CSE Action Plan published in November 2011. Portsmouth Safeguarding Children Board during 2012-13 has established a formal CSE Committee to take forward the local strategy. The LGA Peer Review in October 2012 commented that good progress was being made and that work to promote awareness should continue.

Work to address the risks of CSE is continuing and will be carried forward in the PSCB 2013-14 work plan. Primarily this will focus on identification, awareness raising, the provision of specialist support to victims and the development of arrangements for a preventative approach. There are also detailed plans to take forward disruption strategies between the Police, Children's Social Care and the Barnardo's service. The support of the Children's Trust Board will continue to be important in supporting and sustaining future commissioning of such services and practice.

To continue to promote and develop effective multi-agency early help and early intervention services in the local area

Significant progress has been made with regard to early help during the past year through the support of the Children's Trust Board. Developments have included the establishment of the Joint Action Team; continuation of the integrated working and safeguarding training programme and a successful multi-agency Early Help Conference in November 2012 - which was over-subscribed - resulting in a further conference in March 2013.

There have been significant shifts in activity levels across the city with increasing numbers of Common Assessments being completed. There is also evidence of more appropriate referrals being made to Children's Social Care and a reduction in re-referrals. The publication of new social care thresholds, a re-design of the CAF based on multi-agency and parent/carer input and a new training course on supervision to support front line managers across all agencies have each contributed to improvements in this area of work.

The Integrated Working and Safeguarding Children training programme continues to provide multi-agency training to a large number of managers, supervisors and practitioners in the city. Some redesign of the programme has enabled a stronger focus on front-line managers and the revised guidance on early help. The manager for the programme receives information from various parts of the Safeguarding Board to enhance the training based on local learning. Schools increasingly purchase Safeguarding Awareness training (through a traded services arrangement) delivered to whole school teams and this year there has been a strong focus on nursery providers.

To ensure that the Children's Trust Board and the Health & Well-Being Board work effectively together to drive improvements in children's safeguarding outcomes

The links between the Children's Trust Board and the Portsmouth Safeguarding Children Board have been developing over the past four years. The Chair of the PSCB sits on the CTB and there is a continuing opportunity to ensure that safeguarding is considered and appropriate challenge offered at all levels in consideration of the CTB priorities.

The PSCB Annual Report is presented to the CTB each year and relevant safeguarding challenges from PSCB are addressed to the CTB for their consideration. The Chair of the CTB is invited each year to report on progress which has been made in addressing the issues raised.

In the course of 2012-13 the PSCB Annual Report was also presented to the newly established Health & Well-Being Board for the first time. It is planned that this practice should be maintained.

Appendix 7: How implementing our Business Plan improved safeguarding

EXECUTIVE – Implementing our Business Plan

During 2012-13 the Executive has adopted and strengthened its role to oversee the progress of the Business Plan on behalf of PSCB. Whilst continuing to support the Safeguarding Board through agenda planning and addressing specific issues delegated by the Board, the Executive has adopted an increasing focus on receiving reports from the Committees. This has helped to highlight the wide range of activity being undertaken on behalf of the Board and has created the potential for the Executive to provide additional support or guidance as required.

Achievements (Outcomes)

Overseen the transition from a 'task & finish' group to the establishment of a Child Sexual Exploitation Committee of the Board to develop and progress an appropriate strategy and action plan.

Maintained a 'watching brief' on progress towards a Children with Disability strategy to support the related Children's Trust Board priority with a particular focus on safeguarding aspects of the strategy.

Continued to support the e-safety work of the newly established E-Safety Committee consistent with the business plan objective of delivering key 'safeguarding messages.

Provided funding to support a research project focusing on support to families who may have experienced neglect.

Supporting the commissioning of 'awareness raising of the local LADO arrangements and securing an increase in LADO capacity within the local authority.

A review of the effectiveness of multi-agency training, monitoring the effectiveness of the child sexual exploitation strategy and strengthening engagement with children and young people remain priorities and 'work in progress' for the Executive.

MONITORING, EVALUATION & SCRUTINY COMMITTEE

This year the work of the MESC has been as follows;

Annual Section 11 Safeguarding Compact Audit

In March 2013, the MESC completed its second annual audit of early help and safeguarding. The audit is based on an agency's self-assessment against the 10 standards of the Portsmouth Safeguarding and Early Help Compact which was first designed in 2004.

This year, 125 services were asked to complete the audit and 97 responded. Those that did not respond are to be included in the 2013/14 audit.

The audit demonstrated that there continues to be more work to do to embed the early help processes of the CAF and lead professional practice and more to do to improve allegation management. However, this year only 27 services were asked to return an improvement plan against 45 last year.

Feedback on the process was again positive and the audit continues to raise the profile of safeguarding and of the PSCB in the city.

The PSCB Dataset

The MESC continues to develop and monitor the PSCB dataset. The dataset includes over 70 outcome or process indicators which help us build a picture of safeguarding and early help in the city.

Data analysis this year had demonstrated a number of key improvements in safeguarding including;

- Quality of child protection plans and child in need plans
- Coverage of child in need plans
- Use of the CAF
- Family experience of child protection practices
- Quoracy of child protection planning meetings
- Numbers of Tier 3 children with a plan in place

The data also showed some areas for improvement including;

- Looked After Child placement stability
- Reducing changes of social worker for children
- Multi-agency reports into child protection conferences
- Waiting time for multi-agency safeguarding training
- Educational inclusion for some vulnerable children including less than full-time provision and education following a fixed term exclusion
- Use of LADO arrangements

Deep Dive 3

The third PSCB multi-agency Deep Dive explored the issue of high repeat child protection plans in the city. A multi-agency team reviewed seven cases in detail and made six recommendations for improvement to practice to the PSCB.

Audit Activity
In March 2013, the Committee received a follow-up audit on health referrals to Social Care. This was a re-audit to see if there had been improvements since 2011. The audit demonstrated that the quality of the referrals had improved but there remained work to do around the voice of the child and the analysis of the severity of concern
Children's Social Care and Safeguarding continue to provide accurate and timely audit information to the Committee.

Ofsted 2011 Action Plan
The Ofsted safeguarding inspection of spring 2011 led to 15 recommendations for improvement. MESC developed a multi-agency Action Plan and monitored it up to autumn 2012 when it was felt that most of the recommendations had been implemented successfully. The three areas remaining for improvement (the role of the LADO, repeat Child Protection Plans and child in need cases with an up-to-date plan) were being picked up in new of existing action plans. In November 2012, the PSCB agreed that implementation had reached the point where detailed monitoring of the Ofsted Action Plan could end.

Research
In September 2012, the MESC commissioned an independent researcher to hear the voice of children and their families around their experiences of the child protection system. The research demonstrated that children and families had been visited regularly, had seen the reports made by professionals and were involved well in the process. Of particular note, the random sample of families expressed a very high regard for multi-agency work around them.

There were lessons for the PSCB however in terms of where child protection planning meetings are held, practical access issues (transport, childcare, refreshments etc) and in particular, ‘step-down’ support into Child in Need or Tier 3 support.

Child Sexual Exploitation
From February 2013, the MESC began providing support to the PSCB Child Sexual Exploitation Committee in understanding the prevalence and needs around CSE in the city.

In February 2013, the MESC gave a full report to the main Board of all its findings over the previous year and delivered a set of 18 recommendations; 12 for Children’s Social Care, 2 for the Board itself and 4 for all member agencies of the Board.

PROFESSIONAL PRACTICE COMMITTEE

The Professional Practice Committee was formed in May 2011 in response to an identified need to strengthen inter-agency collaboration and to improve the effectiveness of practice in response to Professor Munro's reforms of Child Protection.

The specific functions of the Professional Practice Committee are as follows:

- To encourage and help develop effective working relationships between different services to promote trust and interagency collaboration
- To improve the effectiveness of practice in the light of knowledge gained through national and local experience and research
- Resolving professional difference and challenging agency attendance at case conferences and core groups
- Identifying gaps in safeguarding practices and implementing strategies to address the gap
- Ensuring that a strategic overview of the implementation of safeguarding plans and services is maintained in a joined up way
- Ensuring that safeguarding is embedded in preventative work and multi-agency agreement around thresholds is agreed in order to reduce the risk of children coming into contact with social care and other tier 3/4 assessments and interventions when it is not appropriate for them to do so
- Ensure the collective identification of good practice and the conditions which support it providing opportunities for staff who work with children, young people and their families to reflect on and discuss local practice issues

Membership

The core members are; Children's Social Care, Health, Police and Education. Other agencies may be co-opted in order to provide specialist information.

Membership will include those able to contribute and analyse information on safeguarding.

Workplan for 2013/14

In April 2013, a new case conference process was developed that included a clear analysis of risk and protective factors, outcome focused child protection planning and ensuring the voice and experience of the child is central to the decision-making process. Multi agency training was delivered and the safeguarding training programme revised to include the new conference requirements. A framework for the quality assurance of case conferences was developed to ensure senior managers had direct experience and knowledge of the conference process.

The Committee has organised a multi- agency audit of child protection, in November 2013, to include an evaluation of early help, referral, S. 47 processes, effectiveness of the child

protection case conference and individual's contribution to the conference, including the effectiveness of child protection planning and core group meetings.

As a result of a Serious Case Review, The Committee developed a framework for staff from all agencies on working with resistant families from identification, risk assessment and defining management responsibilities.

The Committee has reviewed the implications of the practice changes introduced by Working Together 2013 and also Private Fostering as part of its scrutiny function.

The Committee has also reviewed and revised a resolving professional differences protocol and has developed multi agency reflective practice meetings to encourage a culture of professional challenge, discussion and negotiation. Both of these provide clarity on escalation processes and the links to the PSCB.

The Committee works with The Serious Case Review Committee and the Monitoring and Evaluation Committee to ensure identified themes can be incorporated into the workplan. The Principal Social Worker, appointed in July 2013, has also become a Committee member and will be supporting the Committee to ensure the experience of front line practitioners are heard and addressed.

Mary Brimson
Safeguarding Monitoring Commissioning Manager 05/11/13

E-SAFETY COMMITTEE

Background

Following a well-attended E Safety Conference held March 2012, there have been three key areas of activity and priorities for the E Safety Group during the time period April 2012 - March 2013:

- The delivery and development of the e-safety awareness campaign and related resources
- Seek agreement for and recruit an E- Safety Officer to deliver the E Safety Strategy and support the E Associates network
- Data collection in terms of e-safety incidents to establish base-line

The E Safety Awareness Campaign

Awareness raising is and will remain a key priority for the group, targeting children of different age ranges, parents, carers and professionals. The key messages are how to stay safe on-line, what to consider in order to ensure that your own on-line behaviour doesn't cause problems for others and what to do if an incident occurs. This is essential as it is no longer possible or practical to rely on filtering of inappropriate sites to protect children, as the means of access are now so varied. The internet is a constantly changing environment and there continues to be complacency from children and their carers over the need for safe practises. The campaign delivers the message by a range of means which will ensure that the message is received and is trusted.

During this time period the following elements were successfully delivered:

- Distribution of the E-Safety Conference DVD's to all schools and other organisations working with children. Copies are available in all Portsmouth public libraries for loan

- Delivery of three E-Safety roadshows in shopping centres

- Production of the "Stay protected when connected" booklet for parents/carers

- Production of an e-safety leaflet and on-line quiz for parents/carers. The quiz was delivered city wide with the prize of a tablet awarded in summer 2012. A KS2 E safety leaflet completion. The winning entry was published in Termtime autumn 2012.

- A further print run of 10,000 flyers was printed following the parents/carers completion, to continue the e-safety messages

- Two E safety promotions have been published in Flagship

- The E Safety web pages have been developed. They received over 500 visits in the first month after the conference.

- The "Beware of Lurking Trolls" campaign was developed following a KS3/4 competition which was only moderately successful but produced the "Troll" concept. This was then productively developed in consultation with the Youth Parliament and Reading Activist groups. Beyond the time period of this report, this concept has been developed to produce four "Troll" characters to personify the four key on-line threats, cyber bullying, threats to personal safety/stranger danger/CSE, data protection and viruses. A Troll costume has been produced; four pull up banners, leaflets, posters and a picture book for KS2. Funding will now be sought from Safeguarding Boards and other organisations working with children, to create an on-line game, using these characters

E Safety Officer

Agreement was sought and obtained for funding to deliver an E Safety Officer post for an initial period of two years. Following the conference, it became clear that there was a requirement for an on-going post to deal with enquires, work on promotional campaigns and capitalise on the interest and energy generated by the discussion and workshops. This post is required to build an E Associates network of organisation who deals with young people. The post-holder will also deal with the on-going communication and sharing of good practice by members of the network, training and outreach. The post was assessed by the HR Pay and Policy Officer as band 7, that is £22,221 (25) to £26,276 (29) pro rata based on 2012/13 salary scales. On the basis of these costs a decision has been taken to appoint a post holder for 18 ½ hours per week for an initial period of 2 years. The post was placed in the Integrated Youth Support team in Targeted Youth Support. The team made minor adjustments to the job profile and the post was finally recruited in spring 2013 with the post holder taking up their role in June 2013

Data collection/baseline data

This has been unsuccessful over this time period, but communication with the Police may result in changes to the way incidents are recorded. This work is on-going.

Outstanding Areas of Activity for the Group

- Recruitment, training and development of the E Safety Officer role to deliver the E safety Strategy.
- Seek funding from other Safeguarding Boards and organisations working with children to jointly develop an on-line game to deliver the e-safety message. This is likely to target KS3 and 4
- Maximise use of resources developed over this time period to deliver activity in schools and in public places
- Seek consultation with KS1 and Early year's specialists to identify and address e-safety agendas relevant to this group and seek mechanisms to deliver appropriate e-safety messages.
- Continue to work with the Police and CEOP to obtain regional and local data regarding E safety incidents.

SERIOUS CASE REVIEW COMMITTEE

The purpose of the Serious Case Review Committee (SCRC) is to ensure that all serious childcare incidents (SCCI) referred are considered to ascertain if they meet the criteria for a Serious Case Review. Should this be the case the committee would advise the Chair of PSCB accordingly and ensure requirements of the statutory guidance (Working Together 2013) are met. Once a Serious Case Review has been completed and recommendations with agency action plans have been agreed, the implementation and completion of these action plans is monitored by the Serious Case Review Committee. Any lessons learned as a result of this review process should be disseminated widely.

Membership of the SCRC has been widened this year with the welcome addition of a representative from the Children and Family Court Advisory and Support Service (CAFCASS).Partner agencies have the opportunity to refer cases considered to be SCCI to the committee for scrutiny and review if there are concerns about inter-agency practice. The resultant recommendations and actions for agencies involved with the families discussed will be evidenced to and monitored by the SCRC.

During the course of this year the committee has been responsible for monitoring the implementation of agency action plans relating to a 2011 SCR. All agency action plans were completed by June 2012. The committee reported to the PSCB board members on progress made following the implementation of action plans in November 2012

The SCRC met on 6 occasions during this period and reviewed a total of 4 Serious Child Care Incidents. Three of these cases resulted in recommendations for future practice to agencies involved. Importantly one of the new cases referred led to the recommendation for a Serious Case Review. This was initiated in February 2012 with the completed report submitted to Department for Education in October 2012. The Care Proceedings concerning the siblings of the index case resulted in a delay in publication of the overview report

Analysis of the Serious Case Review completed in 2012 identified that there was an overlap in the time period of the agency chronologies with 2011 Serious case Review and as a result of this that there may be issues common to the both 2011 and 2012 Serious case reviews. Consequently, the SCRC has been responsible for the identification of any common issues and also the review and monitoring of actions implemented to address these. PSCB members has received updates on progress made during the period of this report

Aims for 2013/14

During this perio*d* the SCRC will work with the Monitoring Evaluation and Scrutiny Committee (MESC) and the Professional Practice Committee to ascertain the progress and any subsequent improvements made following the implementation of agency action plans for the SCR completed in 2012.

In addition to this the Committee will continue to consider children and families referred and make recommendations with suggested actions as appropriate to Portsmouth Safeguarding Children Board the aim being that of continuous improvements to inter agency working.

Finally it remains the responsibility of the Serious Case Review Committee to ensure that the statutory guidance in Working Together 2013 relevant to the work of the committee is implemented.

CSE COMMITTEE

Background

The Childhood Sexual Exploitation (CSE) Subcommittee was formed in September 2012, transforming what had been originally set-up as a task and finish group. The Board recognised the need for on-going implementation of a multi-agency action plan in order to effectively safeguard children who were at risk or had been sexually exploited. CSE was one of the Board's main priorities and has challenged the Children's Trust Board and the Health and Wellbeing Board.

Membership

The core members are Police, Children's Social Care, Barnardos, Solent NHS Trust, Portsmouth City Council and the Portsmouth Safeguarding Children Board. Whilst the Police have been identified as the lead agency to chair the group, recent restructuring has impacted on their availability to lead the group.

Workplan

The workplan of the Subcommittee has been informed by and linked to 3 main drivers:

- The 4LSCB Missing, Exploited and Trafficked (MET) Group, led by the Hampshire Constabulary to coordinate development work across Hampshire, IOW, Southampton and Portsmouth area. They developed a 6 point action plan, which underpins the local action plan.
- The structure recommended by the National Working Group for sexually exploited children and young people
- Priorities D & E of the Children's Trust Plan, including Targeted Youth Services, the local safeguarding training & the Joint Action Team

The 6 workstreams of the Action Plan are:

- To improve the identification of victims of CSE
- To improve the engagement of and support to victims of CSE and their families
- To improve governance and commissioning around CSE
- To improve disruption activity of CSE perpetrators
- To improve prosecution of perpetrators and support victims
- To improve prevention through universal and targeted work with young people

An Operational Group of key partners (Children's Social Care, Police and Barnardo's service) has been set up to further enhance existing good multi-agency practice around CSE and missing young people. A database of young people at risk of, or already experiencing, sexual exploitation has been created. The purpose of the database is to ensure that every young person at risk has a named lead professional, an up to date risk assessment and a safety plan in place. Every child is being risk assessed to understand

the level of risk. The Operational Group meets fortnightly to update the database and share key information to enhance multi-agency safeguarding practice.

In addition, the database is being used to draw connections between vulnerable young people which is to be used to support disruption activity.

There has also been a concerted effort to improve awareness through the implementation of an e-learning training package and a multi-agency conference. Additionally, the PSCB has funded the printing of leaflets to highlight the issue of CSE which have been distributed to young people and practitioners in the city.

In order to improve the engagement of and support to victims of CSE and their families, joint work with Southampton City Council has been undertaken to develop a joint tender for a specialist CSE service. This will secure a more sustainable 5 year contract; ensuring young people are effectively supported.

CSE knowledge and skills development has been built into the induction for targeted youth workers and contraceptive and sexual health outreach support is available to all identified young people. There are 10 schools participating in PSHE pilot to educate them about the danger of going missing and CSE.

There has been limited progress in relation to disruption activity and prosecution of perpetrators. However having an agreed police lead now for CSE will help move this forward during 2013/2014.

Interface between the E-Safety Committee and the CSE Committee is developing with a development day planned.

Appendix 8: Income and expenditure

BUDGET OUTTURN AT APRIL 2013

Income	Funding	Income Received	Outstanding	Invoice address
Carry forward 2012/2013	£37,033.75	£37,033.75	£0.00	
Portsmouth City Council	£107,600.00	£107,600.00	£0.00	Includes 1% inflation
Portsmouth NHS Clinical Commissioning Group (CCG)	£27,000.00	£2,469.46	£24,530.54	Jackie Charlesworth, XXVRENNIE, NHS Portsmouth CCG, 10R Payables K075, Phoenix House, Topcliffe Lane, Wakefield, WF3 1WE.
Police	£11,445.00	£1,046.78	£10,398.22	ACC L Nicholson, Police Headquarters, West Hill, Romsey Road, Winchester, SO22 5DB.
Probation	£2,000.00	£182.92	£1,817.08	Teresa Richards, Business Support Manager, Hampshire Probation Trust, Portsmouth & Isle of Wight LDU (Local Delivery Unit), 6th Floor, Enterprise House, Isambard Brunel Road, Portsmouth, PO1 2RX.
Naval Personnel & Family Service	£240.00	£21.95	£218.05	Sheila Owens-Cairns, Area Officer, Eastern Region & Overseas, Naval Personal and Family Service, Swiftsure Block, HMS Nelson, Queen Street, Portsmouth PO1 3HH. (fleet-npfs-eo-areaofficer@mod.uk)
CAFCASS	£550.00	£50.30	£499.70	Mandy Lowrie, CAFCASS, Ground Floor, Peninsular House, Wharf Road, Portsmouth, PO2 8HB
Total Funding	**£185,868.75**	**£148,405.16**	**£37,463.59**	

Expenditure	Allocation	Expenditure to Date	Variance
Staffing costs	£99,684.22	£57,968.23	£41,715.99
Serious Case Review	£25,000.00	£384.10	**£24,615.90**
Non staffing costs	£6,400.00	£3,493.58	£2,906.42
HCC - on line CP procedures maintenance	£656.25	£656.25	£0.00
Tri-ex - website maintenance	£600.00	£600.00	£0.00
Contribution to Chronolator Licence – Hampshire	**£406.00**		£406.00
Publicity & Promotions	£6,300.00	£1,690.00	£4,610.00
E-Safety Awareness Campaign	£5,000.00	£1,847.50	£3,152.50
Child Sexual Exploitation	**£6,000.00**		£6,000.00
Child Death Overview Process to HCC	£12,439.00	£12,439.00	£0.00
Monitoring Evaluation & Scrutiny Committee	£5,000.00	£5,000.00	£0.00
PSCB Development Day	£1,466.66	£1,466.66	£0.00
LADO Consultancy	£5,000.00	£5,000.00	£0.00
Unallocated funding	**£11,916.62**		£11,916.62
Total Expenditure	**£185,868.75**	**£90,545.32**	**£95,323.43**

Staffing Breakdown	Cost
Independent Chairs costs	**£18,081.00**
Secretarial costs	£18,983.00
E-Safety Officer	£13,968.72
LSCB Manager cost	**£48,651.50**
	£99,684.22

Notes:

- Surplus funding up to 25% of partners contributions £148,835 can be carried forward to 2014/15 (£37,208.75)
- Staffing costs may increase/decrease - one month vacancy saving has been estimated for LSCB Manager post pending clarification.
- The income received from external partners relates to the refund owed from 2012/13.
- **As at 4th November the unallocated funding, unspent allocation and the variance on the allocation for the Serious Case Review (highlighted above) amount to £42,938.52.**