CHILDREN AND YOUNG PEOPLE
OVERVIEW AND SCRUTINY COMMITTEE

15 JANUARY 2013

MEDWAY SAFEGUARDING CHILDREN BOARD
BUSINESS PLAN 2012/13 – MID TERM
PROGRESS REPORT

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Summary

This report provides a progress update of the Medway Safeguarding Children Board's (MSCB) business plan for 2012/13 which will inform the Annual Report for 2013.

The report and an accompanying presentation to be made to the Committee by the Independent Chair of MSCB will enable members to scrutinise the performance and plans of the Board.

1. Budget and Policy Framework

1.1 The Medway Safeguarding Children Board (MSCB) is set up under the Children Act 2004 and has the following main objectives:

- To **coordinate** what is done by each agency represented on the Board for the purposes of safeguarding and promoting the welfare of children in Medway
- To **ensure the effectiveness** of what is done by those agencies for that purpose

1.2 The MSCB has a pooled budget made up from financial contributions from its constituent statutory partners:

- Medway Council
- Kent Police
- Kent Probation
- NHS Medway
- Medway Secure Training Centre
- HMP YOI Cookham Wood
- Children & Family Court Advisory and Support Service (CAFCASS)

2. Background

2.1 As part of the Board's governance arrangements, the Independent Chair of MSCB presents progress reports to the committee twice a year to enable Members to scrutinise performance and to hold the Chair to account for the impact of the work of the Board.

2.2 The importance of robust and regular overview of MSCB's work by elected Members is consistent with best practice identified in the statutory guidance Working Together 2010. The Lead Member for Children's Services and the Portfolio Holder for Children's Social Care both sit on the MSCB in participant observer roles.

2.3 The MSCB is not responsible for the direct commissioning or delivery of safeguarding services. Its statutory role is to ensure the effectiveness and coordination of the work of local partners individually and collectively to safeguard and promote the welfare of children. It does this through developing policies and procedures, commissioning multi agency safeguarding training and through challenge, support and quality assurance activities.

2.4 Local Safeguarding Children Boards (LSCBs) are required to produce annual business plans which set out their multi-agency agreed priorities and expected work programme for the year ahead. MSCB's current business plan was presented to this committee in July 2012.

2.5 The business plan includes both single agency and multi-agency objectives that partners have prioritised for safeguarding children and young people in Medway and they may continue over a longer period than one year. Priorities are identified from a local safeguarding needs analysis, key objectives set by single agency partners, and may include national priorities. A summary of the 2012/13 objectives are:

I. Demonstrate how partners safeguarding activity improve outcomes in children's lives
II. Ensure the effectiveness of partners' early help pathways and joint working to safeguarding children in Medway
III. Demonstrate how MSCB adds value/impact on the safety of children and young people in Medway
IV. Ensure that procedures are in place, as required in the revised Working Together document and other Munro promoted reforms are implemented in Medway, to improve safeguarding practice
V. Ensure the public, including children, are aware of who to contact when there are concerns about a child's safety or welfare or seek help themselves.
VI. Ensure that children who live in households where domestic abuse is a factor are identified, protected and supported.
VII. Reduce the incidences of children who are trafficked or sexually exploited

2.6 These objectives are aligned with the priorities set out in the Children and Young People's Plan 2011 - 2014

2.7 Partner agencies agree to be the lead for each objective. They also are expected to evidence how they make a difference to families and improve outcomes for children. They report on progress to MSCB at regular intervals.

3. MSCB Strategic Objectives and Progress for 2012/13

3.1 Progress against each objective, as set in the business plan, are shown in the attached table.

4. Serious Case Reviews (SCR)

4.1 Serious Case Reviews (SCRs) are required to be undertaken when a child dies and abuse or neglect is known or suspected to be a factor. Additionally LSCBs may decide to conduct a SCR when a child has been seriously harmed and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children.

4.2 The MSCB is currently working on the third Medway SCR, which involves the death of a 17-year-old boy, who died of drowning. This is due to be completed in February 2013. The MSCB is also contributing to an out of area SCR concerning the death of a 15-year-old boy who was in custody within Medway. This is due to be completed in January 2013.

5. Child Death Overview Panel

5.1 The MSCB Child Death Overview Panel continues to review the deaths of Medway children in a timely manner with full support from all statutory agencies. Outcomes from reviews continue to improve practice and support positive sharing of information. Actions from the CDOP annual report are continuously monitored and reported to the MSCB biannually.

6. Risk management

6.1 Whilst there are no specific risks identified, the MSCB annual report presents an analysis of safeguarding in Medway and works to challenge and support the Council and its other partners to address and reduce risks to children.

7. Consultation

7.1 The MSCB Business Plan is the product of consultation with statutory partners through their representatives on the Medway Safeguarding Children Board. Board partners have reported to the Board on their progress against their specific single agency safeguarding objectives on the basis of the priorities in this report.

7.2 The annual report was presented to the Medway Children's Trust on 10 May 2011.

8. Implications for looked after children

8.1 As many of the children who are looked after will themselves have been the subject of safeguarding and child protection services and arrangements, then improvements in those arrangements will benefit this group.

9. Financial and legal implications

9.1 MSCB is a statutory body funded through financial and "in kind" contributions from local agencies. There are no legal or financial implications for the Council arising from this report.

10. Recommendation

10.1 It is recommended that the Committee scrutinise the progress report against the MSCB Business Plan and make any recommendations to the Board for issues to be addressed.

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Background papers

- Medway Safeguarding Children Board Annual Review of 2010/11 and Business Plan 2011/12 can be downloaded at: http://www.mscb.org.uk/Files/Publication/MSCB%20Annual%20Report%20final.pdf

MSCB STRATEGIC AIMS AND SPECIFIC OBJECTIVES FOR 2012/13

Aim 1: To ensure the effectiveness of the work of local partners to safeguard and promote the welfare of children

Obj 1.1	**Demonstrate how partners safeguarding activity improve outcomes in children's lives**	
Ref	**Action**	**Progress report December 2012**
1.1.1	Develop more detailed understanding of the impact of agencies' work to safeguard children by supporting a further 3 agencies to implement the MSCB QA Framework. To continue to support the 3 pilots, relating to the safeguarding objectives identified in their single agency objectives Progress will be monitored twice during the year by the QACR subgroup and evaluated and reported by the MSCB in early February 2013.	In 2011/12, the MSCB implemented a quality assurance framework which shapes the quality assurance work of the Board as a whole and which is being piloted by Medway Secure Training Centre (STC), Her Majesty's Young Offenders Institute (HMYOI) Cookham Wood and Medway Community Healthcare (MCH). The three agencies all report good progress. Agencies provide evidence of activity, outcomes and views of the child and service users. Some partners found the framework so beneficial they are extending use of it to evidence how they are making a difference to work beyond safeguarding arrangements. Obtaining evidence of outcomes is easier for those that work directly with children and young people (STC, and HMYOI). Feedback also shows that demonstrating outcomes takes time as does changing working processes. Agencies that have had recent inspections particularly welcomed their ability to demonstrate improvements through the use of the framework. An example of specific improvement includes: Secure Training Centre • Use of restraint reduced by 28% between 2011 and 2012. Use of separation has also reduced • Assaults on staff have reduced by 31% from 2011 to 2012. Assaults by young people on other young people have reduced by 63% for the same period.

		HMYOI Cookham Wood • Decrease in young people who say that they have been victimised from 33% in 2010 to 15% . • 100% of young people receiving training in how to de-escalate conflict. This is now included in the induction programme and has resulted in the reduction in the amount of force used for non-compliance. • Young people feel safer than when last inspected and safer against comparators in similar establishments. In 2010 - 44% felt unsafe and 2012 - 23% felt unsafe. • Internal survey asked the question “Have you ever felt unsafe at Cookham Wood” and 73% answered No. In 2012/13 Medway Youth Trust, Kent and Medway Partnership Trust (KMPT) and CAFCASS have implemented the framework in their organisations. A number of the objectives are process changes. An example of specific improvement which has made the difference to the lives of children includes: KMPT • Staff have reviewed their caseloads to ensure that all those with children are identified. • Frontline practitioners have identified patients who are parents and have made them aware of the service’s need to focus on outcomes for children in order to ensure they are being met, aswell as the parents’ own needs. • KPMT are able to work with practitioners to establish how they identify where a child’s needs may not have been met by their parent. Subsequently they are then able to explore which is the most relevant way to work towards being met, including the use of CAF rather than reliance being on referrals to children’s social care.

		Medway Youth Trust • MYT have recruited and trained young volunteers as quality researchers. Their role is to contact all young people that have had dealings with MYT so that they can assess what good will look like. • Questions on the feedback surveys completed by young people are being changed to include questions about feeling safe. CAFCASS • Service user survey has been carried out in relation to service user engagement – awaiting results. • Work to be carried out targeting the voice of the child – awaiting the results. Kent Probation has recently adopted the framework; Kent Police are currently at the planning stage of adopting the framework.
1.1.2	Monitor and assess the effectiveness of post inspection improvements put in place within the Ofsted and CQC Inspection plan to ensure improved performance and outcomes are sustained.	MSCB has received regular updates on progress in delivering the post Ofsted/CQC inspection action plan from the Director of Children's Services and the PCT lead. With the exception of implementation of the new electronic case record within children's social care, which is progressing and on track for April 2013, the Board has received reports showing all actions have been completed. The Board has been keen to track the sustained impact of the changes implemented on quality of practice and outcomes for children. In that context, at its November meeting it decided to focus on two thematic system wide issues – quality of assessment and the operation of thresholds in order to identify the most vulnerable children. MSCB will receive an update at its January meeting.

1.1.3	To monitor and assess the effectiveness of improvement plans put in place by KMPT to ensure that outcomes for children are included in the assessment of parents who have mental health issues. This will be achieved through the piloting of the MSCB QA Framework.	In August 2011 MSCB quality assurance sub group identified concerns from its auditing work of KMPT not identifying issues for children's safety and wellbeing where parents had significant mental health problems. As a consequence the Board raised these concerns with KMPT who undertook a thorough internal review as well as employing staff with additional safeguarding responsibilities. The report concluded in January 2012 with 11 recommendations. An improvement action plan was put in place and the action plan is monitored through the Quality Assurance and Case File Audit Group. The next full review is the end of January 2013. In relation to the recommendation subject to this objective KMPT have made the improvements noted above through their implementation of the MSCB QA framework – see above.

1.1.4	Monitor and assess the effectiveness of post inspection improvements put in place by CAFCASS to ensure improved performance and outcomes are sustained through the piloting of the MSCB QA Framework	In February 2011 Ofsted found that safeguarding in private law proceedings within CAFCASS was inadequate. The safeguarding judgement did not relate to public law cases inspected (please note the inspection covered both Kent and Medway). In particular it concluded that in 2011 • Staff did not apply consistently Cafcass safeguarding policies and procedures. • Monitoring by managers of staff compliance with safeguarding policies was not used effectively. • Although some safeguarding practice was strong, in too many cases the assessment of risk was inaccurate. This meant that some assessments were too cautious and in others the risk was underestimated or missed altogether. • Some schedule 2 letters (work to first hearing – Private Law) to court did not follow Cafcass guidance on reporting information to court about the relevance of previous convictions An internal inspection of the CAFCASS service in July 2012 carried out by CAFCASS senior managers, which included both Private and Public law cases found: • Although the quality of work across the service area is variable and some does not meet a required quality standard, the practice overall is safe. • Some good engagement with children and young people

		• Some examples of comprehensive and timely assessments including risk assessment • The appointment of a permanent Head of Service in January 2012 has brought stability and there are significant improvements since the last internal inspection • Clear evidence of improved oversight of casework by service managers • Case allocation and throughput is good with no avoidable delay.
1.1.5	Scrutinise the impact of NHS reforms on safeguarding practice to ensure any detrimental impact is minimised.	The board has been fully involved in the consultation with the Social Director for Safeguarding NHS Kent and Medway in relation to the reforms. On a positive note the Medway CCG will be the host overall for the safeguarding arrangements in Kent and Medway. A full report on the reforms is due before the MSCB in January 2013.
1.1.6	To scrutinise and review the impact of the current economic recession and the reduction in public spending in the delivery of safeguarding services to children and their families and to ensure any detrimental impact is minimised.	This objective will be discussed at MSCB in March 2013.

Obj 1.2	Ensure the effectiveness of partners' early help pathways and joint working to safeguarding children in Medway	
Ref	**Action**	**Progress report December 2012**
1.2.1	To receive reports regarding early help pathways and work in partnership with the Children's Trust and the Health and Well-being Board and Clinical Commissioning Groups, to implement recommendations to improve and support early help pathways within Medway.	The council has been developing work on a number of strands to improve early help pathways. It has re-commissioned CAMHS. C4EO – an organisation established to share best practice, has been commissioned to review Medway's Family Information Service. The South East Regional Intern Programme has been commissioned to assess Medway's early help services. The council will be updating the Board on progress at the January Board meeting. Formal arrangements with Health and Well Being Board to be agreed (lead officer for H&WB, the Director of Public Health, is a member of MSCB). The CCG has committed to establishing an integrated commissioning team for children and adults services with the council. This will give the opportunity to look at new early help pathways.
1.2.2	Support the Children's Trust to identify and resolve issues relating to poor CAF uptake and ensure that the link between assessment provided through CAF process and the prevention of children and their families requiring statutory intervention is fully understood.	MSCB is supporting the Children's Trust Board in relation to the CAF process. As a result regular updates are provided to the Quality Assurance and Case Review Board. The MSCB Quality Assurance officer will be assisting with a quality assurance audit of CAFs in early 2013. The numbers of CAF's initiated by partners, excluding schools remains relatively low although there has been an increase in the numbers raised. (Calendar year 2010 – 199, 2011 – 409 and Calendar year to September 2012 – 413) Other partners are often involved in the CAF but do not take the lead role and the CAF team are seeking to record this information. New CAF forms and processes have been developed and now subject of a trial.

		The intention is to gain more detailed information at closure on desired outcomes – what has changed for the child/young person/family as a result of the process. This will include distance travelled scores, monitoring at each stage of the process by the CAF team, and comments from parents/carers and feedback from Lead professionals, on the process and the services used or available through out the CAF process. At the current time it is not possible to identify the number of children where the CAF process diverted them from being referred to Social Care. The introduction of an eCAF system should identify how many children have been referred to Social care but not met the criteria and a CAF was started. Feedback questionnaires are currently being sent when the CAF team are notified that the CAF has closed. The return rate is extremely low and the CAF team are looking to change this process, by introducing a short CAF closure form. A joint CAF Pilot commenced in September 2011 involving Midwives and Health Visitors and capacity issues were addressed as part of its remit. The aim of this work was to increase the use of the CAF amongst these groups of professionals. Reports received indicate evidence of some increased use but progress has been slow. During the pilot, 13 CAFs were completed and the pilot was extended**.** It has been agreed that rather than 4 champions leading on CAFs, all midwives will now participate in the CAF process to increase pace of use. Data from the CAF coordinator indicates that between January and September 2012, 7 CAFs have been instigated by MFT staff, 5 by midwives.

Aim 2: To ensure the effective co-ordination of local work to safeguard and promote the welfare of children

Obj 2.1	**Demonstrate how MSCB adds value/impacts on the safety of children and young people**	
Ref	**Action**	**Progress report December 2012**
2.1.1	Review the effectiveness of MSCB through independent review	Ofsted, in its inspection of safeguarding undertaken in October 2011 graded Partnership Working in Medway as being "Good", commenting that the MSCB was "well established and very effective" and that it "regularly reviews progress on priority agencies of safeguarding such as domestic abuse… and provides robust challenge where necessary". However expectations nationally of what LSCBs should do are being extended, in part due to recommendations made by the Munro review and this changing landscape is evidenced in inspection reports of some authorities. Evidence of how MSCB adds value and impacts on the safety of children is illustrated in other business objectives but as a consequence of changing expectations of LCSBs, and in line with MSCB's commitment to continuous improvement, it embarked on an extensive self evaluation programme starting in January 2012 which comprised of 3 strands • An independent specialist in safeguarding observed and reported on 3 Board meetings and 2 subgroups for a research project on success and collaboration in child protection work • The former DCS undertook a self assessment in July 2012 with 11 Board members using the framework from the Ofsted 'Good Practice by LSCBs' • Reflections of the Independent Chair (who had been in post 4 months at the start of the review period) and compared to national findings of LSCBs.

		The recommendations from the evaluation were agreed by MSCB in November 2012 and have begun to be implemented. They include: I. An executive group should be established to support and drive the effectiveness of the board and ensure statutory duties are met including how the board evaluates early help pathways and engages with children, young people and practitioners and responds to what they say II. Officer capacity of MSCB is enhanced by using existing Board funding paid by partners to support the work of the Board and the increased expectations of its work. III. More work is needed on how the Board is able to ensure the sustained impact of improvements that have been made. IV. A review of how MSCB and the Children's Trust Board work together to improve outcomes for children and young people V. All board members to commit to providing evidence based examples of up to date safeguarding practice to ensure that the Board is able to hold each other to account effectively. VI. A review of how school representation enables all schools and academies to be engaged with MSCB is undertaken to ensure good communication flows as required in Working Together. VII. Business planning processes are checked to ensure that they encourage challenge, a focus on priorities and are user friendly

Obj 2.2	Ensure procedures are in place to improve safeguarding practice	
Ref	**Action**	**Progress report December 2012**
2.2.1	Promote take up of all single agency and multi-agency safeguarding training and establish measures of quality, impact and relevance of training on safeguarding practices.	The Children Act 2004 section 11 places a responsibility on key organisations to make arrangements to safeguard and promote the welfare of children and young people and LSCBs are required to monitor compliance. In December 2011, a S11 audit was completed with a focus on Staff supervision, awareness, and training on safeguarding and promoting the welfare of children for all staff working for, with or in contact with children and families depending on the agency's primary functions. The s11 audit demonstrated that training requirements of staff are met and training is available and discussed in Personal/Professional Development Reviews (PDRs). However there is little evidence of how training is monitored for impact on practice. Services do not report to have systems of post course evaluations, which would support the monitoring of impact. The MSCB Learning and Development subgroup is currently piloting an on line post course evaluation to establish the impact of learning and development on safeguarding practice and ultimately, outcomes for children. This will be used for MSCB training courses, and, , as part of the pilot, Medway Community Healthcare training for its own staff. Lessons from this process will support the practice for other services in 2013. The L&D subgroup has also reviewed examples of single agency training programmes to quality assure content in relation to the MSCB minimum standards of competency for safeguarding. In 2013 a comprehensive minimum standards framework will be developed which will include learning from serious case reviews (SCR) and domestic homicide reviews (DHR). Services will be audited for their compliance with the framework and be asked to evidence how many staff have accessed training. The MSCB provides basic and intermediate training and is committed to a

		minimum of 200 places across these courses, a further 200 spaces for domestic abuse training and further training opportunities as needs are identified i.e. through SCRs and DHRs.
Obj 2.3	**Ensure children and general public are aware of who to contact when they have concerns**	
Ref	**Action**	**Progress report December 2012**
2.3.1	Utilise MSCB lay members to support stronger public engagement in child safety issues in Medway and contribute to an improved understanding of the MSCB's child protection work in the wider community	MSCB have three Lay Members who were appointed in March 2011. Their key responsibilities are to: • Support strong public engagement in local child safety issues and contribute to an improved understanding of MSCB's child protection work in the wider community; • Challenge MSCB on the accessibility by the public and children and young people of its plans and procedures; and • Help make links between MSCB and community work. The Lay Members have embarked on a programme of improving marketing and scrutinising work such as the Tell Us Survey to ensure that child safety issues are appropriately considered. They have also met with a representative group of young people who raised concerns about men curb crawling outside of their school area. These concerns have been investigated by the Police who met with the young representatives directly. As a result the Police have made the following recommendations: 1. Consideration for an officer from the Safer Schools Partnership to engage with local schools with a view to offer Awareness Training supported by staff from the Sexual Exploitation Team, to the schools in relation to this subject matter, how to act if approached under such circumstances and the need to report to police.

		2. Medway Police to continue to monitor the reporting of such incidents as described (by the young people) through their daily Intelligence capture and ensure an appropriate level of awareness, prioritisation, ownership and subsequent enforcement action where deemed necessary via the District Tasking & Co-ordination management meetings. 3. In order to gauge the extent of children and young persons' perception, 'Why report as nothing will be done', and the level of understanding and awareness around Child Exploitation amongst the Medway young people, include a couple of questions on the next Local Authority 'tell us' survey targeted at Medway Young People. 4. In order to establish the level of understanding and awareness around Child Exploitation amongst Parents within Medway police to include a couple of relevant questions on the subject in the next Local Authority 'Life Style' survey targeted at Medway Parents.

Aim 3: To protect and promote the well-being of vulnerable groups of children

Obj 3.1		
Ref	**Action**	**Progress report December 2012**
3.1.1	Establish training input aimed at Child Protection leads in schools and primary health care in order that; • Staff understand the impact of domestic abuse on children • Staff can respond appropriately and confidently and share information in cases where because formal	Medway Community Safety Partnership is the lead group for domestic abuse and they have a sub group to lead on the delivery of Medway's response to the Kent & Medway Domestic Abuse Strategy. In support of this work MSCB seconded their development officer for 2/3 days a week for an interim period to support developments. A full report on this work will be available in January 2013. In February 2012 MSCB carried out case audit and focus group work with

	thresholds for intervention have not been met. This will be based upon the assessment and practice principles as referred to in the RIP children experiencing Domestic Violence research review (2011)	staff from across the partnership to identify barriers to information sharing, particularly in relation to domestic abuse. This confirmed that protocols are in place but staff need greater confidence in using them in relation to their own cases. This work is being addressed through multi agency training delivered by MSCB and the MSCB supervision framework currently being implemented across agencies. Domestic abuse training includes: • Since March 2011, 111 practitioners have accessed MSCB full day course on "Domestic Abuse and Safeguarding Children" • In October 2012, 23 have attended the new DASH training – further dates have been scheduled for early 2013. • New Domestic abuse training competency framework has been developed – launched December 2012. Following the appointment of a specialist domestic abuse nurse by Medway Community Healthcare an awareness audit was conducted after her initial induction period. Awareness of domestic abuse increased in 80% of clinical services, furthermore the consultation support provided by this nurse evidences a greater focus on domestic abuse by health professionals. In September 2012 MCH presented the results of a staff survey to demonstrate the effectiveness and impact of this post. The overall results show that 69% of respondents know where to access advice and support around domestic abuse and it has had a positive impact on their practice. The survey also demonstrated the need to widely advertise and encourage attendance at domestic abuse training. The primary school MSCB representative carried out a survey with all primary heads in Medway in relation to their understanding of domestic abuse/violence as well as other safeguarding issues. Their initial response, which was completed by 42% of primary schools told us that: • 100% were confident that their staff knew what to do if they suspected

		DV – all could say how they ensured this – mostly through training and staff meetings • 100% provide PHSCE – most weekly all said that they would provide ad-hoc support if a child needs it – if it was about violence at home this was almost always one to one • There is a wide variety of support for children and adults across the schools – including counselling, play/drawing therapy and parenting classes – only one school said they had nothing but signposted to other agencies • 74% of schools that replied have a Family Liaison Officer, Home School Support Worker, Community Liaison Officer, School Liaison Officer or pastoral manager but almost half of these people have no regular safeguarding supervision
3.1.2	Process to be put in place to increase the notifications by Police of domestic abuse incidents (As defined by the domestic abuse threshold matrix) to health and education as per the Ofsted recommendation.	Domestic abuse has been a component in just over 40% of cases where children are made subject to child protection plans and was a feature in both of Medway's serious case reviews. It has been a consistent priority for MSCB. The Ofsted inspection in November 2011 reported that they were concerned that notifications of domestic abuse in households with children are not currently sent to health providers or schools by the Police may mean that an opportunity to ensure that information is appropriately shared on lower risk cases is missed. The inspectors recommended that the MSCB ensure that appropriate notification arrangements are put in place to ensure that children affected by domestic abuse are identified, protected and supported. In October 2012 a 6-month pilot of police domestic abuse notifications being sent to 5 schools and health services in an area where there is high level of incidences was started. This has been welcomed by Headteachers and health staff but it is expected that the pilot may identify gaps in services and

		highlight the need for even more training for professionals. In January 2013 Medway Council Adult Mental Health and Mid Kent College and further schools will join the pilot. An evaluation of the logistics and outcomes of the pilot will begin in January 2013 with consideration to a full roll out in April 2013. Outcomes will include: • % of schools and health providers reporting they are receiving notifications of incidents. • % of notifications that have resulted in CAF referral, sign posting into a preventative service as a result of DA notification.

Obj 3.2	**Reduce the incidences of children who are trafficked or sexually exploited**	
Ref	**Action**	**Progress report December 2012**
3.2.1	With Kent, establish a data collection process that scopes the incidents of Child trafficking and sexual exploitation. Identifying trends and indicators of when and where children are at risk.	MSCB has a joint sub group established with Kent Safeguarding Children Board (KSCB) on Trafficking Children and Sexual Exploitation, which was established in 2011/12. The initial aim of the group, led by Police, has been to get an evidence based understanding of the scale of the problem. It collated and analysed data held by Police on both trafficking and sexual exploitation across the whole area and Medway specific police information is now being extracted which will then be reported to the board. At the January 2013 MSCB meeting all members will be asked to identify information they hold that may be significant against known indicators of abuse, as well as identify a lead for their organisation. Once an accurate picture of the extent of trafficking and sexual exploitation in Medway has been established, MSCB will agree an appropriate plan of action.

3.2.2	With Kent, review and develop policies, procedures and training to ensure effective strategy and coordinated multi agency response to child trafficking and sexual exploitation, to identify and protect these children.	The sub group have published a toolkit as well as guides for frontline staff on how to recognise and combat trafficking of children, it is currently being rolled out to front line staff in Medway. MSCB will learn from evaluation of work that has been carried out by Barnardo's in the Thanet area considering multi-agency response and training for front line staff to prevent, identify and support children who have been or are in danger of being sexually abused. This has resulted in two training sessions to date, which are currently being evaluated. This work will be considered for adoption by MSCB once the evaluation is completed. The Chair of the sub-group held a workshop at the MSCB annual conference to raise awareness for front line practitioners, which was very well received, and more training is planned for 2013.